CITY COUNCIL
CITY OF NEW YORK

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TRANSCRIPT OF THE MINUTES

Of the

COMMITTEE ON MENTAL HEALTH, DISABILITIES AND ADDICTION JOINT WITH COMMITTEE ON FIRE AND EMERGENCY MANAGEMENT JOINT WITH COMMITTEE ON PUBLIC SAFETY JOINT WITH COMMITTEE ON HOSPITALS

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September 23, 2024
Start: 10:14 a.m.
Recess: 4:19 p.m.

HELD AT: COUNCIL CHAMBERS – CITY HALL

B E F O R E: Linda Lee, Chairperson of Committee on Mental Health, Disabilities and Addiction

Joann Ariola, Chairperson of the Committee on Fire and Emergency Management

Yusef Salaam, Chairperson of the Committee on Public Safety

Mercedes Narcisse, Chairperson of the Committee on Hospitals

COMMITTEE ON MENTAL HEALTH, DISABILITIES AND ADDICTION COUNCIL MEMBERS:

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Erik D. Bottcher
Tiffany Cabán
Shahana Hanif
Farrah N. Louis
Kristy Marmorato
Darlene Mealy

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Althea V. Stevens
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COMMITTEE ON HOSPITALS COUNCIL MEMBERS:

Jennifer Gutiérrez
Kristy Marmorato
Francisco P. Moya
Vickie Paladino
Carlina Rivera

OTHER COUNCIL MEMBERS ATTENDING:

Jumaane Williams, Public Advocate

A P P E A R A N C E S

Jordyn Rosenthal, Director of Advocacy at Community Access and Lead Organizer of Correct Crisis Intervention Today

Peggy Herrera, member of Freedom Agenda

Alex Brass, Steering Committee Member of Correct Crisis Intervention Today, New York City

Eva Wong, Executive Director of the Mayor's Office of Community Mental Health

Jason Hansman, Senior Advisor of Behavioral Health Communications and Policy and Office of Behavioral Health and New York City Health and Hospitals

Chief Cesar Escobar with New York City Fire Department Emergency Management System Operations

Captain Michael Butler from New York City Police Department Interagency Operations

Chief Lola Obe from New York City Police Department Training

Deputy Chief Ebony Washington from New York City Police Department Communications

Joshua Levin, Director of Legislative Affairs at New York City Police Department

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

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

Laquisha Grant, Deputy Executive Director of Mental Health Access from the Mayor’s Office of Community Mental Health

Imani Moore, Razi School in Woodside, Queens

Khadijah Jean Pryce, Islamic Cultural Center School located at Upper East Side

Bracha Rutner, Yeshiva University High School for Girls located in Queens

Deanna Philippe, principal of Cristo Rey Brooklyn High School in East Flatbush

Joseph Rosenberg, Director of the Catholic Community Relations Council

Sydney Altfield, Executive Director of Teach NYS

Logan Clark, Assistant Director of Budget Review at the Independent Budget Office

Elliott Jones, Program Manager for the Oakland Fire Department and Director of the Oakland Fire Department's Mobile Assistance Community Responders of Oakland

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

Jeffrey Bustamante, Deputy Director here at Albuquerque Community Safety (on behalf of Jodie Esquibel)

Samantha Rabins, and I currently serve as the Associate Director of Criminal Justice Services at WellPower

Clarisa Alayeto, manages Community and Government Affairs at DREAM, formerly Harlem RBI

Erin Acosta, Director of Family Engagement and Communications at Growing Up Green Charter Schools

Nicholas Tishuk, Executive Director at Bed-Stuy New Beginnings Charter School in Brooklyn

Ramon Leclerc, New Alternatives for Homosexual LGBTQ Youth

Jonathan Chung, Director of Public Policy and Advocacy for the National Alliance on Mental Illness of New York City

Jim Bohovitch, peer specialist

Joelle Ballam-Schwan, Supportive Housing Network of New York

Raymond Schwartz

Grace Nichols, New York Act Up

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

Reverend Terry Troia, Project Hospitality

Bella Soyoung Park, Korean American Family Service Center

Amber Song, Senior Program Coordinator at the Asian American Federation

Kimberly Saltz, law fellow at the Legal Defense Fund

Cassandra Kelly, attorney at the Legal Aid Society's Criminal Law Reform Policy Unit

Alison Wilkey, Director of Government Affairs and Strategic Campaigns at the Coalition for the Homeless

Annalicia Williams

Sasha Myrie

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

Arlene Machado, Case Manager for the Bronx Heroin Overdose Prevention and Education Initiative of Bronx Community Solutions

Victor Herrera, leader and member of Freedom Agenda

Chaplain Dr. Victoria Phillips

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

Leah Faria, Director of Community Engagement for the Women's Community Justice Association

Helen Skipper, Executive Director of the New York City Justice Peer Initiative

Alexandra Nyman, recovery coach, founder of the Break Free Foundation

Michael Nugent, Director of Employment Services and Education Services at Baltic Street Wellness Solutions

Kayla Hackman

Tamara Begel, CCIT-NYC, Healthy Minds, Healthy Kids Council Member

Mark Laster, graduate of the Citizens Police Academy, Third Vice Chair of Queens Community Board Six, and licensed political social worker

Jenna Schugart, NAMI Ambassador

Priscilla Gorem

Katherine Bajuk, 30-year public defender and mental health specialist at NYCDS

Galloway, Advocacy Manager at the Ali Forney Center

Andrew Smith

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

Sabina Saleh, Vice President of Behavioral Health at Project Renewal

Susan Margaret Murphy, President of Drug Intervention Institute in West Virginia

Beth Haroules, Senior Staff Attorney at the New York Civil Liberties Union

Brooke Taylor, Director of Social Work at the Urban Justice Center Mental Health Project

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2 SERGEANT-AT-ARMS: Good morning. This is a
3 microphone check for the Committee on Mental Health
4 jointly with Public Safety, Hospitals, and Fire and
5 Emergency Services. Today's date is September 23,
6 2024, located in the Chambers, recording done by
7 Pedro Lugo.
8 SERGEANT-AT-ARMS: Good morning, and
9 welcome to the New York City Hybrid Hearing on the
10 Committees on Mental Health joint with Public Safety,
11 Hospitals, and Fire and Emergency Management.
12 At this time, please silence all
13 electronic devices.
14 Also, please do not approach the dais.
15 If you have any questions, please raise
16 your hand, and one of us, the Sergeant-at-Arms, would
17 kindly assist you.
18 Thank you very much for your kind
19 cooperation.
20 Chairs, we are ready to begin.
21 CO-CHAIRPERSON LEE: [GAVEL] Good morning,
22 everyone. We have been anticipating this hearing for
23 quite some time, and I'm very excited that the day
24 has finally come. I just want to thank all the
25 advocates for being here. I want to thank the Admin

1
2 and all the Staff for being here, and the Chairs and
3 my Co-Chairs because I have to say we have Council
4 Members who have very crazy schedules so to get four
5 Council Chairs in the room at the same time to
6 schedule something was very, very difficult so I
7 appreciate all of you being here. As I said, good
8 morning, my name is Linda Lee, Chair of the Committee
9 on Mental Health, Disabilities and Addiction, and, of
10 course, I just wanted to take time to thank my Co-
11 Chairs, Joann Ariola, Chair of the Committee on Fire
12 and Emergency Management, Mercedes Narcisse, Chair of
13 Committee on Hospitals, and Yusef Salaam, Chair of
14 the Committee on Public Safety.
15 Before we begin, I'd like to note that we
16 are joined by Council Members Riley, Abreu, our
17 Public Advocate, Council Member Stevens, Council
18 Member Cabán, and of course, Chair Narcisse, Chair
19 Salaam, Chair Ariola, Council Member Brannan, Council
20 Member Louis, Council Member Schulman, Council Member
21 De La Rosa, Council Member Holden, and then on Zoom,
22 we have Council Member Hanif and Council Member Moya.
23 I would also like to thank, as I
24 mentioned, everyone who has joined us today for this
25 long overdue and important hearing on Behavioral

Health Emergency Response Division, also known as B-HEARD, and Responses to Mental Health Crises. We will be hearing two pieces of legislation today, Intro. Number 532, sponsored by Council Member Justin Brannan as well as Introduction Number 1019, sponsored by Council Member Brannan and myself, in relation to reporting and publication of mental health emergency response data.

In June 2021, New York City implemented a pilot program in East Harlem and parts of Central and North Harlem where both mental and physical health professionals responded to 9-1-1 mental health crisis calls, referred to as B-HEARD. According to OCMH, B-HEARD teams operate seven days a week, 16 hours a day, and include two EMTs and paramedics from FDNY EMS as well as mental health professionals such as licensed clinical social workers from H and H. The goal of the program is to route 9-1-1 mental health calls to B-HEARD teams when appropriate to increase connection to community-based care, reduce unnecessary voluntary transports to hospitals, and reduce unnecessary use of police resources.

At this hearing, the Committees will seek an update on and an in-depth overview of the B-HEARD

program, including efforts to maintain and improve the program as well as any plans for its expansion. We are very interested in hearing more about the newly implemented policy strategies that the Administration announced this past Friday as well as the most recent B-HEARD data that has been released. The Committees are also interested in understanding the roles of each agency involved in carrying out the program, how data is collected to evaluate the effectiveness of the B-HEARD program, and any other issues that have arisen related to the implementation or evaluation of the program, all things I'm super interested in because I love data, and also figuring out how to coordinate between agencies.

Today, we look forward to hearing from the Administration and members of public and other interested stakeholders, including those with lived experiences, who have taken the time to come here today and join us so thank you so much. We thank you all.

I would like to thank my own Staff as well as those of the three Committee Staff Members who worked so hard to prepare this hearing. There was a lot of prep involved. Finally, I'd like to thank

1
2 the Mental Health Disabilities and Addiction
3 Committee Staff, Legislative Counsel Sarah Sucher;
4 Legislative Counsel John LaRosa; Senior Legislative
5 Policy Analyst Cristy Dwyer; Rose Martinez, Assistant
6 Deputy Director of Data; and Danielle Heifetz,
7 Financial Analyst.
8 I will now pass it along to my Colleagues
9 for their opening remarks, beginning with Chair
10 Ariola followed by Chair Narcisse and then Chair
11 Salaam.
12 I'd also like to recognize Council Member
13 Marmorato.
14 CO-CHAIRPERSON ARIOLA: Thank you, Chair.
15 Good morning, everyone. I am Joann Ariola, Chair of
16 the Committee on Fire and Emergency Management.
17 First, I'd like to thank my Colleagues, Chairs
18 Narcisse, Lee, Salaam for collaborating in leading
19 today's important hearing.
20 The medical emergencies involving
21 individuals experiencing mental health crises present
22 unique challenges to first responders and our society
23 at large. The potential volatility and
24 unpredictability of these emergency calls can create
25 meaningful risk of escalating violence that has too

often led to serious injury to first responders and individuals desperately in need of mental health care. As a City, we have an obligation to our citizens and to our workforce to establish training protocols, emergency procedures, and a multi-agency response that bring treatment and care to those experiencing mental health crisis while still ensuring protections are in place that protect the life and safety of our first responders and civilians alike. As you've heard from Chair Lee's statement, the B-HEARD program is one example of a multi-agency response to mental health crisis, one that aims to provide clinical support to those in need.

I am eager to hear from the FDNY, H and H, and NYPD regarding the operations of B-HEARD, evaluations of the success, and limitations of the program, and examine the Administration's vision for the future of B-HEARD and how the City aims to improve outcomes for mental health calls.

I'm also interested in hearing from FDNY about their ongoing efforts to afford EMS workers the training, support, and protections they need to successfully navigate mental health calls as

ambulance workers have increasingly faced occurrences in the workplace that are violent.

Again, thank you all for being here today and hopefully at the conclusion of today's hearing, we will have a better understanding of how the City plans to address the needs of New Yorkers with serious mental illness as well as provide the necessary tools, training, and safety equipment needed for our first responders. Thank you so very much for the time.

CO-CHAIRPERSON NARCISSE: Good morning, everyone, and I want to say thank you to Chair Ariola, Chair Salaam, and my name is Mercedes Narcisse, and I'm the Chair for Committee on Hospital, and thank you, Chair Lee and the Committee on Mental Health and Disabilities and Addiction for spearheading the effort to organize this hearing to discuss the B-HEARD program and our City's approach to addressing mental health crisis. As Chair Lee stated, it has been a difficult task to put this hearing together to listen to B-HEARD because you play really a key role right now more than ever in our community in New York City.

Across the city, B-HEARD has been implemented as a pilot program in high needs areas to provide holistic health-centered care to individuals experiencing mental health emergencies. B-HEARD teams are trained in providing crucial emergency responses that can include mental care, mental health treatment, de-escalation tactics, and linkage to appropriate care. I heard that. New York City Health and Hospitals employs social workers who work alongside EMT and EMS staff as B-HEARD team responders to deliver the excellent mental health expertise that individuals in crisis need and deserve.

Since its launch in 2021, B-HEARD has played a critical role in improving the safety and health of New Yorkers that they serve, but the program has plenty of room to grow, both in capacity and agency coordination. As of August 2024, New York City Health and Hospital Corporation had 42 social worker positions dedicated to B-HEARD program which is currently active in 31 of the City's 77 police precincts. In March of 2023, the Mayor pledged that B-HEARD teams would become available in all police precincts across the city. Yet, that plan has stalled

2 due to Administrative budget constraints and hiring
3 challenges. We know that this type of response system
4 is effective in caring for individuals going through
5 a mental crisis, yet remains awful, or unfortunately,
6 understaffed and under-resourced.
7 Many of our Council Member Colleagues
8 have requested that B-HEARD be expanded to be active
9 in the District, which would allow individuals in
10 crisis to receive appropriate care and thereby
11 improve public safety. I hope that by discussing the
12 merits and the attention to the necessity of
13 expanding this program, a holistic health-centered
14 approach to individuals experiencing mental or
15 behavioral crisis and the only way is the only way
16 forward, and I'm hopeful that we can provide New
17 Yorkers with the care that they need and they deserve
18 and they can be successful.
19 As a registered nurse for over three
20 decades, I have come close to all this mental health
21 crisis. When somebody in their mental crisis, they
22 need someone that understand what they're going
23 through, someone that experience, and not only
24 experience, sometimes you need life experience to be
25 able to help someone in crisis so I want to say thank

you for all the team that here, and I'm looking forward to hear from you.

Now, I will turn it over to Council Member Salaam for his opening remarks.

CO-CHAIRPERSON SALAAM: Thank you. Good morning. I'm Council Member Yusef Salaam, and I am the Chair of the Committee on Public Safety. I'd like to thank the Chairs Lee, Narcisse, and Ariola for joining the Public Safety Committee in convening this most important hearing, and I'd like to also thank the Committee Members who have joined us for this hearing.

As my Colleagues have eloquently stated, today's hearing is an opportunity for the Council to examine how the City can compassionately and safely respond to mental health emergencies. Looking back, history has demonstrated that law enforcement responses to people experiencing mental health crisis can create undue risk of already escalating tensions. Due to fear of arrest, excessive force, or involuntary hospitalization, police presence can trigger heightened reactions by individuals in mental health crisis, which can result in dangerous police-civilian interactions and too often lead to tragic

consequences. I want to note that this is not police-criminal interactions, but rather police-civilian interactions. That's why investing in alternative programs such as B-HEARD, which seeks to identify appropriate circumstances for non-police responses to mental health calls is so essential as part of the City's holistic efforts to address growing mental health needs. To achieve further success, we must continue to train clinical professional and be sure to expend City resources in a way that does not result in increased criminalization and/or victimization of some of the most vulnerable New Yorkers.

Specifically, regarding the NYPD, I'm interested in hearing how officers are trained to successfully navigate engaging with people in mental health crisis and how they de-escalate volatile situations, how emergency calls are dispatched such that NYPD call-takers are provided with the training, processes, and information needed to appropriately triage emergency mental health calls, how NYPD procedures for mental health calls aim to de-escalate situations and protect both civilians and first responders, and how procedures can be improved such

that our City does not fail to protect the lives of vulnerable New Yorkers in crisis, such as the late Winn Rosario, Kawaski Trawick, Deborah Danner, and many others.

I look forward to hearing the Administration's testimony and the valuable perspective brought by members of the public and experts who dedicate their lives to providing care and service to those with mental health issues, and I challenge the Administration to develop long-term strategies that ensure fair compassion and practical approaches for providing care when responding to mental health emergencies.

Additionally, the Public Safety Committee will be hearing unrelated legislation, Intro. Number 532, sponsored by Council Member Brannan, which would expand the existing program to provide reimbursements to non-public schools for expenses related to hiring of unarmed security guards. With that, I yield to Chair Lee.

CO-CHAIRPERSON LEE: Thank you. Thank you so much.

1
2 Now we will hear from Council Member
3 Brannan who will make a brief statement on the two
4 bills we're hearing today.
5 COUNCIL MEMBER BRANNAN: Thank you, Chair
6 Lee, and thank you to this Committee for hearing two
7 of my bills today, Intro. 1019 with regard to
8 reporting and publication on mental health response
9 emergency data and as well as my Bill 532, which I'm
10 proud of that relates to unarmed security in non-
11 public schools.
12 The safety and security in our schools
13 should always be non-negotiable. There's nothing more
14 important than keeping our kids safe, and when it
15 comes to their well-being, we can't afford to take
16 chances. Anything we do to enhance their safety, it
17 should be a non-brainer for this Body and for the
18 City. For school communities not covered by public
19 school safety agents, we have seen firsthand how
20 effective our City's non-public school security guard
21 program can be. The positive results from its initial
22 rollout demonstrate its value, and expanding this
23 program to cover more schools and a greater number of
24 students is a logical step forward. By investing in
25 our children's safety, we empower them to focus on

what truly matters, learning and growing in a safe environment. The shift in focus leads to improved educational outcomes, fostering a brighter future for all of us.

I want to express my heartfelt gratitude to the families, the schools, and the stakeholders who've actively engaged on this critical issue for many years since the original bill was passed back in 2019. Your voices and concerns have driven us to this point today where we can confidently move forward with this crucial legislation. It's clear that expanding our support for non-public school security guards is a win not just for our kids, but also for their families and our communities today and for generations to come. So let's unite our efforts and ensure that every child, regardless of their school, has the protection and security they deserve. Together, we can create an environment where students feel safe and secure, allowing them to thrive academically and socially, and putting their parents and relatives at ease. Thank you very much.

CO-CHAIRPERSON LEE: Thank you, Council Member Brannan.

2 Also now we will hear a brief statement
3 from the Public Advocate, Jumaane Williams.
4 PUBLIC ADVOCATE JUMAANE WILLIAMS: Thank
5 you, Madam Chair. Peace and blessings to everyone.
6 Happy Monday. Good morning again. My name is Jumaane
7 Williams, Public Advocate of the City of New York.
8 Thank you to Chairs Lee, Salaam, Narcisse and Ariola
9 and Members of the Committees on Mental Health,
10 Disabilities and Addiction, Public Safety, Hospitals
11 and Fire and Emergency Management for holding this
12 hearing today.
13 Each year, NYPD responds to approximately
14 200,000 calls related to people experiencing a mental
15 health crisis. Despite most often being the first
16 responders, we know that our police are not the best
17 equipped to safely and effectively handle these
18 calls. Additionally, officers have also themselves
19 expressed that they do not want to be responding to
20 these calls. When law enforcement responds to people
21 in mental health crisis, those who need help are
22 often subject to use of force, arrest, incarceration,
23 and at times, unfortunately, even death. In light of
24 tragedies where people in mental health crisis are
25 killed by law enforcement, municipalities across the

2 country have implemented various alternative response
3 models. In 2021, New York City launched a Behavioral
4 Health Emergency Assistance Response Division or B-
5 HEARD. B-HEARD teams are FDNY EMTs or paramedics
6 teamed with a mental health professional from Health
7 and Hospitals, also H and H. These teams operate 16
8 hours a day, seven days a week in 31 precincts out of
9 a total of 77 precincts. It has been heartening to
10 hear that the number of 9-1-1 calls that B-HEARD
11 responds to is increasing, responding to 73 percent
12 of all eligible mental health calls in FY-24, but our
13 goal should be for those teams to respond to every
14 eligible call that comes in. Also note that when you
15 count in the "ineligible," that number drops very
16 significantly to 30 percent, and we have to look at
17 the definitions of eligible and ineligible.
18 Many of the challenges that B-HEARD faces
19 lie in inadequate staffing. There is a shortage of 9-
20 1-1 operators who can appropriately triage the calls
21 leading to default police response. It can be
22 difficult to discern over the phone what is happening
23 at the scene and whether there is a risk of harm or
24 to the caller or to the responders. The City is
25 hiring more 9-1-1 staff and allowing B-HEARD teams to

join or take over the responses to some calls that were initially routed to the NYPD or EMS, but we do not have the data on how often the NYPD or EMS calls in B-HEARD to assist on a call.

It is also imperative to ensure that 9-1-1 dispatchers are properly trained in how to effectively determine which calls can be sent to B-HEARD. Dispatch training must be improved to incorporate dispatching for mental health crisis through ways such as mental health solution tree that will branch off in separate dispatching categories for various responses. Mental health training must be conducted regularly to ensure calls are being appropriately dispatched to the right teams.

Staffing of the B-HEARD teams themselves is also an issue. Currently, the teams only operate 16 hours per day, and calls that are determined to be eligible for B-HEARD response may go to police or traditional EMS anyway because the B-HEARD team is not available. It is understandable that B-HEARD responses may take much longer than a typical police response as de-escalation in determining what an individual in crisis needs takes time. Just want to

point out that shouting at someone to put something down is not a de-escalation tactic.

These calls can also be more challenging than a non-mental health calls to EMS. We should be incentivizing EMS workers and paramedics to join B-HEARD teams and compensating them fairly for the work they are doing. The City should also be allocating funding directly to H and H to hire social workers, mental health professionals, also peers for B-HEARD teams.

While the City has not detailed what a citywide B-HEARD program looks like, if the program scaled up staffing in the same proportion it had in the 25 precincts, that would mean 280 people for all of the City's 277 precincts compared to 35,000 NYPD offices. If we want an effective alternative to police responses to people in mental health crisis, we must be meaningfully prioritizing resources for that response. Otherwise, we continue to endanger not only those who need help, but those who respond, and we have heard the names of Winn Rosario, Kawaski Trawick, and Deborah Danner, Eleanor Bumpurs. I know Ms. Peggy Herrera is here. Mohamed Bah who called to get help and their children are no longer with us.

2 And I'd be remiss if I didn't mention the subway
3 shooting because we do know that Mr. Mickles more
4 than likely was failed by our system long before that
5 shooting occurred.
6 We are at a point in time where we all
7 agree that we need to do more with mental health, and
8 I hope we have the courage to actually put the
9 systems in place so that we don't have to add any
10 more people to those names. Thank you.
11 CO-CHAIRPERSON LEE: Thank you so much,
12 Public Advocate.
13 I just want to recognize we've also been
14 joined by Council Members Zhuang, Bottcher, and
15 Nurse.
16 Now, we're going to hear from a panel of
17 advocates and folks from our communities that have
18 lived experience before moving on to the
19 Administration so thank you all for your patience,
20 and I think it's really important for us to hear from
21 the folks that are sitting here today. We've been
22 joined by Alex Brass, Peggy Herrera, and Jordyn
23 Rosenthal. It doesn't matter which order, whichever
24 order you guys feel comfortable in testifying, please
25 feel free.

1
2 JORDYN ROSENTHAL: Sure, thank you so
3 much. Should I start or? Okay. Thank you to all of
4 the Chairs and everyone. I submitted formal
5 testimony, but anyone who knows me tends to know I'm
6 better off script so we're going to go off script.
7 My name is Jordyn Rosenthal, and I am a
8 social worker, I am the Director of Advocacy at
9 Community Access, which is a nonprofit that helps
10 people with mental health concerns, and most
11 importantly, I'm a peer. I'm a person with lived
12 mental health experience, and also I'm the Lead
13 Organizer of Correct Crisis Intervention Today, CCIT,
14 which is one of the main advocates that was pushing
15 for this hearing. In 2018, I had kind of like my
16 first big advocacy job, and I literally felt like I
17 was driving a Mack truck with a learner's permit and
18 ended up having a mental health crisis in my
19 apartment. My mom almost called 9-1-1 because she was
20 so scared that I was going to hurt myself when we
21 were on the phone and ultimately respected my choice.
22 Now, I'm here to talk about what would have happened
23 if she called 9-1-1, and also what type of response
24 do I want to be met with. I'm not here to shit on B-
25 HEARD. I'm here to say what are the ways that we can

2 make it better so it can serve more community members
3 and connect people in crisis so we don't have
4 situations like Wynn Rosario, Kawaski Trawick, or
5 Peggy's son. So what does that look like? That really
6 means the inclusion of peers. So in the times that
7 I've called a mental health crisis line, and I've
8 said, you know, like, if this is the rat race, like,
9 oh my God, what, like, exhausting, and they're like,
10 do you have a plan to hurt yourself, and I'm like
11 you're not listening to me, and that's the type of
12 situation that we see a lot. We need peers because
13 the peer actually is able to connect with the person
14 and hear what they're saying and understand what it's
15 like to consider maybe not actively having a suicidal
16 plan, but if this is like the anguish that I deal
17 with every day, how to connect with that person and
18 de-escalate. So even in situations where we're
19 talking about violence, I'm sorry, I realize my time.
20 What I really want you to think about is how can we
21 de-escalate, and having things like sirens, uniforms,
22 and guns does not do that. What we do need are peers,
23 not police. We need 9-8-8 to be a dispatch system
24 that has interoperability with 9-1-1 and 3-1-1. We
25 need a citywide system that is 24-7, and also, you

currently can't request a B-HEARD team, which I understand the logistics behind that, but there should also be some type of acknowledgement that if someone is saying I want a non-police response or I want to be met with this, that that is at least considered so I really encourage you to look at the testimony I submitted. I'm sorry, it's not double-sided. It was early. The formal testimony of Community Access, my other colleagues of CCIT NYC, and I'm here for any questions you have. Thank you so much.

CO-CHAIRPERSON LEE: And we will be getting into a bunch of those topics you mentioned today, especially around 9-8-8 and all the other things and the responses so thank you.

JORDYN ROSENTHAL: I'm so grateful for all of you, thank you.

PEGGY HERRERA: Good morning, everyone. My name is Peggy Herrera. I am a member of Freedom Agenda, a mental health advocate, a youth counselor with incarcerated youth. Most importantly, I'm a mom, a survivor, whose child was taken through gun violence two years ago. And while I thought I lost the fight, today I'm here to fight. Thank you for

having me here today. I'm very confused when it comes to B-HEARD because I don't understand how B-HEARD is a medical response put in place for people who are in crisis or having a mental health crisis or a mental health issue, and so I don't understand how they separate someone who's having a crisis from someone who is not. I believe that those who are having a deeper crisis need a different level of care, right? Someone is sick, you're either sick or you're not. And I don't think that guns help the situation, uniforms do not help the situation. In August 2019, I called for help while my son was having a crisis. I specifically said I wanted the ambulance there. Police showed up and we all know how they show up. When they showed up, I did not want them to come in, afraid of all the stories I've heard, afraid that they would kill my son. By the end of the ordeal, I was in handcuffs, I was dragged away screaming, my son was beat up. My son never got the help he needed, and I spent the night in jail. We need to consider the way we're doing things. All crisis, all mental health calls should go to B-HEARD. There should not be any mental health calls that go to police because they do not escalate the situation. They are not

2 trained to respond to a mental health situation. A
3 person in crisis should feel safe. Crisis doesn't
4 have a timeframe. I think the 16 hours should be 24
5 hours. We don't know what time a person is going to
6 have a crisis so I think it should be constant in
7 every borough, in every school. You know that most of
8 our schools and Rikers Island, they're filled with
9 people with mental health struggles and issues and we
10 need to start to process and make people better so we
11 need peers, not police. We need people with lived
12 experience that could help someone to de-escalate the
13 situation, help them process it, and help them feel
14 safe. Thank you.
15 CO-CHAIRPERSON LEE: Thank you so much,
16 Peggy, for sharing your story. Alex.
17 ALEX BRASS: Hi. Thank you, Chair Salaam,
18 Chair Lee, Chair Ariola, and Chair Narcisse and
19 everyone else here today. My name is Alex Brass. I am
20 a Steering Committee Member of CCIT NYC.
21 In January of 2022, I was experiencing a
22 mental health crisis. My parents called 9-1-1. As
23 soon as that occurred, my mental health crisis went
24 into a high gear and the police responded. There was
25 about four or five police officers. When I saw them,

2 things got even worse. I simply needed someone to
3 speak with, someone who could listen to me, and
4 instead, when the police responded, that just made me
5 feel more lonely. The following two years were
6 consumed by stigma, shame, from my experience. I was
7 a non-functional member of society and not one time
8 during those two years did I have a peer to interact
9 with. Thankfully, I got involved in advocacy work. I
10 seeked out peers and that's been a big part of my
11 recovery. I also had access to resources that most
12 individuals do not have. And unfortunately, my
13 experience is the most mild police interaction that
14 I've heard of to date. We have situations like Peggy
15 and Peggy's son. We also have situations for
16 individuals who are no longer with us. I just met
17 Rholan Pierre, whose younger brother was killed by
18 the police after he called the police himself. His
19 name is Eudes Pierre, and that was on December 20,
20 2021, and this is continuing to happen. I also have
21 friends who, I have one friend who's had 20-plus
22 police interactions. Once again, she needs someone to
23 speak with, someone that can listen to her. She's
24 called the police herself several times and not once
25 did the police ask her how she's feeling. Through my

own peer work, I've seen the value of connecting with individuals, the trust that can be gained through someone with a lived experience without the inherent power dynamics with the police. Thank you.

CO-CHAIRPERSON LEE: Thank you so much to each and every one of you for sharing all of your stories for today, and we'll continue the conversation on, as you mentioned, how to improve coordination of services and response so thank you so much.

Okay. Now, I'm going to actually turn the mic over to Committee Council because we're going to bring up the Administration.

Sorry, before you guys leave. Sorry, my fault. If there's any questions that Council Members have for this panel? Sorry about that. Council Member Cabán.

COUNCIL MEMBER CABÁN: Thank you. First of all, I just want to thank all of you for your testimony and your advocacy. I think like y'all have said it's a wonderful thing that B-HEARD exists here. We're seeing these programs expand across the country, but we want it to be as good, as strong, and

2 as life-saving as possible, and, you know, y'all are
3 a big part of that solution.
4 I just wanted to ask you all a question.
5 I think it's a pretty simple one. I've had the
6 privilege through an organization called Local
7 Progress to visit a lot of alternate responders
8 around the country, even with the CCIT member,
9 Evelyn, who has testified here before, you know,
10 Denver, Portland, these different places so I just
11 want to read a couple of statistics to you, and then
12 I'll pose my question.
13 Community responder programs around the
14 country. So the Denver Star Program, they have
15 responded to several thousand cases, and in those
16 responses, not once have they called in the police.
17 San Diego's Mobile Crisis Team responded in over
18 three years to over 13,000 calls. 98 percent they did
19 not call in armed law enforcement so only 2 percent
20 of the time did they call police. And we're seeing
21 Albuquerque Community Safety Department, out of 8,000
22 calls, only 1 percent of the calls were sent to
23 police. Oakland MACRO Program, out of 10,000 calls,
24 less than 1 percent were transferred to the police.
25 We're going to hear from the Administration the

percentage of which B-HEARD has then called in police backup, but my question for you is this. These are all cities around the country. In your personal experience, in your professional opinion, are folks struggling with mental health diagnoses or mental health incidents in other cities fundamentally any different than those in New York City? Are New York City folks who are struggling with mental health issues more dangerous than folks with a mental health diagnosis outside of New York City?

CO-CHAIRPERSON LEE: Sorry, we just need to keep it quiet in the Chambers. Thank you.

JORDYN ROSENTHAL: So…

CO-CHAIRPERSON LEE: Okay. Okay, sorry, if you could just hold off on that. Hold on one second. Sorry, just hold on one second while we wait.

COUNCIL MEMBER CABÁN: Thanks for your patience, y'all. And you guys heard my question, right? Okay.

JORDYN ROSENTHAL: So I know we're not allowed to hold up signs in here, but is it okay if I hold up my bag? It just has a phrase on it that I think all Council should see.

2 COUNCIL MEMBER CABÁN: And just for the
3 record, it says mental illness is not a crime.
4 JORDYN ROSENTHAL: So this says mental
5 illness is not a crime, and I think that really
6 speaks to what you're talking about. It's not that
7 people in New York have more mental health concerns
8 than anywhere else. I mean, we do live in a very
9 stressful city where it can take a toll on us, but I
10 don't think also that people are necessarily more
11 violent here either or anything like that. I think
12 violence is a concept, and what is violent to one
13 person is very different for another person, and part
14 of the reason I'm so passionate about moving to 9-8-8
15 is that 9-1-1 operators have some of the most
16 stressful jobs in the United States, and they
17 actually have their own mental health concerns, which
18 does make them a peer, you know, but because of that
19 high stress job and not necessarily having the
20 training specifically in mental health triage and
21 types of like dispatch and that type of thing, we
22 need a different type of system that can actually
23 dispatch responses that's able to kind of take into
24 account what this type of situation needs, and I
25

2 don't think that 9-1-1 operators are the appropriate
3 responder for that.
4 COUNCIL MEMBER CABÁN: Thank you.
5 CO-CHAIRPERSON LEE: Thank you, and that
6 is something that we're going to delve into too.
7 Okay, any other questions for this panel?
8 If not, okay, sorry.
9 PEGGY HERRERA: Can I add something to
10 that?
11 COUNCIL MEMBER CABÁN: Sure.
12 PEGGY HERRERA: While the Mayor is saying
13 that it's working and he put out data saying it's
14 working, who is it really working for? Because if a
15 person in crisis who's having a real serious crisis,
16 and they say it's a weapon involved or they're
17 violent, so what does violence, what does he consider
18 violence to be? Because they're in a crisis. And if
19 you show up with a gun, you're going to shoot to kill
20 them as opposed to trying to de-escalate the
21 situation. Police have made the system, have made us
22 feel isolated and traumatized. The STAR program, it
23 works. All the other programs work. Why does it not
24 work here? We need to mirror what they're doing.
25 Whatever they're doing is working. What we're doing

here is not working, and they're not listening to us because those closer to the problem are closer to the solution. We understand what is needed, and so we are trying to tell you, and in 2019, I was arrested, and in 2024, we're still saying the same thing, and no one's changing anything, and we're having success in other cities, then it's because the system is not listening to us.

ALEX BRASS: And one more thing to add. New York City is often touted as the greatest city in the world and, as Peggy's saying, these other cities have shown proven models. We don't have to reinvent the wheel, and it's sad that we're still at where we're at right now.

COUNCIL MEMBER CABÁN: Thank you.

CO-CHAIRPERSON LEE: Okay. I just want to recognize Council Members Joseph and Paladino that we've been joined by, and we're just going to take like a two-minute break just so that we can get the Administrative panel up here, and then we'll just proceed after that so thank you so much.

SERGEANT-AT-ARMS: Keep it down, please, keep it down. Quiet, please. Thank you.

2 Please have a seat. We're about to
3 resume. Have a seat, please. Thank you.
4 CO-CHAIRPERSON LEE: All right, welcome
5 back. Okay, so thank you so much to our Admin team
6 that is here today, and I'm going to hand over the
7 mic to our Committee Counsel to administer the oath.
8 COMMITTEE COUNSEL SUCHER: Now, in
9 accordance with the rules of the Council, I will
10 administer the affirmation to the witnesses from the
11 Mayoral Administration. After stating the oath, I
12 will call each individual by name and please affirm
13 the oath. All please raise your right hand.
14 Do you affirm to tell the truth, the
15 whole truth, and nothing but the truth in your
16 testimony before this Committee and to respond
17 honestly to Council Member questions? Eva Wong.
18 EXECUTIVE DIRECTOR WONG: Yes, I do.
19 COMMITTEE COUNSEL SUCHER: Jamie Neckles.
20 ASSISTANT COMMISSIONER NECKLES: Yes, I
21 do.
22 COMMITTEE COUNSEL SUCHER: Laquisha Grant.
23 DEPUTY EXECUTIVE DIRECTOR GRANT: Yes, I
24 do.
25 COMMITTEE COUNSEL SUCHER: Jason Hansman.

SENIOR ADVISOR HANSMAN: Yes, I do.

COMMITTEE COUNSEL SUCHER: Assistant Chief Cesar Escobar.

ASSISTANT CHIEF ESCOBAR: Yes, I do.

COMMITTEE COUNSEL SUCHER: Captain Michael Butler.

CAPTAIN BUTLER: (INAUDIBLE)

COMMITTEE COUNSEL SUCHER: Can you please come to the mic and state it for the record?

CAPTAIN BUTLER: Yes, I do.

COMMITTEE COUNSEL SUCHER: Thank you. Whoever is not at the, please come to the table so we can affirm. Chief Olunfunmilola Obe?

CHIEF OBE: Yes, I do.

COMMITTEE COUNSEL SUCHER: Deputy Chief Ebony Washington?

DEPUTY CHIEF WASHINGTON: Yes, I do.

COMMITTEE COUNSEL SUCHER: One more time, please.

DEPUTY CHIEF WASHINGTON: Yes, I do.

COMMITTEE COUNSEL SUCHER: And Joshua Levin?

DIRECTOR LEVIN: Yes, I do.

2 COMMITTEE COUNSEL SUCHER: Thank you. You
3 may begin your testimony.
4 EXECUTIVE DIRECTOR WONG: Good morning,
5 Chair Lee and Members of the Committee on Mental
6 Health, Disabilities and Addictions, and Chair
7 Narcisse and Members of the Committee on Hospitals,
8 Chair Salaam and Members of the Committee on Public
9 Safety, and Chair Ariola and Members of the Committee
10 of Fire and Emergency Management, and also good
11 morning, Public Advocate Williams.
12 My name is Eva Wong, Executive Director
13 of the Mayor's Office of Community Mental Health. I'm
14 joined by several colleagues, Jason Hansman, Senior
15 Advisor of Behavioral Health Communications and
16 Policy and Office of Behavioral Health and New York
17 City Health and Hospitals. Chief Cesar Escobar with
18 New York City Fire Department Emergency Management
19 System Operations. From NYPD, we have Captain Michael
20 Butler from Interagency Operations, Chief Lola Obe
21 from Training, Deputy Chief Ebony Washington from
22 Communications, and the Director of Legislative
23 Affairs, Joshua Levin. I'm also joined by my
24 colleague, Jaime Neckles, Assistant Commissioner of
25 Mental Health at the New York City Department of

Health and Mental Hygiene, and Lucretia Grant, Deputy Executive Director of Mental Health Access from my office. Thank you for the opportunity to testify.

In spring of 2021, during the COVID-19 pandemic, New York City launched the Behavioral Health Emergency Assistance Response Division, as we know it as B-HEARD, as a health center response to 9-1-1 mental health calls. B-HEARD has since become an integral part of the City's crisis response and mental healthcare system, transforming emergency mental health responses. Previously, 9-1-1 mental health calls were handled solely by NYPD and FDNY EMS, often resulting in hospital transports which were the only treatment option available. B-HEARD reimagines this process, enabling rapid onsite support for individuals in crisis and essential improvement in our mental healthcare system.

I'll now turn to specifics on B-HEARD. When B-HEARD was announced in November of 2020, many across the country were grappling with how to prioritize mental health and emergency responses instead of relying solely on law enforcement. New York City's solution was to unite FDNY EMS and New York City Health and Hospitals, combining FDNY's

2 emergency response expertise with Health and
3 Hospitals' extensive mental health services which
4 account for over 60 percent of the City's behavioral
5 healthcare. The result was the creation of a new
6 option for people in crisis. Interdisciplinary teams
7 where two EMTs are paired with a mental health
8 professional to respond as a single unit to 9-1-1
9 mental health calls that do not have violence or
10 weapons as the primary concerns. B-HEARD teams have
11 both the experience and expertise to de-escalate
12 crisis situations and respond to a full range of
13 medical and mental health problems. Teams assist
14 individuals in crisis by providing immediate health
15 center assessments from trained medical and mental
16 health professionals. The goals of the program
17 reflect the City's commitment to ensuring the highest
18 patient outcome through routing 9-1-1 mental health
19 calls to health center B-HEARD response whenever it
20 is appropriate to do so, increasing connection to
21 community-based care, reducing unnecessary voluntary
22 transport to hospitals, and reducing unnecessary use
23 of police resources.
24 A core principle of B-HEARD is to provide
25 community-based care for individuals experiencing

mental health emergencies. This approach allows people to receive appropriate help at home or in the community, ensuring that only those who truly need further evaluation are transported to hospitals. Since the pilot start, 44 percent of individuals assessed were connected to community services instead of being taken to a hospital.

In New York City, 9-1-1 remains a primary way to request help during emergencies, including mental health crises. Most calls come from bystanders, making it challenging to gather accurate information. The complexity of these calls directly affects B-HEARD's response capacity. To ensure appropriate deployment, EMS 9-1-1 call-takers assess calls for violence, weapons, and immediate hospital transport needs. Fully triaged calls are more likely to result in meaningful support.

B-HEARD teams respond to mental health calls independently from NYPD dispatch decisions. Although NYPD is informed of B-HEARD deployments, NYPD will respond to high-risk situations and, once a B-HEARD team arrives, they can request police backup if necessary.

2 Since launching B-HEARD in 2021, we have
3 continuously optimized our health center crisis
4 response model based on insights gained. For
5 instance, FDNY EMS developed an automated algorithm
6 to help call-takers determine if an individual has
7 previously been assessed by a mental health
8 clinician. Additionally, FDNY has hired more EMS 9-1-
9 1 call takers in Fiscal Year ’24, and a recent
10 patient satisfaction survey showed overwhelmingly
11 positive feedback for B-HEARD.
12 As the program has expanded to more
13 communities, we have continually examined innovative
14 ways to improve the B-HEARD team's ability to get to
15 more calls as well as strengthen New York City's
16 responses to mental health emergency calls. Last
17 week, the City announced two new strategies that have
18 been implemented to strengthen B-HEARD's ability to
19 provide as many New Yorkers as possible with a health
20 center emergency crisis response. The first strategy
21 is prioritizing sending teams to 9-1-1 mental health
22 calls that have been fully triaged by EMS call-takers
23 as appropriate for a B-HEARD response. For almost a
24 year, B-HEARD teams were dispatched to a broader
25 range of mental health calls, namely ones assigned to

NYPD and/or EMS where eligibility for a B-HEARD response may not have been established yet during the call triaging process. This did result in B-HEARD teams responding to more calls and a higher percentage of mental health 9-1-1 calls. However, after monitoring this new approach closely, the City learned that the teams were experiencing a higher number of instances where the patients were no longer on the scene or in need of their assistant when they responded to the calls that had not been fully triaged. Therefore, the City will prioritize deploying B-HEARD teams to calls that have been fully triaged by EMS 9-1-1 call-takers to maximize the time B-HEARD teams spend serving patients.

Coupled with this approach, the City will be switching from using police precincts as geographic boundaries within the existing pilot area to flexible ones that are more aligned with how EMS units are dispatched. This program modification will allow existing teams to be nimble in their ability to respond to nearby calls outside a precinct boundary once they have completed a call. Rather than being confined to only responding to calls within certain precincts, the team would be given flexibility to go

to calls that are more convenient from an operational standpoint, which will increase their ability to respond to the most appropriate calls.

B-HEARD has consistently been responding to the majority of eligible calls in a pilot area since launch. The number of people who received a B-HEARD response increased significantly from about 2,000 in Fiscal Year ’22 to over 7,000 in Fiscal ’23 and about 15,000 in Fiscal Year ’24. This means more and more people in crisis receive support from a mental professional when they need it the most during the first three years of operations.

Each B-HEARD response reflects the City's historic commitment to providing people experiencing a mental health crisis with the most appropriate care by pairing mental health clinicians with EMTs. Each encounter with a B-HEARD team means that the City is providing a more appropriate response and better care to an individual experiencing mental health crisis.

I thank your Committees for your ongoing partnership and commitment to serving New Yorkers who experience a mental health crisis. We're happy to answer questions you may have, and I would like to pass it along to Jamie Neckles, Assistant

Commissioner for the Bureau of Mental Health at the DOHMH. Thank you.

ASSISTANT COMMISSIONER NECKLES: Good morning, Chairs Lee, Salaam, Ariola, Narcisse, and Members of the Committee. Good morning, everybody back there, up there.

I'm Jamie Neckles, Assistant Commissioner for the Bureau of Mental Health at the New York City Department of Health and Mental Hygiene. I'll refer to it as the Health Department in my testimony. Thank you for the opportunity to testify today. I am pleased to be here with my colleagues to explain the Health Department's vital role in addressing the mental health needs of New Yorkers.

The Health Department's mandate is to protect and promote the health and well-being of all New Yorkers. Promoting mental health is a critical part of this responsibility. We employ a public health approach to this work with the primary goal of preventing mental health crises before they happen. However, when they do occur, we seek to ensure all New Yorkers have access to responsive care that includes health and social supports that are

affordable, accessible, effective, and free of stigma.

Providing support in moments of mental health crisis is a tremendous duty that we share with our city partners. My colleagues at the Mayor's Office of Community Mental Health, OCMH, spoke to one critical piece of this ecosystem, the B-HEARD program. This is a health-centered response to 9-1-1 mental health emergencies and administered by the New York City Fire Department and New York City Health and Hospitals with oversight from OCMH.

I will speak to the mental health crisis response and treatment infrastructure that the Health Department administers. This is to give context for the broader system in which FDNY and H and H's B-HEARD program operates and promotes awareness of valuable services and supports available to New Yorkers from the Health Department.

First, I want to provide some context for the Health Department's work in this space. What constitutes a mental health crisis can look very different from person to person. You do not need a diagnosable mental illness, a serious mental illness, or to be experiencing homelessness. A crisis may be

triggered by myriad of different internal, emotional or cognitive experiences, 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 today. To say it plainly, anyone can experience a mental health crisis. A diagnosis or specific experience is not required. We're here today to discuss the mental healthcare system that aims to support all New Yorkers.

It is important to note that the affordable housing crisis exerts tremendous pressure on our healthcare system. Housing is a well-established determinant of health, and lack of it negatively impacts health in many ways. As a City, we must support both mental healthcare infrastructure and affordable housing for all New Yorkers.

I will now speak to our programs. The Health Department offers three kinds of mental health crisis services, simply categorized as someone to call, someone to respond, and somewhere to go.

I'll start with someone to call. When someone experiences a mental health crisis, it can be

helpful to talk to someone we trust, a family friend, a religious advisor, a mental health or healthcare provider. Anyone can reach out to 9-8-8 at any time of day or night, any day of the year to speak with a trained crisis counselor or a peer support specialist. NYC 9-8-8 is the Health Department's largest mental health crisis service. 9-8-8 provided crisis counseling over 311,000 times via call, text, or chat during Fiscal Year ’24. 9-8-8 counselors and peers will listen to a caller's situation and help them through a moment of crisis with emotional support and coping skills. They will also help connect them to ongoing mental health services that meet their needs. Sometimes a person may be unable or unwilling to seek mental health services to get through their crisis.

This brings me to the someone to respond category. 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 this city. There are 24 teams serving all five boroughs, 19 serving adults, five teams serving children. In Fiscal Year ’24, we received 16,500 referrals for the adult teams alone. Mobile crisis teams include both master's level mental health clinicians and peer specialists. They meet face-to-face with the identified person experiencing the crisis as well as their family or other support systems to engage, assess, de-escalate, and connect individuals to the most appropriate services. Meetings typically occur wherever the person resides, such as a private apartment, a supportive housing setting, or emergency shelter. After a crisis is de-escalated, people can be connected to out- or inpatient care if appropriate. We consider mobile crisis teams a short-term intervention, typically engaging with people one to three times up to a two-week period.

Some people need more support than they can access in their home or wherever they are currently residing. These folks might need somewhere to go, our third and final category of mental health crisis services. For these situations, the Health Department also supports crisis residences, which

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, while getting additional supports through a crisis. People may be referred to a crisis resident by 9-8-8, by a mobile crisis team, by their mental health provider, or they may self-refer.

Now that I've described our short-term crisis services that offer someone to call, someone to respond, and somewhere to go, I'll move on to describe our longer-term treatment and recovery programs. These programs are designed to serve people with the most complex behavioral health needs. We use the term serious mental illness to refer to this combination of behavioral health and functional needs.

The Health Department manages New York City's single point of access system to these specialty treatment and recovery services. People are

connected to these programs by providers who make referrals through the Health Department's website. Referral sources include the crisis service providers I just described as well as community-based mental health, shelter and housing providers who recognize that their client could benefit from a higher level of care. Hospitals, jails, and prisons also make referrals to our single point of access as a part of their discharge planning process. Our single point of access received 4,107 referrals in FY-24. Single point of access, otherwise known as SPOA, sorry for the acronyms, programs include assertive community treatment and intensive mobile treatment, which have a combined capacity to serve about 6,500 people at a time. These programs provide longer-term engagement and treatment for people with serious mental illness who have not found the support they need in traditional settings. One of the many benefits of these programs is reduced risk to future mental health crises. Clinicians at the Health Department's SPOA review eligibility and make referrals to the appropriate level and location of care.

In addition to managing the referral process, the Health Department also contracts with

community-based organizations and hospitals to provide assertive community treatment, also known as ACT. ACT provides longer-term mobile mental health and substance use treatment to people with documented serious mental illness. These teams are staffed by behavioral health clinicians and peers. There are 77 total in New York City. The Health Department contracts for 47 of them. The remainder are contracted or operated by the New York State Office of Mental Health. Some of these teams specialize in certain populations. Our six forensic ACT teams work exclusively with eligible individuals with current or recent criminal legal involvement. Ten shelter-partnered ACT teams work exclusively with eligible individuals residing in New York City mental health shelters.

We also contract with community-based organizations to operate intensive mobile treatment teams. These are interdisciplinary teams, including peers that provide mobile mental health and substance use services for people with serious behavioral health concerns, very complex life situations, transient living situations, and/or involvement with the criminal legal system. We support 36 teams

1
2 serving all five boroughs. These teams are designed
3 to engage the hardest-to-reach New Yorkers.
4 The Health Department works tirelessly to
5 administer short-term interventions to de-escalate
6 moments of mental health crisis and provide long-term
7 treatment and recovery supports in the community for
8 people with complex and high needs. This is in
9 addition to administering a continuum of other
10 essential mental health services, such as youth and
11 school-based programs, supportive housing, and much
12 more. The Health Department is deeply committed to
13 this work and has been for decades. I am pleased with
14 the progress we have made, but we still have so much
15 more work to do. Thank you for the opportunity to
16 testify today. I look forward to answering your
17 questions.
18 CO-CHAIRPERSON LEE: Okay, thank you. I
19 have so many questions, so please bear with me, and
20 again, I think as mentioned on the previous panel,
21 the goal is to have more programs and services like
22 B-HEARD and to have it work well, and how can we
23 improve it, and how can we figure out how to expand
24 it? I have four precincts alone in just my District,
25 for example, and I think all of us recognize that

folks in NYPD, they know they're not mental health professionals and that a lot of times they are not equipped to necessarily respond to these situations the best so how do we use services like this, and so I'm going to just start my questions a little bit off-script from what I have here because I'm going based on your testimonies. Just really quickly, I haven't heard of the crisis residences actually, and I think this could be, is this like the crisis respite centers? Can you just clarify that? Because it could be an incredible resource, but I don't know if people know what this program is so if you could just expand on that a little bit.

ASSISTANT COMMISSIONER NECKLES: Happy to. They are the same thing as the crisis respite centers.

CO-CHAIRPERSON LEE: Okay.

ASSISTANT COMMISSIONER NECKLES: The term is used interchangeably.

CO-CHAIRPERSON LEE: Got it.

ASSISTANT COMMISSIONER NECKLES: The Health Department actually opened up the first four through a federal grant in 2012 so we pioneered the model in the city and we called them respites at that

time. They were really successful, recognized by the Center for Medicare and Medicaid Innovation, became reimbursable and licensed in New York State, and the licensing process gave them a new name to confuse everybody…

CO-CHAIRPERSON LEE: Okay, so I have heard of it, it turns out. Okay, and it's reimbursable by Medicaid?

ASSISTANT COMMISSIONER NECKLES: Yes. There's also funding to support uncompensated care people without insurance so that's not a barrier to accessing it…

CO-CHAIRPERSON LEE: Okay.

ASSISTANT COMMISSIONER NECKLES: But the services are billable.

CO-CHAIRPERSON LEE: Okay, perfect. And do we have more than 15 beds now at this point because I know that one of the things we were trying to do was expand it.

ASSISTANT COMMISSIONER NECKLES: Yep.

CO-CHAIRPERSON LEE: Okay, and how many beds are we at right now?

2 ASSISTANT COMMISSIONER NECKLES: There are
3 38 beds in contract with the Health Department
4 citywide.
5 CO-CHAIRPERSON LEE: Okay, which is better
6 than 15, but I will say, as you mentioned, as housing
7 is a huge part of someone's health, we definitely
8 need more so whatever plans you have, if you could
9 share. I know it may be not necessarily now, but if
10 you could share plans on how the City's planning on
11 expanding that program because that's also something
12 that we had on the Council's Mental Health Roadmap
13 also, was to expand the CRCs. Okay.
14 ASSISTANT COMMISSIONER NECKLES: There's a
15 couple in the works, in the licensing process, so we
16 anticipate the capacity to expand, but it's
17 contingent upon the State Office of Mental Health
18 licensing.
19 CO-CHAIRPERSON LEE: Right, because these
20 licenses are offered by the State, not the City.
21 ASSISTANT COMMISSIONER NECKLES: Yes,
22 that's right.
23 CO-CHAIRPERSON LEE: Okay, right, as
24 everything is very confusing…
25

ASSISTANT COMMISSIONER NECKLES: Absolutely.

CO-CHAIRPERSON LEE: In the State. Okay. Which is, I think, we're going to get to this whole theme and a large part of my concerns, because, and you hit the nail on the head, because I mean, as someone who worked in the mental health sector before and I'm a social worker as well, I'm familiar with the different outreach teams like ICT, ACT, IMT, AOT, all of those things, right, but I think to the general public, it's very hard to sometimes distinguish what and when each of these outreach teams are appropriate, and so I just want to just simplify this, right? If I'm calling 9-1-1 and I'm experiencing mental health crisis, and we all know, as mentioned before, that the 9-1-1 dispatchers have a tremendously difficult job, right? Are they aware of all the different outreach teams and can you speak to, and this is for any of you here, because I don't know who would best speak to this, but can you speak to, and I'll go more into depth about this, but the training that the 9-1-1 dispatchers receive as well as if they are aware of all of these programs that we have available.

DEPUTY CHIEF WASHINGTON: Hi, good morning. I'm sorry, can you just repeat that again?

CO-CHAIRPERSON LEE: Sure, sure. So, considering that we have multiple outreach teams that are available, right? If I call 9-1-1 and I'm experiencing a mental health crisis, maybe it's not quite an emergency, maybe it could turn into an emergency, which is why I think it's so difficult for some of the 9-1-1 dispatchers. If you could speak to the level of trainings that they receive, whether they have all of this information available to them, and how they are trained to appropriately route these calls to either B-HEARD or one of the other outreach teams.

DEPUTY CHIEF WASHINGTON: Okay, so in New York City, 9-1-1 operators receive 90 days training. During that training, they receive about 25 days of hands-on training where they're actually sitting with an operator, an experienced operator. As far as mental health, it is a full day training by a certified instructor, okay, giving them all types of scenarios that they may encounter. As a policy, we always connect the person calling to EMS, okay? We

don't medically triage so our policy is to connect to EMS.

CO-CHAIRPERSON LEE: Okay, so the 9-1-1 dispatchers would call and contact EMS, and then from there, they're automatically dispatched to the scene.

ASSISTANT CHIEF ESCOBAR: Good morning. I'll give you a little brief interpretation of that.

CO-CHAIRPERSON LEE: Sorry, hold on one sec. Can we just make sure that the outside is a little quiet because I just want to make sure that everyone hears what you're saying. Sorry. Thank you.

ASSISTANT CHIEF ESCOBAR: Okay, so you're correct. The 9-1-1 call will come in, and NYPD dispatcher will take the call, classify it as a mental health emergency, and it will be moved over to EMS for additional triaging. Our dispatchers go through 10 weeks of training to become assignment-receiving dispatchers. Those are the members of EMS that take in the calls. They will be the ones that will ask additional questions of the caller to be able to target these calls to the appropriate resources. The members of our emergency medical dispatch do an amazing job. They handle 1.6 million calls a year. These are 1.6 million calls that all

have to get triaged, questions asked, so that we can send the appropriate resources.

We also have at emergency medical dispatch, dispatchers that get an additional 10 weeks of training to be able to dispatch those calls to the appropriate resources.

In addition, our members in communications get ongoing training when new procedures come out regarding mental health emergencies so they are aware of some of their services. They are aware of B-HEARD, and they dispatch all the calls that come in using computerized triage algorithm to be able to categorize the calls appropriately for B-HEARD.

CO-CHAIRPERSON LEE: Okay.

ASSISTANT COMMISSIONER NECKLES: Can I add to this, because I get this question a lot in the mental health context. If you need police, fire, or EMS, call 9-1-1. If you're not sure, call 9-8-8, and the crisis counselors can spend time on the phone with you. That's their job, is to listen and spend as long as you need to figure out what makes sense next so we do not expect anybody to be expert in all of the acronyms that I just went through. That's

2 unreasonable. And once we become expert in them,
3 there'll be new acronyms, right? There's no point in
4 the public learning them. I think the focus is, if
5 you're not sure, call 9-8-8, and they can help you
6 figure out what makes sense next.
7 CO-CHAIRPERSON LEE: Okay. I think my big
8 issue there is that I think still a lot of folks are
9 not aware of 9-8-8 and the fact that that exists, and
10 I know that the State, from what I've heard, is
11 planning on putting more resources into expanding the
12 outreach for 9-8-8, but I guess my question though
13 is, if I call 9-8-8 then, how is that going to
14 connect to all the different other services? If you
15 could go through that and walk us through that a
16 little bit too.
17 ASSISTANT COMMISSIONER NECKLES: Sure, I
18 can do that right now. So the 9-8-8 promotion
19 campaign started this month across New York State so
20 I hope many of you will be seeing those ads. 9-8-8
21 counselors are trained in the services that are
22 available across our city, which changes, right, so
23 they're always incorporating new information. They
24 assess callers, right, form a bit of a relationship
25 in a very small period of time and can provide in the

moment, immediate coping skills and de-escalation on the phone. For many people, that call is sufficient. For most callers, in fact, the telephonic intervention or text exchange or online chat is sufficient and they resolve whatever it is, the emotional distress that they're experiencing comes to some resolution and then there's agreed upon next steps, right? Whatever that is, that might be going out and taking a walk, right? It may be something much more acute depending on the person's situation. And so they will de-escalate on the phone, assess, provide coping skills. Sometimes the person may need more. They will dispatch mobile crisis teams to respond in person within a few hours so they're doing that thousands of times a year.

CO-CHAIRPERSON LEE: Yeah, and I think you just answered my question because if it's the reverse situation where they do call 9-8-8 and it actually does turn out that there needs to be some more serious responses, then do they connect and do they know how to bring things to either 9-1-1 or EMS?

ASSISTANT COMMISSIONER NECKLES: Yes.

CO-CHAIRPERSON LEE: Okay, I just want to make sure.

ASSISTANT COMMISSIONER NECKLES: Yes, absolutely.

CO-CHAIRPERSON LEE: And then for B-HEARD, I know you said for mental health they get a one-day training. Is there any more that they get for the 9-1-1 dispatchers? Because I feel like it's just a lot.

DEPUTY CHIEF WASHINGTON: They're provided with different scenarios, right? Essentially when you call 9-1-1, you're asked do you need police, fire or medical, right, and then we're going to ask what's your location so we can verify where you are, and then the caller will go into what the emergency is and what's needed. If it's someone experiencing a mental health crisis, we will get the gist of what's going on and always connect to EMS.

CO-CHAIRPERSON LEE: Because I know in a lot of other fields that are out there, if I wanted to keep my social work license, I would have to do continuing education credits, right, so I'm assuming that there's also a refresher every year hopefully.

DEPUTY CHIEF WASHINGTON: Yes, sure, so about six to eight weeks, we provide in-service training with any updates to any procedures or any new policies that may be going on…

2 CO-CHAIRPERSON LEE: Okay.

3 DEPUTY CHIEF WASHINGTON: But our
4 operators are not medical professionals.

5 CO-CHAIRPERSON LEE: Right.

6 DEPUTY CHIEF WASHINGTON: They're just
7 provided with the type of calls we may encounter.

8 CO-CHAIRPERSON LEE: Right, and typically
9 how long does it take for a B-HEARD team to get
10 dispatched once it's determined that there is one
11 that needs to go out?

12 ASSISTANT CHIEF ESCOBAR: Thank you for
13 the question. Typically, once a call comes in to 9-1-
14 1 and it reaches our assignment receiving
15 dispatchers, they go through a series of questions.
16 Sometimes that takes minutes to categorize this call
17 appropriately. Once the call is categorized where it
18 meets the criteria for a B-HEARD response, which
19 would include having no indication of violence,
20 having no indication of weapons, then that call would
21 be transferred over to our dispatchers, and the call
22 would be transferred to whatever dispatcher is
23 working in the dispatch area that they're working,
24 whether they're working the Bronx or Upper Manhattan,
25 and then that dispatcher will assign that call to the

appropriate resources if there's one available. They also will dispatch calls in priority order, and sometimes there are calls that take a little longer to dispatch because the dispatchers are in the process of dispatching our life-threatening emergencies so we do have times where the B-HEARD unit is dispatched in priority order, which means it'll be the next one to be dispatched after we dispatch the very critical assignments, which are things like cardiac arrest, choking, unconsciousness, things like that.

CO-CHAIRPERSON LEE: Okay. And you kind of started answering my question because I just wanted to, if you could state for the record, like what specific criteria is used to determine whether a call is B-HEARD eligible?

ASSISTANT CHIEF ESCOBAR: So we used an application called Computer Triage Application, which will lead the person on the phone to ask a series of questions. Every time the algorithm will be dependent on the previous question so the first initial questions are always things that relate to life-threatening emergencies. For example, is the person awake, is the person breathing, so if the answer is

yes to all those questions, then it leads them down the track of asking, why did you call 9-1-1, what is the mental health emergency, and then a series of questions that will trigger a B-HEARD response, which will include no weapons, no violence, no suicidal tendencies, and then that call will get categorized a specific criteria for our B-HEARD units. We have a specific call type that is only for our B-HEARD units, and it has to match that criteria for them to be dispatched.

CO-CHAIRPERSON LEE: Okay, and what is the specific call type designation?

ASSISTANT CHIEF ESCOBAR: The calls that we dispatch B-HEARD units to are classified as EDPM, EDPM.

CO-CHAIRPERSON LEE: Okay, perfect, thank you. Also, how many response teams are available per precinct, and is it still 31 precincts right now that you guys are operating in, and just wanting to know how that's prioritized.

ASSISTANT CHIEF ESCOBAR: We currently have nine B-HEARD teams that are operating during the daytime, and we have nine teams that are operating in our afternoon shift and, recently, as the Mayor

2 announced, we have eliminated some of the precinct
3 boundaries so that our units can respond to areas
4 that are right outside the precinct boundaries, which
5 was our limitation in the past. So, as of right now,
6 our B-HEARD teams are able to respond to many more
7 areas of the city now that we've eliminated those
8 artificial boundaries of precincts.
9 CO-CHAIRPERSON LEE: Okay, so those nine
10 teams can pretty much go anywhere in any of those
11 nine precincts that have a B-HEARD team.
12 ASSISTANT CHIEF ESCOBAR: That's correct.
13 CO-CHAIRPERSON LEE: Okay, and how does
14 the B-HEARD program decide which precincts to expand
15 to next, and are there current plans, and what is the
16 current plan to expand B-HEARD, and the timeline, if
17 you have that information?
18 DEPUTY EXECUTIVE DIRECTOR GRANT: B-HEARD
19 expansion has been paused as a result of the most
20 recent FY-25 PEG. Decisions around where B-HEARD will
21 expand to next have not been made yet. The Mayor, the
22 City is still committed to citywide expansion of the
23 B-HEARD program. At this time, we're using kind of
24 this pause, this delay, to really make some
25 operational changes like the one that Chief Escobar

2 just described with the removal of the precinct
3 boundaries. We're looking at ways to get the teams to
4 respond to the most appropriate calls. So, in the
5 past, decisions around where the teams expanded to
6 were made based off of high 9-1-1 mental health call
7 volume in addition to some operational
8 considerations, and that will likely continue to be
9 the case, the criteria that we look at, but at this
10 moment, there are no plans for expansion.
11 CO-CHAIRPERSON LEE: Okay, so then, two
12 follow-up questions to what you just said, because
13 I'm going back to the testimony, which says that in
14 FY-22, there were 2,000 calls or people served, FY-
15 23, 7,000, and FY-24 so far, it's 15,000. So, my
16 question then is, is that in terms of budget and
17 PEGs, which are concerning, because we don't want the
18 PEGs to impact obviously direct services on the
19 ground…
20 DEPUTY EXECUTIVE DIRECTOR GRANT: Yes.
21 CO-CHAIRPERSON LEE: But if that's the
22 case, what's the budget situation, do you have enough
23 funding? If you have nine teams, the numbers in my
24 head don't make sense, right, so, if that's the case
25 where you're receiving that many more calls, I guess

2 the first question is, how many of those 15,000, does
3 that mean that all 15,000 calls received B-HEARD
4 responses in FY-24 and, if so, how does that look in
5 terms of the funding and the budget?
6 DEPUTY EXECUTIVE DIRECTOR GRANT: Yeah,
7 so, with the same funding, we were able to gradually
8 increase the amount of calls that the teams have gone
9 to. As of FY-24, it was up to almost 15,000 calls,
10 and so those were how many times the teams were
11 dispatched and went out to respond to…
12 CO-CHAIRPERSON LEE: Which I want to
13 reiterate is the goal, right? We want these teams to
14 go out more. I'm just concerned that there's not
15 enough funding or budget to support that.
16 DEPUTY EXECUTIVE DIRECTOR GRANT: The
17 funding that we have at the moment is sufficient, and
18 we have seen the numbers go up with the funding that
19 we have.
20 CO-CHAIRPERSON LEE: Okay, then, correct
21 me if I'm wrong, I'm skipping around a little bit,
22 sorry so then, in 2025 Fiscal Year, the budget has
23 allocated a combined 35.1 million to H and H and FDNY
24 for the B-HEARD program, and this number is a
25 reduction, it seems like, from recent years, right,

so, I guess, can you sort of explain, I know it's enough. The first year, I know that there was 55 million in the budget, but there was trouble hiring staff and getting things up and running, which is why, in the first year, I get why the number decreased from 55 million to whatever it was, right? I think it was 20-something million, I'm just going off my memory, but if the number for FY-25 is now 35.1 million, can you just sort of speak to, if that's a reduction, is that still enough, because I'm anticipating there's probably going to be more calls this year.

DEPUTY EXECUTIVE DIRECTOR GRANT: I'll let H and H speak to the changes in their budget, but I will say that at the start of the program, there were a lot of first-year startup costs associated with operating this program, and so that sort of reduction takes into account us no longer needing some of those startup costs.

CO-CHAIRPERSON LEE: Yeah, so I guess the better question would be, take a full year of operation, comparing that to now FY-25, right, so if you could compare a little bit of the year over year,

2 how that works in terms of the increased calls and if
3 the budget is sufficient for that.
4 SENIOR ADVISOR HANSMAN: Yeah, so what I
5 would say, at least between ’24 and ’25, there is not
6 an appreciable difference in kind of the number of
7 social workers that we would be able to hire so there
8 wasn't a reduction in our headcount so that allows us
9 to continue to respond to the same number of calls
10 that we have responded to in FY-24.
11 CO-CHAIRPERSON LEE: I'll go more into the
12 budget questions later, but just really quickly,
13 going to the, this is one of my, I guess, pet peeves
14 is how to make sure that we're all sort of sharing
15 data with respect to HIPAA laws and violations,
16 right, so if there's any techie people in the
17 audience that are looking to do pro bono work for us,
18 just come see me after this, but do the B-HEARD
19 teams, FDNY, NYPD, and Health and Hospitals share
20 data regarding past responses to mental health
21 crises, right? So, if someone has been in the system
22 before, how are we tracking these folks, how are we
23 making sure that there's some sort of history that
24 follows them that we can tap into so that we can
25 better treat them moving forward?

2 SENIOR ADVISOR HANSMAN: So I can talk
3 about from the H and H perspective. Certainly, if
4 someone is seen by a B-HEARD team and meets mental
5 health assessment criteria in the field, we can see
6 those past B-HEARD responses. We can also see,
7 because of our electronic medical record, other
8 hospitalizations that might have occurred within the
9 Health and Hospitals system so if someone had
10 previously been in the ER at Bellevue, for instance,
11 right, we would be able to see that interaction once
12 that individual met mental health criteria and we
13 began to serve that patient on the ground.
14 CO-CHAIRPERSON LEE: Right, but then my
15 question then is how do you share that data with the
16 other agencies sitting here, right, and I think
17 that's the thing, is how do we make sure, because I
18 have to say, even within the Health and Hospitals
19 system, it's great, but then from where you guys drop
20 off to where they go to outpatient treatment, let's
21 just say, how do we, what system is in place to
22 actually follow these folks?
23 SENIOR ADVISOR HANSMAN: So, it certainly
24 can be a little tricky, as you mentioned with HIPAA
25 and our ability to share protected health information

2 of patients, especially, you know, if there's prior
3 instances of hospitalizations, what that looks like.
4 What we do do is we're looking at this data
5 internally to H and H and when someone does have
6 multiple instances, we are looking at that, those
7 instances and what we can do differently the next
8 time. So, does that mean they need a higher level of
9 support and service on that next interaction? We're
10 going to work with them in the field to get them
11 connected to that higher level of support.
12 CO-CHAIRPERSON LEE: Right, and then I
13 guess my question is for OCMH, because as you guys
14 are sort of the overarching, you know, coordinators
15 of this program for B-HEARD, is there a system in
16 place that allows you all to follow someone through
17 and also track whether they've had a previous, you
18 know, if they've been seen previously by a B-HEARD
19 team?
20 DEPUTY EXECUTIVE DIRECTOR GRANT: We do
21 not track that. We don't look at any sort of medical
22 data. So, that would be H and H who has access to
23 those sorts of medical records as Jason just
24 described. Yeah, and just to note, we don't share any
25

2 data from H and H or FDNY with NYPD. The data is
3 shared amongst these agencies.
4 CO-CHAIRPERSON LEE: Okay, and for FDNY
5 and EMS, do you guys all have access to this data as
6 well, or do you have your own data?
7 ASSISTANT CHIEF ESCOBAR: Every time a B-
8 HEARD team responds, we generate a call report for
9 that particular interaction, and that information
10 stays with us. Because of HIPAA protection, we are
11 not allowed to share much of that information.
12 CO-CHAIRPERSON LEE: Okay, so if I
13 approached each of your agencies separately, and I
14 asked you for some demographic and also, without
15 revealing someone's identity, right, and, you know,
16 incidences, would you guys all have the same answers
17 I guess is my question, like is everything going to
18 add up to be the same?
19 ASSISTANT CHIEF ESCOBAR: I think we would
20 have slightly different answers, and let me tell you
21 why. Because when EMS responds, they're looking at
22 that entire picture of everyone they respond to so
23 they have everything from dispatch down to the people
24 who are served on the ground. Whereas H and H, we
25 only have the number of people and the information on

the people that we're serving with our social workers on the ground so we have a piece of the pie. I will say it is the same answer, but we are a subset of the larger answer of EMS.

CO-CHAIRPERSON LEE: Okay, if we could figure out how to get the whole pie, I think that'd be awesome because, and I know that may seem like I'm harping on the data point, but the reason why I am sort of drilling down on this a little bit is because I think in order for us to figure out how to better respond and improve the program and help improve it, we need to get a clear sense of what the data is, and I think right now, even I'm sitting here confused about which information lies with which agency so I just want to be clear on my intentions of asking and drilling down these questions so if we can have maybe further conversations about this afterwards, that'd be great.

I'm sorry. I keep forgetting to recognize Council Member Yeger and Mealy. I'm sorry, guys so I just wanted to take time to do that.

Really quickly, so Friday, the Mayor announced B-HEARD. Can you sort of talk us through the differences in the metrics that you are reporting

on year over year? For example, it doesn't seem like that we're getting data on the number of folks transported to community-based healthcare sites, as an example, and I know that previous reports have articulated average response times for B-HEARD calls, but it's missing from the latest report so do you know what the FY-24 average response time is, and does the City have plans to include this in upcoming reports?

DEPUTY EXECUTIVE DIRECTOR GRANT: Well, I'll speak to the transports to, did you say transport to the hospitals?

CO-CHAIRPERSON LEE: Yeah, community-based healthcare.

DEPUTY EXECUTIVE DIRECTOR GRANT: That is a number that we continue to report so we, I'm sorry, yes. That is something that we continue to report. In the FY-24 data that we recently released, 43 percent of individuals that were assessed by the mental health clinicians on the B-HEARD teams either stayed in the community in their homes or wherever the 9-1-1 call took place or were connected to a local resource like a supporting connection center in East Harlem.

CO-CHAIRPERSON LEE: Okay, thank you. Just really quickly for budget purposes, for both H and H and FDNY EMS, could you give us the breakdown of the B-HEARD budgets and how much is allocated for personnel services versus OTPS?

ASSISTANT CHIEF ESCOBAR: I don't have that right in front of me. I would have to get back to you. I certainly can provide that before the close of this hearing.

CO-CHAIRPERSON LEE: Okay, perfect.

SENIOR ADVISOR HANSMAN: Same for H and H. I would just say that the majority is OTPS. Or I'm sorry, the majority is PS, is personnel services.

CO-CHAIRPERSON LEE: Right, personnel, yep. What are your strategies for recruitment because I know that, according to you, you have enough teams to respond to the current calls, but I know in the beginning, it was challenging to onboard and hire staff and so just wanting to hear what the strategies are for recruitment as well as what funding you would need to make your recruitment goals achievable.

SENIOR ADVISOR HANSMAN: Absolutely, so I'll just say that our struggles with staffing are part of, I think, a nationwide trend in being

2 difficult to find mental health providers globally so
3 I would say it's not unique to B-HEARD that we're
4 having some difficulty finding social workers. What I
5 will say is that what we have done is a lot of
6 different campaigns to bring social workers to Health
7 and Hospitals generally. We just did a recent ad
8 campaign, you might have seen it in the subways, I
9 see it on my ride home most days to attract social
10 workers to health and hospitals to include B-HEARD,
11 and we've done some very specific B-HEARD-related
12 social media and other ad campaigns to bring in
13 social workers into the B-HEARD program and have
14 really increased the number of B-HEARD clinicians
15 that are a part of the program.
16 DEPUTY EXECUTIVE DIRECTOR GRANT: And we
17 would welcome Council support in amplifying those
18 messages.
19 SENIOR ADVISOR HANSMAN: Got it, yep,
20 definitely.
21 We've been joined also by Council Member
22 Rivera on Zoom.
23 Let me just ask one or two more final
24 questions before I hand it off, and then we'll come
25 back because I know some of my Colleagues have to

1
2 leave. As someone who worked for many years in the
3 non-profit immigrant community where language access
4 is very difficult, there is so much stigma, what
5 happens in situations where it turns out that you go
6 to the site and it's very clear that there needs to
7 be someone who speaks a various different language
8 and, of course, I'm just thinking off the top of my
9 head of Winn Rosario's family situation. If it's
10 necessary where they need some sort of more language
11 capacity, like, yes, I know there's Language Line,
12 but if you could speak to situations that you've run
13 into where that's been a challenge, has Language Line
14 worked, what percentage of your responders are
15 bilingual and speak different languages if you could
16 speak to that as well?
17 SENIOR ADVISOR HANSMAN: I'll talk just on
18 the H and H side quickly so, yes, we would use, in
19 this instance, Language Line for the majority of our
20 translation needs in the community, I think, and also
21 thinking about, I think there's another part of this,
22 which is about the care and service that they might
23 be connected with as well and thinking about what
24 care and services would match their language
25 preference so we're using Language Line out in the

2 field. We have not gotten any reports back that it's
3 not meeting our needs out in the field, and we have
4 certainly employed it a number of times. We can
5 circle back with some more data on that, but it's
6 also about those responses and where we send folks to
7 within the larger behavioral health system when it
8 comes to language access.
9 CO-CHAIRPERSON LEE: Okay. In terms of the
10 other agencies and the folks on your response teams,
11 if you could speak to if there are folks that are
12 speaking multiple languages and in the recruitment
13 process. If I could, I would highly, highly urge that
14 to be something that we include, because as we know,
15 we live in a city that is so diverse and speaks so
16 many languages, and so if you could just speak to
17 that as part of the recruitment, and also whoever's
18 on the response teams on your end, whether it's the
19 EMS or OCMH.
20 ASSISTANT CHIEF ESCOBAR: So I'll just
21 speak a little bit about our B-HEARD teams. We have
22 amazing personnel that work in the B-HEARD team that
23 are recruited specifically for the B-HEARD. Many of
24 them have an experience with a mental health
25 emergency in their family or in their life, and

that's why they chose to be part of the B-HEARD team. Many of the members that work in B-HEARD are bilingual. Some of them speak Spanish and use their Spanish skills. We also just a couple months ago instituted a new application on our department phones, which every member carries, which is a translator application to assist them with any language that may need to better communicate with the members of the public.

CO-CHAIRPERSON LEE: Okay, great, thank you.

I'm going to take a pause and then just recognize also we've been joined by Council Members Brewer, Gutiérrez, and Restler.

I'm going to pass it off because I know Chair Ariola needs to leave soon so Chair Ariola, if you wanted to go ahead and ask your questions.

CO-CHAIRPERSON ARIOLA: Thank you, Chair. Let's talk about EMS. EMS' operating guidelines and procedures relating to the department's response to mental health calls was recently updated. Can you please tell us what those updates were and describe them?

ASSISTANT CHIEF ESCOBAR: The procedures that were recently updated had to do with the type of calls that our mental health response units are assigned. So previous to June of this year, our crews were responding to mental health emergencies, some of them which were not completely triaged by our communication personnel. Oftentimes that happens when we have days with excessive numbers of calls coming into the system, and some calls end up going to relay positions which do not get a full triage. We have been doing a lot of work in the last year to increase the number of members assigned to emergency medical dispatch to improve our capacity to triage the mental health calls so that change that we did recently was to target the calls more appropriately to our B-HEARD teams so instead of sending them to some of these calls that were not fully triaged, may not have (INAUDIBLE) information, and may need the response of NYPD because of the lack of information, now we are better triaging those calls and only sending the B-HEARD teams to calls that are appropriate for their response without NYPD assisting.

2 CO-CHAIRPERSON NARCISSE: Thank you. Do
3 voluntary hospital units respond to EDP incidences to
4 your knowledge?
5 ASSISTANT CHIEF ESCOBAR: Yes, the
6 voluntary units respond to many emergencies in New
7 York City, and part of their response assignments are
8 certain mental health calls that are designated for
9 them to be assigned so, yes, they do.
10 CO-CHAIRPERSON NARCISSE: Okay. For
11 hospital transports for emotionally disturbed
12 persons, do police officers accompany the ambulance
13 every time?
14 ASSISTANT CHIEF ESCOBAR: Every call is
15 different. Every call that we respond to poses a risk
16 to the members of EMS, and it is their decision
17 whether to request the assistance of NYPD if it is
18 necessary. Many times, NYPD does respond to the
19 hospital with us for our safety and oftentimes they
20 do not. When the EMS crew has a great rapport with
21 the person and there's no immediate danger, they will
22 take the person to the hospital without NYPD
23 assistance.
24 CO-CHAIRPERSON NARCISSE: If EMS arrives
25 on the scene to a mental health call and an

2 individual in crisis exhibits violent behavior, what
3 is the scope of duties for EMS personnel until the
4 police arrive on the scene?
5 ASSISTANT CHIEF ESCOBAR: I'm sorry. I
6 didn't hear the first part of the question.
7 CO-CHAIRPERSON NARCISSE: Sure. If EMS
8 arrives on the scene to a mental health call and the
9 individual in crisis exhibits violent behavior, what
10 is the scope of duties for EMS personnel until the
11 police arrive on the scene?
12 ASSISTANT CHIEF ESCOBAR: Thank you so
13 much for that question. That is a great question. Our
14 members are trained to respond to many types of
15 assignments. Many of them have a risk and many of
16 them have violence involved, and they are trained to
17 attempt to de-escalate the situation first and, if
18 that is not working, they are trained to back away
19 and wait for NYPD to respond.
20 CO-CHAIRPERSON NARCISSE: All right, thank
21 you. That's all the questions I have for now, Chair,
22 but I'd like to go on the list for the second round.
23 I appreciate it. Thank you for the consideration.
24 Thank you for your answers.
25

CO-CHAIRPERSON LEE: Okay, and now we'll move on to Chair Salaam.

CO-CHAIRPERSON SALAAM: Thank you. I'm wondering in terms of the calls for the 9-1-1 operators, how they evaluate the eligibility for B-HEARD or to route the calls to B-HEARD and what types of behaviors indicate a potential threat of violence? For instance, yelling, throwing plates, property damage, things of that nature. I'm just trying to figure out like what's the process that they say, you know what, this doesn't need to be responded to with a threat of death but rather mental health challenge.

DEPUTY CHIEF WASHINGTON: Okay, so after verifying the location, the operator will ask the caller essentially what's going on. We take at face value what the caller is saying. If someone is experiencing a mental health crisis, we will then ask are they a danger to themselves or anyone present or is anyone hurt? If none of that exists, we will connect to EMS either way, whether there is or isn't. Once the call is connected to our emergency medical dispatch call-takers, they will go through a series of questions, and every call that comes into 9-1-1 that is transferred to our EMS call-takers goes

2 through the same process of questions so, even if it
3 gets categorized as a mental health emergency by
4 NYPD, once it gets to our EMS call-takers, they have
5 to ask a series of questions and I'm just going to
6 give you a couple of them. It starts off with, is the
7 patient awake, is the patient breathing so, if the
8 answer is no to any of those, it goes a different
9 track, and we dispatch an ambulance right away.
10 Obviously, that is a life-threatening emergency. You
11 know, we try to get to those emergencies very
12 quickly. Our priority one, two, and threes, which are
13 things like cardiac arrest, unconscious, choking,
14 things that will kill you in a couple minutes. But
15 once the answer is that they are awake, that they are
16 breathing, then they go down the series of questions
17 asking the mental health emergency questions to make
18 sure that this call is appropriate for the B-HEARD
19 team. Some of the questions are like, is there any
20 immediate danger, is there any violence, is there any
21 weapons, so those are the type of questions and, if
22 any of those are yes, then the call will be
23 classified as something differently and a B-HEARD
24 team will not respond.
25

1
2 CO-CHAIRPERSON SALAAM: How about, you
3 know, things like yelling, property damage, does that
4 require a police response?
5 DEPUTY CHIEF WASHINGTON: That would
6 require a police response. And just to make it clear,
7 when we connect to EMS, we're not disengaging the
8 call. The operator's trained to stay on the call
9 until EMS is finished triaging because conditions in
10 the field are very fluid, right, things change, so we
11 want to make sure the person is getting the right
12 resources that they need.
13 DEPUTY EXECUTIVE DIRECTOR GRANT: And I
14 would just add that to Chief Washington's point, NYPD
15 does stay on the line as a call is being triaged. If
16 EMS determines that a B-HEARD team is going to be
17 dispatched, then a message is sent to NYPD that says
18 that they are not needed.
19 CO-CHAIRPERSON SALAAM: Hold on one
20 second. Has there been any instances where the NYPD
21 has been told they're not needed, but they still
22 responded?
23 DEPUTY EXECUTIVE DIRECTOR GRANT: That
24 does happen. It depends on when the message is
25 received by NYPD so, if NYPD is already on their way

2 or already at a scene, it's possible, yes, that PD
3 will be on scene for a call that the B-HEARD teams
4 respond to and, once they're there, they can, that
5 once the B-HEARD team arrives, they will let PD know
6 that they're not needed.
7 CO-CHAIRPERSON SALAAM: Has there been any
8 data captured as to how many instances like that have
9 happened?
10 DEPUTY EXECUTIVE DIRECTOR GRANT: We do
11 not have that data. We don't have data from NYPD, and
12 I'm also not sure that NYPD captures that data.
13 DEPUTY CHIEF WASHINGTON: B-HEARD is not
14 an NYPD resource so we don't track that data.
15 CO-CHAIRPERSON LEE: Sorry, can I
16 interject for a sec? Okay, sorry, I was just
17 thinking. Okay, so I know that it's not technically
18 in your wheelhouse and realm, but is there at least
19 some sort of notation by your officers when they get
20 there that there is a B-HEARD team available or that
21 this was a mental health crisis response?
22 DEPUTY CHIEF WASHINGTON: The officers
23 will make a notation of it and notify the dispatcher.
24 That information could be pulled. It's kind of time-
25

2 consuming, but it would be available if you wanted
3 it.
4 ASSISTANT CHIEF ESCOBAR: If I could just
5 mention, there are instances where the, like Laquisha
6 stated, that when the call is being triaged, the call
7 goes through different cycles and, initially, it
8 might be classified as something. As it's being
9 triaged, it'll be classified as something else. So
10 there are times when NYPD goes because they think it
11 is a call that they need to respond to. Once we
12 triage it, we see that we don't need, we will send
13 them that message, like Laquisha said, B-HEARD
14 responding, no NYPD needed but, on occasions, NYPD is
15 already en route because depending on how they
16 categorized it, an NYPD resource is already en route.
17 But our units have the ability to get on the scene if
18 they determine that NYPD is not needed to tell them
19 we don't need you right now and they can back away so
20 that is something that is an option for them.
21 CO-CHAIRPERSON SALAAM: In that same
22 instance, in terms of, I'm just thinking about like
23 who's in charge, a chain of command kind of thing, of
24 have there been any instances where they've been told
25 they're not needed but they said this looks like we

are needed and therefore we will take control or take command?

ASSISTANT CHIEF ESCOBAR: I don't have any information of any calls like that that have occurred. Is it possible? Probably. But I don't have any information on things like that. I do know that we do training with our H and H partners and NYPD and our teams that are out there, our B-HEARD teams work very well with the NYPD precincts in the area and communicate whatever is needed on scene, and we know the objective is to de-escalate the situation and, if that's possible, we will ensure that nothing else comes on the scene that will escalate the situation. But if they are needed, we know that they are around because every situation that EMS responds to is a potentially dangerous situation.

CAPTAIN BUTLER: And, Chair, if I may add, our operational guidance to police officers is that if there's a difference of opinion between EMS and PD, we'd like to have the patrol supervisor as well as an EMS supervisor consult on scene to see what would be the best outcome to provide the best care for the individual.

CO-CHAIRPERSON SALAAM: Has there been any instances of disagreement, and what happens in that particular case?

CAPTAIN BUTLER: I don't have for this hearing any instances of that nature.

CO-CHAIRPERSON SALAAM: Of the emergency calls, how many 9-1-1 mental health calls were there, and I'm wondering by year, for the year 2023, 2022, ’21, ’20, and ’19, etc., and are there any trends of such calls increasing over the recent years?

ASSISTANT CHIEF ESCOBAR: So according to our data, our mental health emergencies overall in New York City have gone up by 12 percent since 2019. We certainly can get specific numbers for every year, but we have seen an increase in mental health emergencies in the past few years.

CO-CHAIRPERSON SALAAM: Not 12 percent per year, but over the…

ASSISTANT CHIEF ESCOBAR: Yes, since 2019 overall.

CO-CHAIRPERSON SALAAM: Okay.

ASSISTANT CHIEF ESCOBAR: So there is fluctuations. In some years we have higher numbers of

mental health calls, some years it dips, but overall it has been increasing by 12 percent.

CO-CHAIRPERSON SALAAM: Of 9-1-1 mental health calls, how many result in emergency dispatch and how many calls were referred to other resources, for instance, NYC Well, or community-based services?

DEPUTY EXECUTIVE DIRECTOR GRANT: So we don't currently have an option to send 9-1-1 calls outside of the 9-1-1 system so not to what was formerly NYC Well, 9-8-8, so all calls that come into 9-1-1 do receive an emergency response from either NYPD and/or EMS.

CO-CHAIRPERSON SALAAM: Of calls leading to police civilian encounters, how often are people designated emotionally disturbed and what implication does that carry?

DEPUTY EXECUTIVE DIRECTOR GRANT: So I think that's probably a question for NYPD. It's important to note that both NYPD and FDNY categorize mental health calls as EDP, but the numbers are different for each system so NYPD has a total number of EDP calls that they categorize and FDNY has a total number that's different, and that's partially

2 due to kind of the differences in how they triage and
3 how calls come in.
4 DEPUTY CHIEF WASHINGTON: Okay, so just to
5 give a little context, I have figures from 2023. Over
6 9 million calls came into the system in 2023. Of
7 those calls, police officers responded to radio runs
8 of EDPs less than 2 percent of the time, okay, so
9 it's actually 1.8 percent. Our officers last year
10 responded to 174,893 calls for service of an
11 emotionally disturbed person. This year so far, we've
12 taken 6.5 million calls, and we've responded to
13 118,387 EDP calls.
14 CO-CHAIRPERSON SALAAM: Of mental health
15 calls leading to police-civilian interactions or
16 encounters, how many of these encounters resulted in
17 individuals being arrested and for what charges?
18 DEPUTY CHIEF WASHINGTON: I don't have
19 that in front of me right now, but I could get that
20 to you.
21 CO-CHAIRPERSON SALAAM: What is the rate
22 of use of force in these potential circumstances, and
23 how does that compare to other calls for services,
24 and has that changed since some officers started
25 receiving CIT training?

2 CHIEF OBE: I can speak to CIT generally.
3 I don't have the stats you're asking for.
4 CO-CHAIRPERSON SALAAM: How many officers
5 completed CIT training by quarter in the years 2024,
6 ’23, ’22, ’21, all the way down to 2015?
7 CHIEF OBE: Okay, so just real quick, CIT,
8 just some background. It's a national model adopted
9 in 2015. I just want to stress to the Council that we
10 don't work in a vacuum as the NYPD. We do work in
11 conjunction with DOHMH through an MOU, and also we
12 use clinicians from CUCS. Through the four-day
13 training at the Police Academy, there's also one-day
14 session where we have a peer panel just to support us
15 in the training. Since inception, since 2015, we've
16 trained 21,705 members. That's active and retired
17 members. Currently about half of the NYPD is trained.
18 That's 16,454 members currently trained in CIT. Some
19 of the concerns that come up always is how is it we
20 don't close up that gap to get closer to about 90
21 percent compliance or more. The numbers have not
22 dropped. Again, 21,705 active and retired, and
23 currently half of the members have trained. Since
24 2015, I just want to mention to the Council, we had a
25 two-year gap with COVID. So from March 23, 2020,

through March 21, 2022, two years, we did not have CIT training. We recognize the seriousness of the training, and some of the things that we've done to really close that gap and really to get a lot of our members a refresher or trained, I just want to mention, I mentioned this at a last Council hearing, is since October 2023, every single recruit gets the same four-day training so when you think about four classes in a year, average class about 600 recruits, on average about 2,400 recruits will be trained in CIT. I also want to mention that as we train, one of the things we do is to prioritize the operational commands. Why? Because they are the most likely officers to have any type of encounter with someone that's suffering from the throes of a mental crisis so we're certainly doing that. I just want to mention that with patrol, as of September 19th of this year, overall patrol total numbers is 14,915. We've trained 7,750. That's about 52 percent of patrol command officers assigned to patrol trained. Housing, about 73 percent. Transit, 75 percent. And other units, we don't prioritize as much, but we focus really on the operational commands.

We've also expanded CIT. The initial design was to have intimate small classes, 25 per class. We have two sessions now, an a.m. and a p.m. class. We also have doubled each class now to about 50. So in a week, we have two sessions going back-to-back. On average, 80 to 100 members are trained in CIT. 33,000 members, right? Ebony just mentioned 9 million calls, 174 calls that we've responded to. We have to reach 33,000 members, and one of the things we've done with great success is to put out a training video, virtual training, a little bit of a refresher, and this particular one that we put out this year is titled Engage in Individuals in a Mental Health Crisis. So far, we put that out as of September, as of today, actually, we have 70 percent of our members trained. That equates to 23,352 members trained.

There's also a concern about supervisors on the scene and what's their role. One of the things we've also done this year is to implement a one-day refresher course so for every new captain trained, every new lieutenant trained, every sergeant trained, we have a one-day refresher. We work, again, very closely with CUCS. We're very happy with our

partnership with them, and they also help us to have that, they bring on the peer panel who actually speak through their lived experiences. I sat through the training myself, and I think I found that to be the most moving experience out of this CIT training. So total this year so far, again, we just started July 1st with the supervisors. 330 supervisors trained so far, captains, lieutenants, and sergeants. And occasionally, every quarter or so, we put out a refresher bulletin if there's procedures that change, policy that change, and we put out a refresher bulletin. We published one in April of this year, and I'm pleased to say that we had really good responses with that, and we have over 90 percent of our members trained through the virtual training so that's just quick background on CIT.

CO-CHAIRPERSON SALAAM: I'm thinking about current news-related or newsworthy incidents, like the police shooting on the train station last week, and also Winn Rosario, in this particular instance, how does the department triage emergency calls that officers who have received CIT training or relevant specialized training, and how are they deployed in mental health calls?

2 CHIEF OBE: So you're asking if we use CIT
3 training, do we have officers who are CIT trained, do
4 we dispatch them to those calls?
5 CO-CHAIRPERSON SALAAM: Well, I'm
6 assuming, and I don't want to go through the whole
7 statement of what an assumption is, but I'm assuming
8 that of the fact that we have CIT training, is every
9 officer trained in that and, as it related to the
10 Winn Rosario incident, as an example, because it
11 appeared that the officers may not have been trained
12 in CIT.
13 CHIEF OBE: So I can't speak to that
14 specific incident. I could just tell you that these
15 are very tragic incidents, and any loss of life is
16 tragic. I could speak to how we train in de-
17 escalation and use of force specifically, but I
18 cannot speak to that particular incident. What we see
19 on ground is not, I think what I get a little bit
20 from what you're asking is, do we have CIT officers
21 assigned to those jobs when the EDP jobs come along,
22 and we're dealing with volume. You heard what Chief
23 Washington talked about and, honestly, we just want
24 to get our officers out there to help as best we
25 possibly can, de-escalate situations as best as we

2 can. I don't know that we have enough time to pair
3 officers to say, hey, who's CIT qualified and who's
4 not so, or maybe, I don't know if we can, I know that
5 we don't do that, and I would assume also that Chief
6 Washington's job does not take the time to, we just
7 want to get them out. There's a 9-1-1 call, there's
8 an emergency, the idea is to get our officers out
9 there. We would like to have CIT officers present,
10 yes, but I don't know that we do that tailored
11 approach of having a CIT officer present in every
12 situation.
13 CO-CHAIRPERSON LEE: Sorry. Can I just ask
14 a real quick follow-up to that? So my understanding
15 was also during COVID, I understand that the CIT
16 trainings were sort of decreased in terms of the
17 budget so can you speak to whether that's fully
18 brought back up? Also, do you think that it would
19 help decrease some of the numbers of instances where
20 force is used and improve overall safety for the
21 public as well as the officers if CIT was mandatory
22 because I can tell you that of all the COs that I
23 have and the captains in the precincts, Borough North
24 and South that I work with, they all actually want
25 more of this training, and I think it would benefit

2 everyone if we made that mandatory so do you think
3 that would help, number one? And number two, how much
4 would it cost, do you think?
5 CHIEF OBE: So just to speak to the
6 budget, I think about 2 million dollars. We mentioned
7 this the last time. It is absolutely, it's helpful,
8 it's mandatory and, again, mandatory for all our
9 recruits, they go through it. Every single recruit
10 since October 2023 has been trained in CIT, and we
11 continue to have the classes and, as I mentioned,
12 I've expanded attendance so we're happy with it, and
13 we'll continue to push.
14 CO-CHAIRPERSON SALAAM: I'm wondering, and
15 this is a ask, will the department commit to using
16 only CIT-trained officers to respond to mental health
17 calls or participate in mental health calls, and I'm
18 wondering because it seems like that type of training
19 for those types of instances helps save lives, and I
20 think that that's the ultimate goal that we want to
21 achieve, and will the department commit to that?
22 CHIEF OBE: Absolutely, we agree with you,
23 yes.
24 CO-CHAIRPERSON SALAAM: I think I'm going
25 to go for a second round.

2 CO-CHAIRPERSON LEE: Oh, okay, you want
3 to?
4 CO-CHAIRPERSON SALAAM: Well, yeah.
5 CO-CHAIRPERSON LEE: So we'll move on to
6 Council Member Narcisse, Chair Narcisse, sorry.
7 CO-CHAIRPERSON NARCISSE: Council, Chair,
8 is the same person. My question is about who offers
9 the training for social workers and EMT paramedics to
10 ensure that they are giving appropriate guidance for
11 de-escalation tactics and other clinical skills
12 required to respond to an individual experiencing a
13 crisis? What specific de-escalation techniques? I
14 know you've been answering some question around
15 there, but what specific de-escalation techniques are
16 currently implemented by B-HEARD teams?
17 SENIOR ADVISOR HANSMAN: So I can talk a
18 little bit about the training. So it's a four-week
19 training that's done jointly with EMTs and social
20 workers, which really covers the range of experiences
21 and training that they would need to operate out in
22 the field responding to mental health calls. So you
23 have two different jobs coming together to work
24 together, and we're training them together, right? So
25 the social workers are getting experience and some

training on EMT fundamentals, and then the EMTs are getting training on mental health fundamentals. So we're training on everything from motivational interviewing to trauma-informed care to hearing from peers that have had a response out in the field by EMS and by NYPD so it is really a comprehensive four-week training for, again, both the EMTs and the social workers. I will also note for the social workers themselves, we're hiring social workers that have extensive experience already doing crisis services so, whether that is working on a mobile crisis team, working in a comprehensive psychiatric emergency program within a hospital, or another mobile-based training team, we're really bringing in social workers that have a lot of that crisis experience as well as a preference for social workers that have lived experience, right? So part of our application process from the very beginning at New York City Health and Hospitals has been a preference for folks with lived experience on top of kind of that fundamental crisis experience.

CO-CHAIRPERSON NARCISSE: Thank you. I'm assuming it's H and H that's in charge of that.

SENIOR ADVISOR HANSMAN: It's a combination of H and H, and we actually bring in some other providers as well in areas where they can do potentially a better job than we can do. So motivational interviewing, for instance, we do contract out for that.

CO-CHAIRPERSON NARCISSE: Okay. If an individual is serving as a B-HEARD responder, do they also serve other roles within FDNY or H and H currently?

SENIOR ADVISOR HANSMAN: I'll speak for H and H first, and then I'll hand it over to Chief Escobar. For H and H, their only role, they're 100 percent on B-HEARD teams.

CO-CHAIRPERSON NARCISSE: Okay.

ASSISTANT CHIEF ESCOBAR: So for FDNY EMS, our members are trained EMTs that get specialized training to be able to work in the B-HEARD team, and that is their primary assignment. However, those members, because they are trained EMTs, are able to work in other bureaus and areas of the department on overtime if they wish to do so.

CO-CHAIRPERSON NARCISSE: Thank you. Coming back a bit on the language part, what language

1
2 is that your staff speaking right now for the one
3 that dispatching? What languages that you provide
4 services now?
5 ASSISTANT CHIEF ESCOBAR: I'm sorry. I'm
6 having a hard time.
7 CO-CHAIRPERSON NARCISSE: I said what
8 languages are B-HEARD services offered in?
9 ASSISTANT CHIEF ESCOBAR: I don't have the
10 exact number, but we have an application that allows
11 our members to use a translator application to be
12 able to communicate in many different languages to
13 the members of the public.
14 SENIOR ADVISOR HANSMAN: And then for,
15 just for H and H, just going back to the Language
16 Line question, it's over 200 languages through
17 Language Line.
18 CO-CHAIRPERSON NARCISSE: For the app?
19 SENIOR ADVISOR HANSMAN: Yeah, for the, I
20 assume through the, I mean, I don't know much about
21 the app, but for through Language Line through the
22 telephonic translation.
23 CO-CHAIRPERSON NARCISSE: After all, we
24 are New York City, and depending on app, when
25 somebody have a mental health crisis, app is not

going to help you much so I want to know how many languages that you have served, like your folks, your staff having in place.

SENIOR ADVISOR HANSMAN: Yeah, we'll circle back on how many. So for the multilingual, bilingual staff, we'll circle back on how many folks are bilingual, multilingual, and then the languages that they speak.

CO-CHAIRPERSON NARCISSE: That's very important.

SENIOR ADVISOR HANSMAN: Absolutely.

CO-CHAIRPERSON NARCISSE: Even in physical health, it’s a problem so can you imagine somebody having a mental crisis and you're trying to put an app for them?

SENIOR ADVISOR HANSMAN: Absolutely.

CO-CHAIRPERSON NARCISSE: All right.

CHAMBERS: (APPLAUSE)

CO-CHAIRPERSON NARCISSE: No clap, yeah. At times, B-HEARD response times have averaged about 20 minutes. What can be done to decrease the B-HEARD response times to match the approximate 8 to 11 minutes for other emergency services?

ASSISTANT CHIEF ESCOBAR: So thank you for that question. So I'll give you a little context. So all calls that come into the 9-1-1 system have to go through a categorization process.

CO-CHAIRPERSON NARCISSE: You're talking about that 9-1-1 one?

ASSISTANT CHIEF ESCOBAR: Yes.

CO-CHAIRPERSON NARCISSE: Okay, that's it. I'm going to…

ASSISTANT CHIEF ESCOBAR: Yes.

CO-CHAIRPERSON NARCISSE: Okay, go ahead.

ASSISTANT CHIEF ESCOBAR: All calls that come into the 9-1-1 system go through a categorization process because we are 9-1-1, we respond to life-threatening emergencies, and we have to provide the greatest good for the greatest number of people, and part of that involves us asking a lot of questions during the interaction with the caller to properly categorize this call so that the right resources are assigned. Unfortunately, some of the mental health calls that come in, because the way we categorize our 9-1-1 calls will have a lower prioritization than, for example, a cardiac arrest or an unconscious or a baby choking so, because of that,

some of those mental health calls are dispatched after we dispatch all the medical emergencies that we have to respond within minutes so that is one of the reasons why some of the mental health response calls have a little bit more of an extended response times, but we understand that we are trying to get the specialized teams that have additional training to the most appropriate calls, and sometimes that means that we need to take a little more time to dispatch these units. In addition, because we categorize these calls to a certain priority, the teams do not respond with lights and sirens, and they do not respond like our traditional ambulances responding to cardiac arrest and life-threatening emergencies so that is also why they would have an extended response, but we know that getting these specialized teams to these mental health emergencies is very important, and we take great pride that our teams are specially trained and get to these calls still quicker than some other services offered for mental health emergencies.

CO-CHAIRPERSON NARCISSE: Okay. Can you compare that to 9-8-8? If someone called 9-8-8, wouldn't it be faster if you called directly?

2 ASSISTANT COMMISSIONER NECKLES: So I can
3 try to respond to your question. Let me know if I'm
4 getting at your point. So if you call 9-8-8, right,
5 we're picking up the phone within 30 seconds, having
6 a conversation with the person which can take an
7 undetermined amount of time. We don't strive to be
8 brief, that's not the point of it, it's not 9-1-1, so
9 they may talk for five minutes, 10 minutes, an hour.
10 If 9-8-8 assesses a person as being in need of a
11 mobile crisis for in-person response, those teams are
12 responding, citywide the average was 2.3 hours last
13 year so we're thinking of that as urgent, it's
14 distinct from emergency services. It's the difference
15 between saying, I need to go to the emergency room
16 now, or I'm going to stop at the urgent care center
17 when I'm done with work, right? There's sort of a
18 similar distinction.
19 CO-CHAIRPERSON NARCISSE: The reason I'm
20 doing that is because when somebody have a mental
21 health crisis, we don't have to go to all the
22 loophole of all the other heart problem, and you know
23 specifically that person have a mental health, and we
24 want the mental health team to reach that person, and
25 I feel that we're not doing enough to promote the 9-

8-8, to let people know that this is the help that they can get instead of going to that triage process. I'm a registered nurse and triage nurse as well so that's the reason I get to that point because we have to differentiate mental health from physical health to make sure they get the services in a faster way. Because when somebody go into a crisis, I understand heart, I understand that because I'm an ER nurse, but I'm saying like mental health doesn't have to go to all the loops that we're going through.

One quick question that I have (INAUDIBLE) If a B-HEARD response team is dispatched to an individual experiencing a mental health crisis, is the individual billed for the B-HEARD services? If the response team deems it's necessary to provide emergency medical care or call an ambulance, will the individual be billed for such care? Will they notify if the cost prior to actions being taken, that would result in a medical bill?

SENIOR ADVISOR HANSMAN: So I'll talk about the B-HEARD response itself. So the two EMTs and the social worker responding to a patient in the community, that interaction with the two EMTs and with the social worker, that is not billed. Right

now, that is fully covered by the City and is not part of what the patient would be billed for.

CO-CHAIRPERSON NARCISSE: All right. No, the difference between medical and the mental health crisis, if they're going to be billed but, anyway, we move forward because so many people are waiting. I don't want to go back and forth on that one.

Does B-HEARD respond to people under the age of 18? If so, what is the age of the youngest person you have served? If not, do you have plans to expand the eligibility criteria?

SENIOR ADVISOR HANSMAN: So yes, B-HEARD does respond to patients under the age of 18. I don't have in front of me the youngest, but I can circle back with the youngest, but we have often responded to schools, to homes where there is a minor who is a patient in crisis.

DEPUTY EXECUTIVE DIRECTOR GRANT: The youngest age for eligibility for B-HEARD is six. It used to be…

CO-CHAIRPERSON NARCISSE: Six?

DEPUTY EXECUTIVE DIRECTOR GRANT: Yes. We used to respond to all ages but learned through the

1
2 implementation of the program that individuals under
3 the age of six require a different sort of response.
4 CO-CHAIRPERSON NARCISSE: This is not a
5 favorite topic, but we talk about it all the time.
6 Involuntary removal. Since the Mayor's November 2023
7 announcement on involuntary removal procedures, how
8 many people have been identified as needing mental
9 health removals? How many encounters have not
10 resulted in hospital transport?
11 DEPUTY EXECUTIVE DIRECTOR GRANT: We don't
12 have specific data on involuntary removals under the
13 Mayor's announcement and policy. What we can say is
14 that during the announcement of that policy, we as a
15 City put procedures in place for all of the agencies
16 that are involved in involuntary removals to begin to
17 track and collect how often those involuntary
18 removals are happening. We're gathering that
19 information and we will be able to report that
20 information in accordance with Local Law.
21 CO-CHAIRPERSON NARCISSE: So you don't
22 have no data on that?
23 DEPUTY EXECUTIVE DIRECTOR GRANT: On
24 involuntary removals citywide.
25 CO-CHAIRPERSON NARCISSE: Uh-how much.

DEPUTY EXECUTIVE DIRECTOR GRANT: No.

CO-CHAIRPERSON NARCISSE: And about NYPD?

DEPUTY EXECUTIVE DIRECTOR GRANT: Not here.

CO-CHAIRPERSON NARCISSE: Do NYPD have the data?

CAPTAIN BUTLER: No, the NYPD does not have data at this hearing.

CO-CHAIRPERSON NARCISSE: You don't?

CAPTAIN BUTLER: I do not, but we will follow up and get the data over. We'll circle back to that.

CO-CHAIRPERSON NARCISSE: You know what, Chair? I think I'm going to take a pass because I know some of my Colleagues have some questions. Thank you for your time.

CO-CHAIRPERSON LEE: Okay, great. So first up we have Council Member Cabán followed by Council Member Schulman.

COUNCIL MEMBER CABÁN: Thank you. I'm going to ask you all to be as succinct as possible, and I'm going to apologize in advance if I interrupt or cut you off.

2 Okay. I'm just going to dig in. Why does
3 each data brief created by the City use different
4 variables and measurements to show outcomes
5 associated with B-HEARD, and do you have plans to
6 standardize what information is in the B-HEARD data
7 briefs?

8 DEPUTY EXECUTIVE DIRECTOR GRANT: The
9 metrics that we report on have evolved with the
10 growth of the program. As we identify different
11 metrics that the public, that Council are interested
12 in, we try to report on those. As of right now, we
13 released a new data page on Friday that has data
14 spanning from the start of the program through the
15 end of Fiscal Year ’24, which just ended two and a
16 half months ago.

17 COUNCIL MEMBER CABÁN: Thank you. I will
18 say that that data that you dropped on Friday, which
19 didn't leave us a lot of time to dig into over the
20 weekend, but it is pretty thin compared to the data
21 that is kept by other cities at this point. In
22 Portland, Oregon, for example, Portland State
23 University, they conduct the program evaluation of
24 their street response team. Would you guys consider
25 partnering with a local university like CUNY to do

2 something similar because it would expand your
3 capacity, but also I think that independence is
4 really important too.
5 DEPUTY EXECUTIVE DIRECTOR GRANT: We have
6 been in conversations with different academic
7 institutions about B-HEARD and evaluation.
8 COUNCIL MEMBER CABÁN: And specifically
9 about them doing these evaluations?
10 DEPUTY EXECUTIVE DIRECTOR GRANT: Yes.
11 COUNCIL MEMBER CABÁN: Great, thank you.
12 This is a quick yes or no. Can the City commit to
13 public and timely quarter data briefs with consistent
14 variables with the things that you're already doing,
15 but some of the things that we've talked about and
16 we'll continue to talk about here today?
17 DEPUTY EXECUTIVE DIRECTOR GRANT: We are
18 committed to timely data reporting.
19 COUNCIL MEMBER CABÁN: Okay. Sorry, it's
20 one more minute, Gail, sorry, Council Member Brewer.
21 I'm kidding.
22 Out of the calls that B-HEARD responds
23 to, what percent of those, after they get there, do
24 police then get called in?
25

DEPUTY EXECUTIVE DIRECTOR GRANT: We do not have that data at the moment.

COUNCIL MEMBER CABÁN: Okay, and I named earlier the very, very low, almost non-existent percentages in other cities so I think that's important to keep.

We talked about the 118,000 dispatches. I'm going to do two questions together, but we talked about the 118 dispatches. While that's only a small percentage, I think that's probably still too many when we know that one third, one out of every three people killed by a stranger are killed by a police officer. Half of the people killed by police officers in this country are people living with a mental health diagnosis. So we know what's at stake here. We know that the officers that killed Kawaski Trawick were CIT trained. In fact, one of them was trained just three days before that shooting so it hammers home that police, no matter the training, are not the right responder here so I just want to emphasize that.

Then my last question in this round is, you said that 44 percent of people were connected to a community resource. What's the breakdown? How many

of that 44 percent are staying where they are? How many are going to a local resource? Which local resource are they going to? Of that 43 percent, how many did you respond to on a subsequent call again? Are there any trends that you're noticing from the breakdowns of those interactions? Because none of that information is available.

SENIOR ADVISOR HANSMAN: So I don't have that information in front of me, but we'll follow up with that. It's something that we do track about how many folks are and where folks are going, but it's a combination of referring back to a provider, it’s a combination of taking someone to a support and connection center, and a combination of referring someone even to our virtual express care.

COUNCIL MEMBER CABÁN: You do have it, but you didn't bring it here today?

SENIOR ADVISOR HANSMAN: There's issues with the amount of data that we can provide based on how many times we did it and HIPAA and our ability to share.

COUNCIL MEMBER CABÁN: I don't know what HIPAA has to do with how many people you left in the community that opted not to go to a program or what

2 programs are being utilized without giving anybody's
3 personal information. I was a lawyer. I had my client
4 sign HIPAAs. I know exactly what type of information
5 must be protected, and what I'm asking you has
6 nothing to do with HIPAA at all.
7 SENIOR ADVISOR HANSMAN: So again, some of
8 the…
9 CHAMBERS: (APPLAUSE)
10 COUNCIL MEMBER CABÁN: I'm just disturbed
11 that you didn't come here with the information that
12 we were likely to ask about today. I'm sorry. I've
13 gone over time. I want to be respectful. I will hand
14 it over to the Chairs.
15 CO-CHAIRPERSON NARCISSE: Thank you. We're
16 going to have a second round. The next, Council
17 Member Schulman, please.
18 COUNCIL MEMBER SCHULMAN: Okay, thank you
19 very much, and I want to thank Council Member
20 Bottcher for trading with me because I have a hearing
21 I want to go to, but it was very important for me to
22 speak today. I have a little bit of a statement and I
23 have some questions.
24 So Winn Rosario was a constituent of mine
25 and the system failed him. I said that on March 27th

when he was killed, and I'm saying it again today. This is an individual who knew he was going through a mental health crisis, whose family knew he was going through a mental health crisis, called 9-1-1 and he got killed as a result of that. That should not have happened. The mental health system is broken and, separate from that, his family had indicated that they had tried to get him treatment prior to that call in our hospital system and that failed him as well so this is separate from the B-HEARD and everything else. We have to really take hold of that, and I'm somebody that's very committed to that.

But I have some questions about the whole B-HEARD system and the response and everything else. So one is, I heard previously that there is a difference between the definition between FDNY and NYPD of an emotionally disturbed person. Why is that? Why is that not consistent across the board? Can nobody answer me?

ASSISTANT CHIEF ESCOBAR: So I could speak to just some of the procedures once the call comes to EMS. So the calls when they come into 9-1-1 start off first with an NYPD call-taker. They will categorize the call a certain type, which I'm not going to speak

2 of because I am not familiar with the call types.
3 Depending on that call type, it goes to EMS and we
4 start our triage process. We have various call types
5 that we classify our mental health emergencies. NYPD
6 has different call types because we are using two
7 different criteria, and I'm not going to speak for
8 NYPD, but our criteria is based on safety, any
9 medical conditions that may change it from a mental
10 health emergency to a medical emergency so that is
11 why we kind of speak different languages in the call
12 typing because we go through a series of questions
13 which will potentially have that call change several
14 times during the interaction.
15 COUNCIL MEMBER SCHULMAN: Because I think
16 there's an assumption when it goes to NYPD that
17 there's a violent situation, and so the reaction is
18 based on that… Chair, can I just finish my line of
19 questioning?
20 CO-CHAIRPERSON NARCISSE: Okay, try to
21 wrap it up, please.
22 COUNCIL MEMBER SCHULMAN: Does NYPD want
23 to respond or yes, no?
24
25

DIRECTOR LEVIN: I know we're quick on time. (INAUDIBLE) you're asking. You're specifically asking, does NYPD want to comment on?

COUNCIL MEMBER SCHULMAN: Why there's a difference between, if somebody calls 9-1-1 and they have a mental health emergency and having a mental health crisis, but it only goes, because in the case of Winn Rosario, only NYPD responded, nobody else, so that's why I want to know the differences and how that determination is made in the 9-1-1 system.

DIRECTOR LEVIN: Sure. So I'm going to speak to this quickly, and then if I get anything wrong, please let me know, Chief. There are certain things that the call-taker will be looking for when they first call 9-1-1, right? Some of those things are a weapon. Some of those things are violence. When those factors are present, all calls are still connected to EMS, okay? FDNY ultimately makes a determination about whether B-HEARD is eligible to respond to that, okay?

COUNCIL MEMBER SCHULMAN: Okay.

DIRECTOR LEVIN: But when we see certain situations where a civilian should not be walking into, because the civilian does not have the

2 training, the civilian does not have, and I hate to
3 admit, sometimes weapons, right, or body armor, those
4 are times where it would be appropriate for NYPD to
5 respond to.
6 COUNCIL MEMBER SCHULMAN: I'm not saying
7 NYPD shouldn't respond. I'm saying that they
8 shouldn't be the sole response. That's the issue.
9 DIRECTOR LEVIN: Understood. I hear your
10 point. Your point is NYPD alone shouldn't be going. I
11 certainly hear that, but there are certain times when
12 it's going to be outside the scope of safety for
13 other agencies to respond to our jobs to preserve the
14 peace.
15 COUNCIL MEMBER SCHULMAN: Yeah, we can
16 debate that. I'm not going to debate that here.
17 I have a question about, so B-HEARD, I
18 know it's on pause, did I hear correctly?
19 ASSISTANT COMMISSIONER NECKLES:
20 Expansion.
21 COUNCIL MEMBER SCHULMAN: The expansion is
22 on pause. It's fiscally prudent to expand it as
23 opposed to not expand it because you save money on
24 the other end and you save lives on the other end so
25 I just want to make that statement.

My other question is, in the testimony, it says the Health Department manages New York City's single point of access system to specialty treatment and recovery services. It says here that the referrals come from providers and all that. Are there no referrals from hospitals because very often what happens is somebody who's having an emotional or mental health crisis goes to the hospital and they're released right away so that's why I'm asking the question.

ASSISTANT COMMISSIONER NECKLES: Sure, that's a common referral pathway. In fact, the most common, the single largest source is the hospitals.

COUNCIL MEMBER SCHULMAN: Okay, because it wasn't mentioned in here.

Because I know a lot of people want to ask questions, but I'm going to end it here, and I appreciate it and I hope we have more discussions on this. Thank you.

CO-CHAIRPERSON NARCISSE: We have a second round, Colleague.

Next is Councilman Bottcher.

COUNCIL MEMBER BOTTCHER: Thank you very much. Who's getting the B-HEARD program next? When

1
2 the freeze is lifted and you get the green light to
3 expand the program, which neighborhoods will start
4 getting behavioral health responses to behavioral
5 health 9-1-1 calls?
6 DEPUTY EXECUTIVE DIRECTOR GRANT: We have
7 not made that decision yet.
8 COUNCIL MEMBER BOTTCHER: You stated that
9 the decisions with respect to which precincts get
10 these programs is based chiefly on the volume of 9-1-
11 1 mental health calls. Where do the precincts in City
12 Council District 3 on the West Side of Manhattan, the
13 1st, the 6th, the 13th, the 10th, Midtown South,
14 Midtown North, where do those fall with respect to
15 the volume of mental health 9-1-1 calls?
16 DEPUTY EXECUTIVE DIRECTOR GRANT: We don't
17 have that data with us, but one slight correction,
18 the decisions around which communities we expand to
19 are partially based off of 9-1-1 call volume but also
20 based off of other operational considerations.
21 COUNCIL MEMBER BOTTCHER: On the 16th of
22 September, I emailed and requested, and you're
23 nodding so you got the email, I requested a list of
24 precincts in order of the volume of 9-1-1 mental
25 health calls, followed up on Friday, asking that that

be brought to this hearing. Is that a request you're familiar with?

DEPUTY EXECUTIVE DIRECTOR GRANT: Yes, we were not able to pull that data in advance of this hearing, but we can get you that data.

COUNCIL MEMBER BOTTCHER: Okay, you can pull it after the hearing.

DEPUTY EXECUTIVE DIRECTOR GRANT: Sure.

COUNCIL MEMBER BOTTCHER: Okay. Other factors to be taken into consideration, would the fact that Times Square, for example, gets 50 million visitors per year, would that be a factor that you'd consider in the expansion of this program?

DEPUTY EXECUTIVE DIRECTOR GRANT: I can't say. I wouldn't be able to speak to that. There are a number of different operational considerations that go into the decisions around the communities that next get a team.

COUNCIL MEMBER BOTTCHER: In your collective conversations, what neighborhoods are under consideration as you just talk about where the program goes next? What areas do you have in mind?

DEPUTY EXECUTIVE DIRECTOR GRANT: That decision has not been made yet, but I will say that

2 we do have a number of other mental health crisis-
3 related resources in the communities where B-HEARD
4 does not currently exist, and my colleague from the
5 Health Department, Jamie, has talked about some of
6 those things like mobile crisis teams, which are
7 city-wide and can be accessed through 9-1-1.
8 COUNCIL MEMBER BOTTCHER: They're not
9 doing the trick. We all know, and you agree, that
10 ultimately, 9-1-1 calls about mental crises should
11 have a behavioral health response, not just a police
12 response. We agree, that's why we're here. The West
13 Side of Manhattan has, we've got big problems. I know
14 my Colleagues can say the same thing about their
15 Districts, too, but we want this program in our
16 District. Looking forward to working with you to make
17 that happen. Thank you.
18 CO-CHAIRPERSON NARCISSE: Thank you,
19 Member. The next is Council Member Joseph.
20 Okay. Is Nurse here? Council Member
21 Brewer, Gale Brewer.
22 COUNCIL MEMBER BREWER: Thank you very
23 much. I mean, I know how much work you're putting
24 into this topic, and I can tell you it is the number
25 one issue in New York City now, and so this hearing

is incredibly important. I just want to tell you one quick story. It was the other day, I was in the District office. Young man came by. He actually said to us, I am in bad shape, I could kill somebody, I need help, I went to GMHC, I went to Bellevue, I got no help. Now, me, I should know about 9-8-8. I didn't think about it. I happen to have been one of the people who was there when Ryan Health Center started, and I called Ryan because I got everybody's cell number, and the next day, he got service. He met them at Ryan in the morning. They took care of him, and he has care. That's how I know how to do stuff, but I worry if I don't have somebody's cell number, what am I going to do? What would have 9-8-8 done if this young man had not had me who has everybody's cell number in the city of New York?

ASSISTANT COMMISSIONER NECKLES: Can we give 9-8-8 your cell phone number?

COUNCIL MEMBER BREWER: Yes. And you know what? I can handle it. I can handle anything, I'll be honest with you, but what would he have gotten from 9-8-8?

ASSISTANT COMMISSIONER NECKLES: So, I don't know the full circumstances, obviously.

COUNCIL MEMBER BREWER: I mean, I didn't know either. He was really in bad shape, and he was, like others, admitting it.

ASSISTANT COMMISSIONER NECKLES: Yep. So, that's great that he found help, and so thank you for helping him.

If he had called 9-8-8, they would have spent time on the phone with him, trying to listen to him, and understand what he was going through, to reflect on that, right, so he can feel heard, and they can do a more thorough assessment. They may have connected him to the Ryan Health Center, right down the street there. That's entirely possible. One of the most common things.

COUNCIL MEMBER BREWER: This was 6 o'clock at night.

ASSISTANT COMMISSIONER NECKLES: So, it depends, right? They will know the operating hours of the places to which they are referring people, and they will connect people to things that are commensurate with the acuity of the situation and immediately available.

COUNCIL MEMBER BREWER: Okay, I'm just saying, sounds good. I know you're trying. We just

need a more immediate response. I'm just saying, and it's a 24-hour issue, etc.

The second question I have is just beds at Health and Hospital. I was actually not here, but I listened to everything, and you're right, housing is the issue so my question is, the Mayor's talked about these beds. How many are now available for people who have mental health issues, and what is it? Obviously, we want alternatives to Rikers, which is part of the issue so I'm confused about these beds, like what do we have now? Are there any that are alternative to going to Rikers? That's my second question. What is with these damn beds?

ASSISTANT COMMISSIONER NECKLES: So, there's a number of services that might describe themselves as beds. I could talk about the housing and the crisis beds. Health and Hospitals can talk about inpatient beds.

The Health Department supports over 12,000 units of permanent supportive housing so that's where people sign leases and live for decades, as long as they want to live in that place. We also have crisis residences, which provide an alternative

2 to hospitalization. We may characterize their
3 capacity as beds as well.
4 COUNCIL MEMBER BREWER: I heard you have
5 38 or something.
6 ASSISTANT COMMISSIONER NECKLES: We have
7 38 of those in contract with the city.
8 COUNCIL MEMBER BREWER: Good memory from
9 earlier.
10 ASSISTANT COMMISSIONER NECKLES: Yes,
11 excellent, good. There's also 12 more in contract
12 with the State so there's currently 50 open and
13 available in New York City and more to come online as
14 those new services become licensed by the state.
15 COUNCIL MEMBER BREWER: Is there a waiting
16 list for those? Is there a waiting list, I assume?
17 ASSISTANT COMMISSIONER NECKLES: Is there
18 a waiting list for those services? I don't know the
19 answer to that question off the top of my head.
20 COUNCIL MEMBER BREWER: Okay, because it
21 seems to me that's what people need and want right
22 now.
23 ASSISTANT COMMISSIONER NECKLES: Yeah,
24 there are tremendous…
25

COUNCIL MEMBER BREWER: How long do people stay at those crisis beds, usually?

ASSISTANT COMMISSIONER NECKLES: It ranges, average around a week. They can stay up to 28 days, I think, but we can make exceptions as needed.

COUNCIL MEMBER BREWER: Okay. The other issue is, and the whole issue is you serve, like you get, you have somebody through EMS, through NYPD, whatever the situation is, they're served by you, but then they leave whatever, whether it's a crisis, whether it's Bellevue, then they, you know, how do you track them because that's what the problem is. You have people in, you know, the public is now crazed about people in the subways, etc., you know the press, and the tabs have it on the front page every day. How do you track what's happening to these folks? Now, I have to give DA Bragg credit. I assume you know he has somebody at arraignment now, and he has, he put three million into that, and six million into street work. Seems like it's working. Are you coordinating with him because he's doing that. What is happening to people once they leave arraignment? What's happening to people when they leave Bellevue? What's happening to people when they leave your

2 crisis beds? That's what I'm concerned about. I had
3 35 foster care kids. I know what it means to have
4 people in trouble so what happens, how do you track
5 those people when they leave?
6 ASSISTANT COMMISSIONER NECKLES: So I
7 think there's definitely a lot of opinions about
8 tracking people.
9 COUNCIL MEMBER BREWER: I know, but you
10 have to do it in a positive way (INAUDIBLE) do it in
11 a positive way so they continue to get help.
12 ASSISTANT COMMISSIONER NECKLES: Yeah, so
13 at the clinical level, and at the care delivery
14 level, our services, all of them will be required by
15 contract to have a follow-up contact, right, relative
16 to the scope of their intervention so a mobile crisis
17 team may check that a person attends the appointment
18 to which they were connected. An ACT team that worked
19 with a person for a few years will check in at 90
20 days post-discharge so they're built in at the
21 clinical level where the person knows the situation
22 uniquely.
23 COUNCIL MEMBER BREWER: Okay, because my
24 experience, a lot of people just don't go to the next
25

1
2 appointment. That's my experience so that's where the
3 problem is.
4 ASSISTANT COMMISSIONER NECKLES: Yep,
5 following up and making services easy to access is
6 critical, right?
7 COUNCIL MEMBER BREWER: Correct.
8 ASSISTANT COMMISSIONER NECKLES: So that
9 it's not hard to walk in and to get what you need is
10 what we're focused on.
11 COUNCIL MEMBER BREWER: So that's the
12 challenge, I would say, big time.
13 Finally, those who have drug overdose or
14 just drug issues in general, are there enough
15 programs? Are the hours correct? Is the service
16 there, etc., because I have a lot of friends who are
17 judges, and this is an issue for them. They say there
18 are not enough programs for the individuals who come
19 before them in court and they are trying to find the
20 right services. They say they're not there. So is
21 that something that you feel is sufficient? A lot of
22 them are State-funded, I know, and oversight by the
23 State. I used to be on a board for 25 years of a drug
24 treatment program. I know these programs. Just help
25 me, walk me through somebody who's got a drug issue.

2 EMS is there. Maybe police are there. How does that
3 get handled? Not easy.
4 ASSISTANT COMMISSIONER NECKLES: So I
5 think, you know, you asked about police or EMS. I
6 think drug overdoses are a horrible problem that our
7 city is focused on turning the tide on the overdose
8 epidemic. I think this hearing is focused on mental
9 health crises. Certainly, there's an overlap…
10 COUNCIL MEMBER BREWER: But you could be
11 mentally ill and have…
12 ASSISTANT COMMISSIONER NECKLES:
13 Absolutely, absolutely. But I'm not prepared to talk
14 about substance use treatment capacity. I think that
15 was the question you were asking, and I don't have
16 those details here today.
17 COUNCIL MEMBER BREWER: Okay, so if a
18 person is also mentally ill, how would that play a
19 role, and using drugs.
20 ASSISTANT COMMISSIONER NECKLES: Yes, so
21 certainly that's common, and I think we…
22 COUNCIL MEMBER BREWER: Very common.
23 ASSISTANT COMMISSIONER NECKLES: Expect
24 and require all of our mental healthcare providers to
25 be able to assess substance use, take a harm

2 reduction approach to welcome the person into the
3 services, not to reject them and say, oh, sorry,
4 you're using, you're not welcome here. That's
5 unacceptable, and so we want all those folks to feel
6 welcome in our programs, to be able to do overdose
7 reversals through Naloxone, and get people access to
8 things like medication-assisted treatment through
9 their mental health programs so they can get
10 evidence-based care for their addiction.
11 COUNCIL MEMBER BREWER: So something like
12 that would be able to be dealt with if you see
13 there's a mental health aspect to that person.
14 ASSISTANT COMMISSIONER NECKLES:
15 Absolutely.
16 COUNCIL MEMBER BREWER: What would you do
17 with that person? Would it go to Bellevue in
18 Manhattan? Where would one take that person with a
19 mental health issue and obviously using drugs.
20 ASSISTANT COMMISSIONER NECKLES: Sure, so
21 I think, I don't know that I'm answering your
22 question about where we would take a person. I'm
23 talking about the sort of care that we would provide,
24 and so most people are getting care in the community
25

where they live so I talked about a medication-assisted treatment and overdose prevention, Narcan.

COUNCIL MEMBER BREWER: Okay, I mean, all right. It's not what I see on the street, I have to tell you.

And then just finally on the data tracking, I understand there's been a lot of data questions today. I would have the same questions. So what are you doing to standardize? What's the next step after this hearing to try to standardize some of this data because obviously, with all due respect, you don't have much data today.

DEPUTY EXECUTIVE DIRECTOR GRANT: We published a lot of data on the OCMH's webpage for B-HEARD, data spanning from the start of the program through the end of FY-24. We'll continue to report data there and make data available on that webpage, and we are committed to releasing data in a timely manner.

COUNCIL MEMBER BREWER: Okay, does it also go to the Open Data platform?

DEPUTY EXECUTIVE DIRECTOR GRANT: Oh, that's a good question.

COUNCIL MEMBER BREWER: That's my bill.

DEPUTY EXECUTIVE DIRECTOR GRANT: Okay, we will find out.

COUNCIL MEMBER BREWER: Thank you.

CO-CHAIRPERSON NARCISSE: Council Member, can you wrap it up for me?

COUNCIL MEMBER BREWER: I'm done.

CO-CHAIRPERSON NARCISSE: Now, coming back to CIT training, we understand that you are prioritizing the training for officers who are likely to interact with someone in crisis, right? Is there any timeline in mind to get 100 percent? Because I heard 70 percent. I don't know if I'm wrong.

CHIEF OBE: There is a timeline with CIT training. So again, it's 33,000 members. We're about halfway through. To close the gap, because besides just CIT training, we also have to be concerned about refreshers. So essentially, if you took that course, say, in 2017, here we are in 2024, where is this refresher? So we have that virtual training is done. We're good with that. But the concern is just to get 100 percent to get all our new recruits through training. So again, four classes a year, approximately 600 per class. On average, we train about 2,400 of our recruits per year. So this is just

steps that we're taking to close that gap. We have the virtual training. We have the supervisors also because they have a role also in their response to these incidents. So there's a lot that we're doing to get our people trained.

CO-CHAIRPERSON NARCISSE: Okay, thank you for that. Let me quickly, Member Cabán, just one second. Local Law 53 of 2023, it was a training for autism how to interact with people with autism so can you tell me where we at with that, with the training?

CHIEF OBE: I'll tell you that we went above and beyond so that video was put together this year. As we speak today, we have 84.2 members trained. Again, focus on operational commands, but overall NYPD, 84.2 percent, so that equates to about 28,218 members trained. A few Council hearings ago, we had a Council Member that was concerned about children, and we have now expanded that training to incorporate in the recruit training. We have the DOE always speaks to our recruits, and we also have the Aspen Institute that also speaks to our recruits so the DOE presentation is based on police response to children in crisis in public school settings, and the

Aspen Institute trains our recruits on a topic of safeguarding children so we've gone above and beyond.

CO-CHAIRPERSON NARCISSE: I appreciate that. Keep on doing it because a lot of, the reason that question come up, because a lot of people in mental health crisis, interacting with young folks that have autism, and you cannot make the difference in that so I thank you for that.

Now we're going back to Council Member Cabán.

COUNCIL MEMBER CABÁN: Thank you. Same disclaimer as before. This is a quick one. What's the average salary of a social worker on a B-HEARD team, and what's the average salary of an EMS worker?

ASSISTANT CHIEF ESCOBAR: The average salary for an EMS EMT who is three years on the job would be somewhere along the line of 46,000.

COUNCIL MEMBER CABÁN: That is horrendous. It's appalling. You spend time training these folks up, and then they're not making a living wage in this city, and so when we talk about capacity and the ability to hire people, and how do we expand, because we can't do that, it starts with making sure that that particular sector of first responders gets paid

what they should be paid, and I know that that's not your decision, but that's, I mean, it's a condemnation of the position that the Administration has taken on paying these folks.

I'm going to shift over to the Department of Health. You testified earlier that CIT uses peers, correct?

ASSISTANT COMMISSIONER NECKLES: So CIT would be a Fire Department, I'm sorry, Police Department.

COUNCIL MEMBER CABÁN: Oh, I'm sorry, but you had testified that you have peer teams involved in your mental health response work.

ASSISTANT COMMISSIONER NECKLES: Yes.

COUNCIL MEMBER CABÁN: Okay, and why is that?

ASSISTANT COMMISSIONER NECKLES: Peers add tremendous value to the work that we do.

COUNCIL MEMBER CABÁN: And I'm going to add to your answer and say that it has also been empirically proven. Research data evidence shows that peers create safer environments and produce better health and public safety outcomes so my question to the B-HEARD team is why aren't you incorporating

peers on your teams, and will you commit to incorporating peers onto your teams? You just heard that your partners in government, your Health expert partners in government use peers.

SENIOR ADVISOR HANSMAN: Yeah, I think that's absolutely correct, right? So peers are a valuable part of our healthcare system, right? So in Health and Hospitals, we have them in our…

COUNCIL MEMBER CABÁN: My question is why don't you use them, and will you commit to adding them to your teams? Really, really quick, because I've got a minute and a half.

SENIOR ADVISOR HANSMAN: Absolutely, yep. The reason that we don't have them on our B-HEARD teams is that we are relying on a clinical assessment out in the field about whether or not an individual should be referred back to the community, to a community provider…

COUNCIL MEMBER CABÁN: Why does that preclude you from having a peer on a team? If it's a three- to four-person team, you have a clinical professional to assess and you could have a peer so…

SENIOR ADVISOR HANSMAN: Because you have…

COUNCIL MEMBER CABÁN: That doesn't seem like it… will you commit to adding peers to your teams?

CHAMBERS: (APPLAUSE)

SENIOR ADVISOR HANSMAN: This is something we are looking…

COUNCIL MEMBER CABÁN: Yes or no, will you commit to adding peers to your teams?

SENIOR ADVISOR HANSMAN: At this time, we are looking at it, so.

COUNCIL MEMBER CABÁN: Okay, okay.

SENIOR ADVISOR HANSMAN: I just want to mention that a peer can't do that clinical assessment. We have two EAPs.

COUNCIL MEMBER CABÁN: I didn’t say that the peer should do the clinical assessment. I said they should be part of the team. I'm going to move on to my next question, thank you.

I want to ask about just how, this is more about dispatch and sort of how they're assessed. It was testified earlier that operators are not medical professionals. Is there a mental health expert in dispatch helping to screen calls or to do the training? I visited several cities and, in one of

2 them, they actually did have a mental health expert
3 in dispatch helping dispatch those calls with the
4 full-time dispatchers. Just the question is, is there
5 a mental health expert in dispatch assisting with
6 that work?

7 ASSISTANT CHIEF ESCOBAR: So the Fire
8 Department has, as part of the emergency medical
9 dispatch, several medical doctors that are assigned
10 to come up with all the algorithms that are used.

11 COUNCIL MEMBER CABÁN: But are they in
12 dispatch was my question. Are they doing…

13 ASSISTANT CHIEF ESCOBAR: They're not
14 physically in dispatch.

15 COUNCIL MEMBER CABÁN: Are they having
16 face-to-face interactions and conversations with
17 dispatchers?

18 ASSISTANT CHIEF ESCOBAR: The answer is
19 no.

20 COUNCIL MEMBER CABÁN: Thank you. Do
21 dispatchers get pulled off the floor for counseling
22 after a particularly traumatic call, like are they
23 taking a break after some of that? Again, this is
24 something, I stood in the middle of a dispatch room
25 in another city, and they had a protocol for taking

folks off the floor, making sure that they're all cared for. Is that happening in dispatch?

ASSISTANT CHIEF ESCOBAR: I'll speak for EMS dispatch because we have different agencies here that do dispatch. For EMS, whenever any of our communication members experience a very traumatic call, we have supervisors that are trained to offer peer counseling, our CSU unit, and so the answer is yes.

COUNCIL MEMBER CABÁN: Thank you. And NYPD, the two questions. Do you have a mental health expert in dispatch with the dispatchers, and are you pulling people off the floor to provide support?

CHIEF OBE: No, we do not have a mental health professional, and we do have a Stress Class, we call it, and we do identify operators that experience a traumatic incident that they may handle the call.

COUNCIL MEMBER CABÁN: Thank you. I just have two more questions. Chair, may I, or chairs, may I? Thank you. I got the nod from Chair Salaam.

Okay, so my first of the two last questions, when I was in dispatch, right, I'm talking to, first of all, that is a hell of a job. That is a

really hard job to do, and they're getting in information, and they have to make a call based on the information they have, and there are legal liabilities, and I had never thought about this part of the equation before, and I said, why aren't more calls going to the alternatives, why aren't they, and they said, well, I have to legally go off of the information that's being given to me by whoever it is on the other line, even if I think it might not be the most accurate description of what's happening. Do we have a public education program, or will you consider a public education program so that individuals who are calling 9-1-1 are better reporters of behavior because the way that we talk about mental health, the way we talk about how somebody presents makes a difference on what the dispatcher has to do, and so if we want to make this better, that's like a critical, critical piece. Do we have a public education program like that, and are you willing to explore and dig into that? That's my first question. I have one more question.

DEPUTY EXECUTIVE DIRECTOR GRANT: So the Mayor's Office of Community Mental Health is working with the Health Department, with a number of City

agencies around public messaging around what is an emergency versus what is an urgent mental health crisis, and so we are working together to identify the best way to publicize this to the community because we too, whenever we do a presentation about the B-HEARD program, we talk about it in the context of all of the other crisis response services in the system, and we do know that more education is needed around when to call 9-1-1 versus 9-8-8.

COUNCIL MEMBER CABÁN: Well, and it's not even a matter of when to call 9-1-1 versus 9-8-8. It's just, it's how do you describe somebody's behavior? Like, that's actually, the language you use to describe somebody's behavior is actually what's important, and I wonder if people within the Administration understand that, and also, again, if the public understands that, and this question is connected to that.

I want to know more about how dispatch defines violence because if you ask our Mayor, he's been on the record describing shadowboxing as violence. Somebody else might think that a person experiencing a mental health episode yelling obscenities is violence, but it's not, and again, a

real-life example is I was with mental health, the Portland team, and they told me this story. They said, you know, we went to a call, and we showed up, and you know, the police are back there. They don't get called in, but the gentleman when we got there who was experiencing the mental health crisis had a bunch of rocks in his pocket, he had a couple rocks in his hands, and the police tried to come in, saying, he's got a weapon, we have to go in, and the mental health responder says, no, no, no, it's okay. We don't need you to come in, and he walked in. He sat down next to this person, which the police officers, because of the training, would have been like, that's not protocol, you cannot do that, you don't sit side-by-side, you’re vulnerable, X, Y, and Z. He said, no, I feel safe. That's what I did, and over the course of a conversation, one rock comes out of the pocket, two rocks come out of the pocket, three rocks come out of the pocket, and they have this really good conversation, and it sets the tone, right? And so, and this, again, goes back to language and how we're describing things. How does dispatch define violence? How are the teams defining violence? How is the NYPD assessing what is violent or not

2 violent? Because that dispatch team said, no, this
3 person holding rocks, that's not a weapon and it's
4 not violence, and we should be the team responding,
5 not the police, but in this situation, the police
6 could have very well said, no, that's a weapon, we're
7 going to do that. So how are each of these pieces of
8 sort of the process defining violence?
9 DEPUTY CHIEF WASHINGTON: I want to start
10 by saying thank you for recognizing the hard work
11 that operators have. It's not easy.
12 COUNCIL MEMBER CABÁN: No, it's not.
13 DEPUTY CHIEF WASHINGTON: Right? And so my
14 operators are taught to take what the caller is
15 saying at face volume, right? We're not going to
16 assume anything. We're going to document what they're
17 saying and give them the services that they need,
18 whether it's police, fire, or medical, okay? I would
19 say that an aggressive or destructive behavior could
20 be considered violence, all right? So if they're
21 describing someone saying that they're swinging at
22 me, or they're banging on a car, or they're
23 destroying items in the house, that would trigger a
24 police response along with possibly EMS, if there's
25

2 some type of medical history, possibly, if there's
3 something more.
4 COUNCIL MEMBER CABÁN: Well, if there's
5 some sort of destruction of property, but not a
6 threat to a person, can the team say, hey, no, we
7 feel comfortable, this actually isn't violence, and
8 we're equipped to deal with this situation?
9 DEPUTY CHIEF WASHINGTON: Well, that's
10 going to have to be determined on the scene, right?
11 The operator's not going to determine that.
12 SENIOR ADVISOR HANSMAN: Right, and so if
13 it's on the scene with a B-HEARD team, they're making
14 independent judgments about what they feel
15 comfortable with in the moment.
16 COUNCIL MEMBER CABÁN: But they might not
17 even be there in the moment, depending on what
18 happened in dispatch.
19 SENIOR ADVISOR HANSMAN: Correct, correct.
20 So I was answering your question about what the team
21 thinks, and what the team might feel is violent or
22 not violent, right, so if it is undirected
23 destruction of property and a B-HEARD team is there,
24 they might not feel that that is violent in the
25 moment.

DEPUTY CHIEF WASHINGTON: And I mentioned earlier that things are very fluid, right? Initially, when a person calls, they may be exhibiting that behavior. Two, three minutes goes past, people calm down, and vice versa, it could be very calm initially, and then escalate.

COUNCIL MEMBER CABÁN: But is there clear training, sort of expanding workers' knowledge of, again, what is defined as violence?

DEPUTY CHIEF WASHINGTON: Again, I…

COUNCIL MEMBER CABÁN: Or like are y'all walking through these ideas of like, well, maybe that's actually not violent (INAUDIBLE) that's not violent, or is that part of the training?

DEPUTY CHIEF WASHINGTON: I'm going to go back to what I said earlier. They are trained to take things at face volume. It's what the caller is stating is going on at that moment.

COUNCIL MEMBER CABÁN: Okay, I'll leave it at that.

I'll leave you with a very, I think this is a good question. When I spoke to the Denver Star Program, I asked them, hey, what's in your dream world? Like, what's the next step for the program,

2 what would you do, and they said, in our dream world,
3 if we had all of the resources, anything and
4 everything we wanted, we would actually already be in
5 the community. The same way that you see police
6 officers like on the beat in the neighborhood, that's
7 how we want our teams. We don't just want to be
8 responding to calls. We just want to be ever-present
9 and available to have these interactions. In y'all's
10 dream world, what's the next step for B-HEARD?
11 DEPUTY EXECUTIVE DIRECTOR GRANT: As a
12 City, we want to make sure that we are providing the
13 most appropriate response to every mental health
14 call, every mental health situation. As often as
15 possible, that includes a mental health professional.
16 SENIOR ADVISOR HANSMAN: I mean, I agree.
17 I think it's dream world, dream thinking, blue sky.
18 It is ensuring that every response has a mental
19 health clinician to be able to do both de-escalation
20 and to help someone navigate that situation and to
21 get someone to the care that they need. The
22 composition of that team might change based on,
23 again, the dispatch decision, but having a mental
24 health clinician at every call, I think, is kind of
25 the dream.

COUNCIL MEMBER CABÁN: Thank you. Thank you, Chairs. I encourage y'all to dream bigger so that you're chasing something more robust, but thank you.

CO-CHAIRPERSON LEE: Great, thank you. And we're going to head over back to Chair Salaam.

CO-CHAIRPERSON SALAAM: Thank you. Just two questions. One is, how does the NYPD evaluate the success of CIT training? For example, do officers with CIT training have lower rates of use of force, higher rates of voluntary compliance?

CHIEF OBE: We don't track our officers and success rates with incidents that they respond to.

CO-CHAIRPERSON SALAAM: Okay. So it was said that all 9-1-1 calls receive an emergency response. My question is, is it feasible and would it be beneficial to have 9-1-1 to 9-8-8 transfers? Do you have operational concerns?

DEPUTY EXECUTIVE DIRECTOR GRANT: We know that a lot of jurisdictions, that some jurisdictions, I won't say a lot yet, across the country are looking at interoperability or ways to connect 9-1-1 to 9-8-

8, and that is something that we are also committed to exploring.

CO-CHAIRPERSON SALAAM: Just lastly, in terms of the blue sky question asked earlier, I think it would be really beneficial. I'm a newcomer to politics, and as a public servant, I've often said that those closest to the pain should be at the table, should have a seat at the table, and I've heard that kind of echoed throughout, and I think that that'd be a really, really great opportunity for us to really have a robust system because New York is the leader. I mean, we know that, right? We are on the cutting edge of everything great, and to be able to keep moving forward in that reality, that dream reality, the American dream, for instance, I think would be very, very beneficial. Thanks.

DIRECTOR LEVIN: Chair, can I just follow up on something you had asked earlier data-wise for NYPD, and I think this actually ties into your question recently about the effectiveness of CIT trainings. Just zooming the camera out a little bit, 9 million 9-1-1 calls approximately every year. Looking at use of force reports for NYPD, only 1,700 times has force been used on somebody who is

designated as emotionally disturbed person. Okay, what I want to emphasize is, in a vacuum, 1,700 does sound like 1,700 more than it should ever be. Trust me, we got that. But 9 million calls, approximately 180,000 or so EDP, some of those are same calls for the same person, right. And then the second thing I wanted to say is 30 to 40 adversarial discharges of firearms for those 9 million calls, right? And the last thing I wanted to say is that in regards to the effectiveness of the crisis intervention training, there was an incident, I believe it was in June, March maybe, June, there was somebody who was exhibiting signs of extreme emotional distress and they were, it looked like maybe possibly going to jump off of a bridge, and five officers came up to that person, four out of the five of them were trained in CIT and they talked him down off of the bridge and it was a positive resolution, and so we believe in this training, you heard Chief Obe, we have, Council Member Cabán, she talked about peer evaluators, right? CIT has a peer panel, people who have experienced these crises come in and actually talk to the recruits. All recruits get this training going forward. One of the questions you had earlier

was, will PD commit to a policy where we send people with CIT training? Yes, because the goal is to have every single person trained with CIT training and it's going to happen, right? Every recruit's getting it. So I wanted to give you that one data point that you asked for before we walked out, so, and it kind of dovetailed into your other question.

CO-CHAIRPERSON SALAAM: No, thank you for that. I'm hoping that that also provides us an opportunity, you know, I think oftentimes about like after action plans and looking back and saying, how can we get it better? Just, you know, from my own lived experience, I'm wondering, and I know that part of this is like dealing with transparency and things like that, but you mentioned about the 9 million overall and 7…, what was it, 79,000?

DIRECTOR LEVIN: My apologies, 174,000.

CO-CHAIRPERSON SALAAM: 174,000.

DIRECTOR LEVIN: Emotionally disturbed person's calls of those 9 million ADP calls so 2 percent or so less.

You want to, sorry, Chief, I might've got one of those wrong, my apologies. Here, come on up.

2 CHIEF OBE: Just taking a look at 2023,
3 we've taken over 9 million calls. Of those calls,
4 174,000 were radio runs that the officers actually
5 responded to, which is less than 2 percent were EDP
6 calls, emotionally disturbed persons.
7 CO-CHAIRPERSON SALAAM: Gotcha. Okay,
8 thanks.
9 CO-CHAIRPERSON LEE: And Council Member
10 Brewer.
11 COUNCIL MEMBER BREWER: Thank you. Maybe
12 you answered this and I wasn't paying attention, but
13 how does the mobile unit crisis teams work with,
14 specifically, with all the amazing work you're doing
15 with B-HEARD? How do they work together? Is it
16 different locations? Is it different clients? How do
17 they work together, if at all?
18 ASSISTANT COMMISSIONER NECKLES: Sure, so
19 B-HEARD…
20 COUNCIL MEMBER BREWER: I know what they
21 both are.
22 ASSISTANT COMMISSIONER NECKLES: As B-
23 HEARD goes to 9-1-1, mobile crisis teams are accessed
24 through 9-8-8. Sometimes B-HEARD, after going out,
25 will refer to mobile crisis teams for further

2 assessment and connection to care for adults and
3 children so B-HEARD may refer to mobile crisis.
4 COUNCIL MEMBER BREWER: Okay, so it
5 doesn't go the other way, because that wouldn't make
6 sense.
7 ASSISTANT COMMISSIONER NECKLES: Correct.
8 COUNCIL MEMBER BREWER: And how many
9 crisis, I know how many B-HEARD, you've talked about
10 that, how many teams do you have? I know you said
11 that earlier, but how many crisis teams?
12 ASSISTANT COMMISSIONER NECKLES: Sure, so
13 last Fiscal Year, there were 16,500 referrals to
14 mobile crisis teams.
15 COUNCIL MEMBER BREWER: Okay.
16 ASSISTANT COMMISSIONER NECKLES: The size
17 of the teams vary between programs. There are 19
18 serving adults and five serving children.
19 COUNCIL MEMBER BREWER: Okay, and you
20 could always use more. They're fully staffed?
21 ASSISTANT COMMISSIONER NECKLES: We can
22 always use more of everything.
23 COUNCIL MEMBER BREWER: Okay, and that's,
24 I know, but is that something, but it seems to, I
25 keep saying this, there's only one issue in New York

City right now, and that's called challenges of mental health. Right, that's what's on the front page of every newspaper every day.

ASSISTANT COMMISSIONER NECKLES: And housing.

COUNCIL MEMBER BREWER: Housing, but they go together, because the mental health is often there because there is no housing, I got it, or the right kind of housing so my question is, in terms of the crisis teams, is that the same status in terms of personnel you've had for the last few years? Has there been an increase?

ASSISTANT COMMISSIONER NECKLES: So the teams we've had have been around for quite some time.

COUNCIL MEMBER BREWER: Right.

ASSISTANT COMMISSIONER NECKLES: So we haven't changed the number of teams that we've got.

COUNCIL MEMBER BREWER: Same number.

ASSISTANT COmMISSIONER NECKLES: Correct.

COUNCIL MEMBER BREWER: Okay, thank you.

CO-CHAIRPERSON LEE: Okay, and I just want to recognize we've been joined by Council Member Gennaro. Just really quickly, before we move to public testimony, Council Member Gennaro, or any

other Council Members, Bob Holden, or anyone, do you guys have questions also you wanted to ask? Okay. Council Member Holden?

COUNCIL MEMBER HOLDEN: Thank you, and I'm sorry I had to run out. We had another event, and this might have been answered, but the triage, when you get a call, and you said, when I left, you were getting multiple calls on the same individual, let's say, and deciding on what to do, who to send. That sometimes is very, very difficult, because you don't want to err, and then something happens. The error is made, and then somebody loses their life. So that 9-1-1 operator has a tremendous responsibility, or operators, so if it comes in five different, six different ways, six different calls, the assessment has to be done quickly, right, because seconds matter. What's the turnaround time on, the average turnaround time on these calls when somebody's having a mental health crisis? Like, is it, do you have a general, how many minutes, five minutes before a decision is made?

ASSISTANT CHIEF ESCOBAR: I don't have the exact number, but we have been improving the number of communication members that we have at our dispatch

center in order to be able to triage more calls. And many calls that come in, obviously start off with NYPD. Once they are transferred to EMS, they go through a computerized triage algorithm where one of our specialists will be asking questions to see if it meets the criteria for our B-HEARD teams to respond. Now, when there are multiple calls in the systems that come in, usually those all get linked up and only one person is really talking to the caller, but we have seen that many of the calls that come in for mental health emergencies are not the caller directly. It's a third-party caller or somebody else that has very limited information, and that is why we err on the side of caution with many of these calls. And I know previously we talked about violence and the definition of violence, and we do take what the members that are on the call tell us as what is happening so one of the questions is, is there violence, and if the person says yes, they will go down the line of needing an NYPD response.

COUNCIL MEMBER HOLDEN: And we all know sometimes when somebody does call, it's not the way they said it or the way it was interpreted so that is not an exact science, because I know when I call 9-1-

2 1, I'll tell the operator something, and it comes out
3 very differently, same thing on 3-1-1, so there's
4 always that human error part of it, or at least how
5 it's interpreted so that is why we need to come up
6 with a system that can get very accurate information
7 as quickly out there as possible because lives are at
8 stake here, but thank you for that answer, thanks.
9 CO-CHAIRPERSON LEE: Okay. Any other
10 Council Members have questions? That's it?
11 Okay. Thank you so much. I really, really
12 want to encourage, before we switch out and move into
13 public testimony, if you guys could have folks from
14 your agency stay, maybe not everyone, but at least
15 one person, because we've been really waiting for
16 this hearing for such a long time, and I think it's
17 very important for you all to listen to and stay as
18 long as possible, if you could listen to the public
19 testimonies that folks have. With that, I'm going to
20 conclude the Admin portion, and thank you all so much
21 for your time and for being here and for answering
22 our questions.
23 So just in a couple minutes, I'll call up
24 the first panel.
25

2 Okay, if I could just ask for the Admin
3 folks to switch out so that we can actually get ready
4 and move on to the next panels or stay, I hope you
5 guys stay.
6 SERGEANT-AT-ARMS: Folks, can we get
7 everybody to settle down, settle down while we switch
8 over to public, please? Everybody settle down and
9 find a seat.
10 CO-CHAIRPERSON LEE: Okay, so I now open
11 the hearing for public testimony, and I remind
12 members of the public that this is a government
13 proceeding and that decorum shall be observed at all
14 times. As such, members of the public shall remain
15 silent at all times.
16 The witness table is reserved for people
17 who wish to testify. No video recording or
18 photography is allowed from the witness table.
19 Further, members of the public may not present audio
20 or video recordings as testimony, but may submit
21 transcripts of such recordings to the Sergeant-at-
22 Arms for inclusion in the hearing record.
23 If you wish to speak at today's hearing,
24 please fill out an appearance card with the Sergeant-
25 at-Arms if you have not done so already and wait to

2 be recognized. When recognized, you will have two
3 minutes to speak on today's oversight topic, B-HEARD
4 and Responses to Mental Health Crises, and on
5 Introduction 532 and Introduction 1019.
6 If you have a written statement or
7 additional written testimony you wish to submit for
8 the record, please provide a copy of that testimony
9 to the Sergeant-at-Arms. You may also email written
10 testimony to testimony@council.nyc.gov. within 72
11 hours of this hearing. Audio and video recordings
12 will not be accepted.
13 I just want to emphasize that I hate
14 playing bad cop when it comes to time, because, and
15 everyone here knows this, because I want people to
16 have as much time as possible, because we have a lot
17 of folks, so we're going to try to stick to the two
18 minutes, but please believe me when I say that any
19 written testimony you guys submit, we read each and
20 every word of it, and that is something that we take,
21 actually, when it comes to feedback in drafting some
22 of the legislation and policies and how to move
23 forward so we really appreciate all of you to submit.
24 Make sure you submit your written testimony, because
25

2 that's super, super important, and we actually do
3 read every single word so I want to say that first.
4 Really quickly, we're going to be
5 shifting to witness testimony on Intro. 532 first so
6 we're going to have the first in-person panel, which
7 is Deanna Philippe, Khadjah Pryce, Bracha Rutner, and
8 Yerucha Silber, and I apologize ahead of time if I'm
9 mispronouncing names so if you guys could please come
10 and sit, take a seat.
11 Okay, perfect. So if you, maybe we could
12 go this way, and however you guys, if you want to
13 start first, and if you could tell us your name. Yes,
14 yes.
15 IMANI MOORE: My name is Imani Moore, and
16 I'm here to represent the Razi School in Woodside,
17 Queens, and also to support my fellow principals and
18 administrators in the Catholic schools, the Yeshivas,
19 as well as the Islamic schools, asking for assistance
20 to lower the eligibility number for the safety guards
21 with the schools. Our school personally experienced
22 issues after the October 7th incident, where several
23 of our students were accosted outside the school and,
24 with the ongoing situation overseas, we're fearful
25 that more situations may happen going forward. Now,

2 the public schools have school safety. We have to
3 either dig deep and ask for parents' contributions to
4 provide security. Many of our schools, the security
5 that we have, are grandparents, or stay-at-home moms,
6 or sometimes elderly grandparents that will stay and
7 work as security. My school in particular, we only
8 have six male members in the building. The rest of
9 the staff are all women. God forbid if something were
10 to happen. We need that assistance, and I'm sure my
11 other fellow administrators feel the same. We feel
12 that it's the government's responsibility to provide
13 the students of the City of New York with security.
14 It's adamant. We should not wait until some
15 devastating situation happens, and then in hindsight,
16 we say, oh, we should have done that. Let's do it
17 now. We've worked hard to get Albany to expand the
18 budget, and now you have the money. All we need for
19 you to do is lower the eligibility rate so that
20 schools that say have 100 students can be safe.
21 KHADJAH PRYCE: Thank you. I'm Dr.
22 Khadijah Jean Pryce. I represent the Islamic Cultural
23 Center School located at Upper East Side. To follow
24 on my esteemed colleague's comments, we've always had
25 an issue with security because of where we are. We're

2 affiliated with the largest mosque in Manhattan,
3 actually on the East Coast, so we've always had a
4 security issue. It's not rare for us to come to
5 school and see security forces outside because we've
6 had somebody phoned in a threat so my staff, myself,
7 my students, my parents have always been concerned
8 about security. It has been heightened because of the
9 number of threats during the last year or so. So
10 again, I want to expand what my colleague said, that
11 yes, we also, most of our parents are taxi drivers so
12 our income is very limited. We are tuition driven.
13 We're very limited so we need more security, but at
14 the time we're not able to afford it. So if we could
15 just lower, security should not be about numbers.
16 Security should just be about students in schools. So
17 I also support the eligibility number being lowered.
18 It should not have a number, and it should definitely
19 be lower than 300. Thank you for this opportunity to
20 speak.
21 CO-CHAIRPERSON LEE: Thank you.
22 BRACHA RUTNER: My name is Bracha Rutner.
23 I represent Yeshiva University High School for Girls
24 located in Queens. I think that there isn't always so
25 much that we agree upon, but I think that we

2 definitely agree that the safety of our children
3 comes first. Even before October 7th, but certainly
4 since then, I have worried incredibly about my
5 students. We've seen a continued increase in school
6 shootings around the country, and we're very worried
7 that our students need to be safe. Data shows that
8 even schools under 300 are facing similar security
9 risks as larger schools, but we often lack the
10 resources to protect our students. We might therefore
11 be perceived as soft targets because we don't have
12 sufficient security. I know that since October 7th,
13 we added an extra security guard, which is an
14 increasing financial pressure on both our school and
15 our families. We don't have the economics of scale of
16 larger schools, and we're very worried. There've been
17 global tensions rising since October 7th that are
18 clearly going to have an impact on all of our schools
19 in New York, and we really need to go ahead and
20 increase our funding. Every student deserves
21 protection, no matter how small their school is, and
22 these policies that we have should reflect that
23 reality. We really want to go ahead and protect our
24 students, and they are our most vulnerable
25 population. Who can argue with protecting kids,

knowing that they can come to school every single day and be safe so I hope that we will consider lowering the threshold below 300 to provide added security for our students to protect them. Thank you.

DEANNA PHILIPPE: Good afternoon. My name is Deanna Philippe, and I'm the principal of Cristo Rey Brooklyn High School in East Flatbush. Cristo Rey Brooklyn has a strong tradition of providing quality education to students who come from underserved communities and students who have a strong desire to go to college. One way we're able to make this work for our families is that our students go to school four days a week and they work one day a week. In corporate settings, these sponsorships provide their tuition and basically make Catholic education affordable to families who otherwise would not have the opportunity. I want to thank you for holding this hearing, and thank you for considering the passage of Intro. 532 in order to protect small schools like mine and the women sitting next to me. As stated before, there is no reason why students in religious schools and students in small schools should not be protected just like students in any other school. When this grant was passed about 10 years ago, we

2 were eager and excited, and we certainly did apply
3 for this grant, only to be disheartened when we
4 learned that as our enrollment has decreased since
5 COVID, now we are ineligible to have this protection.
6 So quite honestly, I serve as protection as the
7 principal with my dean of students and a few other
8 teachers. That's unfair to me, unfair to our faculty
9 and staff, and certainly our school community. By
10 passing this bill, Counsel, you would affect change
11 for a community that's been marginalized in a number
12 of ways. Passing this bill means not only Cristo Ray
13 Brooklyn, but other schools like mine would be able
14 to protect students, family, and staff. Non-public
15 school students should be provided with the same
16 safety measures that all their counterparts received
17 in other public schools. It is unjust to do
18 otherwise, especially in the current environment that
19 we are living in right now, where schools that are
20 typically the safe space have now been under threat.
21 So again, I want to thank you for this opportunity.
22 Thank you on behalf of Cristo Ray Brooklyn and other
23 religious schools in our city.
24
25

2 CO-CHAIRPERSON LEE: Thank you so much.
3 Does anyone have questions here for this panel?
4 Council Member Yeger.
5 COUNCIL MEMBER YEGER: Thank you, Madam
6 Chair. Principal Philippe, just to be clear and to
7 expand a little bit, did you at one point have a
8 school safety or school security guard that was
9 reimbursed?
10 DEANNA PHILIPPE: No, we did not. So the
11 height of our enrollment was 324, and when we applied
12 for the grant, we were still just under. We were told
13 no.
14 COUNCIL MEMBER YEGER: Do you have a
15 school security officer that you pay for that's not
16 reimbursed?
17 DEANNA PHILIPPE: We do not have any
18 school safety at all.
19 COUNCIL MEMBER YEGER: So the lack of this
20 program is costing you your ability to actually have
21 a school security officer?
22 DEANNA PHILIPPE: Absolutely.
23 COUNCIL MEMBER YEGER: All right. Thank
24 you very much.
25

CO-CHAIRPERSON LEE: Okay, great, thank you. Thank you to this panel so much.

Next, we're going to call our second in-person panel for Intro. 532, Logan Clark, Sydney Altfield, and Joseph Rosenberg.

JOSEPH ROSENBERG: I'll start. Good afternoon, I'm Joseph Rosenberg, Director of the Catholic Community Relations Council, representing the Archdiocese of New York and the Diocese of Brooklyn and Queens. We strongly support Intro. 532, a bill that would help increase the safety of children, faculty, and staff at non-public schools throughout our city by expanding an important school security guard program passed by the Council in 2015. Ensuring the health and safety of school children and protecting them from violence is a priority for all of us. New York City's public schools, for example, have had a security guard system in place for many years. The tens of thousands of children in our city's non-public schools, however, did not have such a program until 2015, and that was when the New York City Council recognized this inequity, and by a vote of 43 to 4, passed Local Law 2. The law allowed non-public schools to hire uniformed school security

agents and be reimbursed for this cost by the City of New York. More than 200 non-public schools, including Catholic, Jewish, and Islamic schools currently are in this program, but Local Law 2 is deficient in that only schools with 300 or more students can be part of this initiative. As a result, non-public schools with enrollments as large as 299 students are not eligible. Intro. 532 would rectify this problem. It allows all non-public schools to be eligible for this program regardless of the size of their student enrollment. This change significantly increases the number of non-public schools citywide that will be entitled to hire school safety guards to help protect their students, their faculty, and their staff. The Catholic schools in New York City have over 80 schools with 300 or more students that participate in this program. Passing this bill would enable an additional 78 Catholic schools to hire security guards and be reimbursed. The Catholic schools of New York City have a longstanding history of excellence with high school graduation rates of over 98 percent. These young people reflect the demographics of their local communities with over 60 percent being students of color. They and their counterparts in Jewish and

2 Islamic schools deserve to be safe. With the number
3 of religious hate crimes increasing in our city and
4 episodes of horrific violence against school children
5 in our country becoming commonplace, security
6 measures to protect these young people should be
7 expanded. On behalf of parents, children, and
8 faculty, we urge the passage of this bill. Thank you.
9 SYDNEY ALTFIELD: Hello, distinguished
10 Chairs and Members of the Council. Thank you for
11 having me. My name is Sydney Altfield and I'm the
12 Executive Director of TeachNYS. I also want to thank
13 the esteemed principals that were here to testify
14 during their day of school and those in the gallery
15 watching. For years, Local Law 2 has been a lifeline
16 for schools above 300 students enrolled. They need
17 this program. They use this program. Hundreds of
18 schools use this program and thousands of students
19 are safe because of this program. But also every year
20 since Local Law 2 was passed, thousands of students
21 are not eligible for this safety and hundreds of
22 schools are being left out. Every year, I get this
23 phone call. I get a phone call from a school
24 administrator telling me that last year they had 304
25 students and this year they have 297, and where are

they supposed to get that extra money to have a security guard in front of their school? They have to turn to the parents. This inevitably becomes an anti-Semitism tax for the Jewish schools, this becomes an Islamophobia tax for the Islamic schools that are being paid from the parents to keep their students safe. I get these calls every single year and, since October 7th, hate crimes have risen exponentially as well as spending for security. Teach NYS did a survey after October 7th and found that security costs increased in schools 47 percent, and the majority of that cost was being covered from the parents. It is enough that these families are paying and have this financial burden on their shoulders to keep their students safe, the most basic right that our government should be giving us, and so I urge the Council to pass this Local Law 2 expansion to lower the threshold from 300 students to include every student, no matter what size their school is, no matter where they go to school. Thank you.

LOGAN CLARK: Good afternoon, all distinguished Chairs and Members of Council. My name is Logan Clark. I am the Assistant Director of Budget Review at the Independent Budget Office, or IBO. My

portfolio at IBO covers analysis of the Department of Citywide Administrative Services in addition to other citywide operational costs. Thank you for the opportunity to testify today. I'm here today to provide analysis on Intro. 532 of 2024, which concerns the reimbursement of non-public schools for the cost of security guard services paid for through DCAS' budget. The Intro. would expand eligibility of the program to smaller schools, which IBO estimates would double the potential cost of the program. IBO estimates that the total potential cost of this legislation could be an additional 19.8 million if all eligible non-public schools opted in, bringing the total possible program cost up to 39.6, which is above the cap as it currently stands. However, even with the current program, spending remains below capped levels. Under Local Law 2 of 2016, the City allows for non-public schools with more than 300 students to apply for reimbursement for the cost of security guards. It is a multi-tiered program, allowing for schools with greater numbers of students to apply for more security guards. Schools are required to hire security guards according to the prevailing wage schedule set by the City Comptroller,

and DCAS maintains a pre-qualified vendor list. Assuming 180 days of school as required by state law, the cost of a security guard for a full school year would be at a minimum 36,114 dollars, depending on the guard's years of experience. The program is currently capped at 19.8 million annually. However, as the table below shows, the City has not ever actually reached that limit. As of the 2023 to 2024 school year, using data from the New York State Education Department, the total number of eligible schools is 277, and under the tiered system, that equates to a possible reimbursement of approximately 460 security guards. Just to wrap up really quickly, the number of schools that would be eligible using the 2023 to 2024 data that are under 300 would be about 548, and so that's another 548 guards. It's about 19.8 million, and we are more than happy to talk about some crosstabs on that if you would like.

CO-CHAIRPERSON LEE: So what was the 277 number again?

LOGAN CLARK: 277 is the number of schools currently eligible.

CO-CHAIRPERSON LEE: Okay. Council Member Yeger.

1
2 COUNCIL MEMBER YEGER: Thank you. Mr.
3 Clark, using the high-end number that you have, if
4 every single school that could be possibly eligible
5 would take advantage of it, that means New York City
6 would get 548 good union jobs?
7 LOGAN CLARK: It would be 548 new security
8 guards that would be eligible for reimbursement.
9 COUNCIL MEMBER YEGER: At a prevailing
10 wage?
11 LOGAN CLARK: At a prevailing wage, yes.
12 COUNCIL MEMBER YEGER: Good union jobs?
13 LOGAN CLARK: I can't speak to whether or
14 not they're all unionized, but they are at a
15 prevailing wage rate, and so at the union wage or
16 above.
17 COUNCIL MEMBER YEGER: All right. Thank
18 you.
19 CO-CHAIRPERSON LEE: Okay. Any other
20 Council Members have questions?
21 Good? Okay. Thank you so much to this
22 panel.
23 Now, we're going to go back to our B-
24 HEARD topic hearing, public testimony. We're going to
25 move to a really short Zoom panel, and I just want to

call the following three names so, if you're on Zoom and you hear your name, please wait for a Staff Member to unmute you and until the Sergeant cues you to start so I'm going to call Elliott Jones, Jodie Esquibel, and Sam Rabins.

Elliott Jones will go first, followed by Jodie and then Sam.

SERGEANT-AT-ARMS: You may begin.

ELLIOTT JONES: Hello, can everyone hear me?

CO-CHAIRPERSON LEE: Yes, we can hear you.

ELLIOTT JONES: Awesome. Well, it's an honor to be here today. My name is Elliott Jones. I am the Program Manager for the Oakland Fire Department. I'm also the Director of the Oakland Fire Department's Mobile Assistance Community Responders of Oakland, better known as MACRO, and this has really been an enlightening hearing to hear this today. I just want to really commend you all on investing in the B-HEARD program. It's only a few years in, and just like the fire department of today is not the fire department when it first launched, you need to give these programs opportunity to grow and really come into their own in the public safety

landscape. Across the country, I believe every program is dealing with the data challenges. Not only are cities not great at keeping and sharing data, it is something that we are constantly trying to improve upon to make it digestible so that the public can understand our impact.

Another challenge that was often mentioned here is the dispatch challenge, and I think that that's something that can't be discounted. The dispatch challenges that we all face are evident. These systems are underfunded and under-appreciated, and they need to be invested in. To kind of enhance your call-taking capability, I would recommend having a couple of different sources to contact or request support, either a direct line managed through one of your dispatch centers or an email. If something is truly non-emergent, I think that you can spend time to write an email.

Finally, I know I don't have a lot of time. I think a lot of people like to focus on crisis, and there is so much that can be done up to crisis. Our model is similar to yours in a way that we have an EMT that rides with a peer or a community intervention specialist, and they're able to take on

so many of these low-acuity calls that it never meets the need of not only needing further EMS support, but law enforcement. I think the fire department is also left out in a lot of these discussions. Firefighters often have to respond to these low-acuity calls that may have a minor medical component so having an EMT and a…

SERGEANT-AT-ARMS: Time expired. Thank you.

ELLIOTT JONES: Community intervention specialist, I did my best. Thanks, guys.

CO-CHAIRPERSON LEE: Oh, if you wanted to just wrap up real quick, sorry.

ELLIOTT JONES: Absolutely. Having those two components can really address the majority of these low-acuity calls that clog up the system. So continue to invest and work out this model, and you guys are doing great so far, and we're happy to help all the way out in Oakland if we ever can.

CO-CHAIRPERSON LEE: Perfect, and then next we have Jodie.

SERGEANT-AT-ARMS: You may begin.

JEFFREY BUSTAMONTE: Hi there, Committee Members. I apologize about the slight delay there.

1
2 I'm actually Jeffrey Bustamante. I'm a Deputy
3 Director here at Albuquerque Community Safety,
4 filling in for Jodie on what has become a very
5 dynamic Monday, but really excited to be here and
6 share briefly some input. So again, my name is
7 Jeffrey Bustamante. I'm the Deputy Director here at
8 Albuquerque Community Safety. Here in Albuquerque, we
9 recently just celebrated our third birthday. Our goal
10 through our programming is to provide Albuquerque
11 with a holistic, empathetic, and informed response to
12 behavioral health and mental health related calls for
13 service. Our responses are personalized to the needs
14 of the individual, family, and community so that ACS
15 can bring the right response at the right time, and
16 over our three years, we've responded to over more
17 than 80,000 calls for service. As you know, across
18 the nation, we're working through many of the
19 questions your conversation has brought up today.
20 This is why during our time, ACS has been fortunate
21 to work in partnership with other cities as we re-
22 imagine public safety. We thank New York, Sacramento,
23 Seattle, Durham, Denver, Oakland, and many, many more
24 for working individually and collaboratively to
25 ensure that their city residents receive the best

1
2 possible response. We believe that behavioral health
3 response is an integral piece of the future of public
4 safety and strongly encourage the continued robust
5 development across the United States. Thank you
6 again, and please never hesitate to reach out with
7 any of your questions.
8 CO-CHAIRPERSON LEE: Great. Thank you. And
9 next, Sam.
10 SERGEANT-AT-ARMS: You may begin.
11 SAMANTHA RABINS: Thank you to the
12 distinguished Chairs and City Council Members for
13 hosting this hearing. It is a true honor and
14 privilege to be with you today. My name is Sam
15 Rabins, and I currently serve as the Associate
16 Director of Criminal Justice Services at WellPower, a
17 non-profit community mental health center known
18 nationally as a model for innovative care. We proudly
19 serve the city and county of Denver and support
20 communities in their wellness and recovery. In my
21 role, I oversee multiple programs that focus on the
22 intersectionality of mental health and criminal
23 justice.
24 Today, I'd like to talk about one of our
25 programs at the forefront of innovation and mental

health crisis response. STAR, or Support Team Assisted Response, serves as Denver's response to alternative to low-risk, low-acuity 9-1-1 calls, many of which are related to substance use and mental health concerns. Launched June 1, 2020, the STAR program is a partnership between WellPower, Denver Health, one of Colorado's premier healthcare institutions, Denver Department of Public Health and Environment, the Office of Social Equity and Innovation, Servicios De La Rosa, and the STAR Community Partner Network, and Caring for Denver. Since 2020, STAR has expanded from one pilot van consisting of one mental health clinician and one medic to 16 initial response vans with eight clinicians and eight medics on board, and a group of community organizations that help support individuals in crisis post-van response. The intent of STAR is to support community members in crisis by sending the right response at the right time. People call 9-1-1 for an array of reasons, and it's not always something that presents with a legal nexus. Previously, 9-1-1 calls were handled solely by police, fire, or emergency medical services. Denver took steps to look at how to best meet the expansive

needs of a community and added the STAR program to the emergency response system. One of the components that makes STAR such a successful program is the collaborative partnership that we have with Denver 9-1-1. Denver 9-1-1 views STAR as a fourth type of response alongside police, fire, and emergency medical services. This means that there are policies, procedures, and trainings put into place to identify the most appropriate response type for each call that comes through Denver 9-1-1, and thus, send the most appropriate type of support for the Denver community. This is a paradigm shift from how we previously supported community members in crisis. STAR provides a trauma-informed response to those that request an emergency or imminent crisis response.

SERGEANT-AT-ARMS: Your time has expired.

CO-CHAIRPERSON LEE: But you could just wrap up, yeah.

SAMANTHA RABINS: Thank you. The initial response team, or STAR van team, provides direct clinical de-escalation, community service connections as well as on-demand resources such as water, food, clothing, and basic living supports. Our team helps the emergency response system handle the overwhelming

2 number of 9-1-1 calls that don't require a police
3 response. The team can provide medical assessment,
4 triage, crisis, intervention, de-escalation, and
5 connection to community resources. STAR teams can
6 also transport clients to those resources as
7 necessary. We provide harm reduction, trauma-informed
8 philosophy with people and are able to creatively
9 meet whatever need they are pursuing.
10 CO-CHAIRPERSON LEE: Okay, sorry, if you
11 could just wrap up in one or two more sentences.
12 SAMANTHA RABINS: Yep. Just wanted to give
13 some stats really quick. Over the past 12 months,
14 STAR successfully responded to 4,489 clinical
15 encounters with 2,943 unique individuals, and of
16 those, there has not been a single arrest.
17 CO-CHAIRPERSON LEE: Great. Thank you. I
18 want to open it up to questions from Council Members.
19 I know Council Member Cabán has a question, and I
20 also have one after that too so feel free to go
21 ahead.
22 COUNCIL MEMBER CABÁN: Thank you so much,
23 and I just want to thank all the partners across the
24 country that have joined us here today. I have a
25 question for Oakland, and then I also have a question

for Denver. But out in Oakland, you mentioned that, it's a simple question, you mentioned that you use peer support on your teams, correct? Oh, did they leave? Oh, it was the first person on the, Elliott Jones.

ELLIOTT JONES: Yeah, I'm back. Yes, still here. Sorry, so yes, we do have a team, we operate in teams of two, one, an emergency medical technician, and, two, a community intervention specialist, which is more in line with that peer support role, but they are both members of the fire department, they came in equally, and they are union members of SEIU 1021.

COUNCIL MEMBER CABÁN: I love that. So not only do you have peers on your teams, but they are union workers.

ELLIOTT JONES: Absolutely, and the one thing that we think works really well with this is that if we do our job and focus on the up to crisis, having those more advanced teams with whether it be paramedics or clinical support, that could be available as needed for those crisis level situations. If everybody does their part, we can all eat the whole pie together.

COUNCIL MEMBER CABÁN: Thank you, thank you so much. And then my next question is for Sam. And I just want to point out, Sam, that I actually got to visit y'all, and I got to go into one of your vans and meet some of the members of the Denver STAR teams, and y'all just do incredible, incredible work so thank you for that, and also thank you for Local Progress for making those connections who also helped us invite people to testify here today from around the country so that's why you're hearing from some of these folks. Can you talk a little bit about some of the data that y'all collect and publish? Like what are the different data points, metrics, and kind of how you then use that data to improve the work you've been doing over time?

SAMANTHA RABINS: Great question. I'm super glad that you had an opportunity to come visit Denver and visit our STAR program as well.

Yes, we collect an array of data here in Denver. We collect all of our demographics as much as we are able, and we also collect veteran status, houseless status. We're also collecting, if there is a mental health diagnosis, we are collecting that information as well. We are consistently re-looking

at our data to see what needs to be collected, what's important, and then how do we use that data to identify our response in the community? How can we, from a DEI perspective, better respond to the community even more fruitfully than we already are? And how can we use the data to better inform where we're serving people as well as how we're referring people to the next step?

COUNCIL MEMBER CABÁN: And you guys, if I'm not mistaken, because I've looked at your published reports, you guys also publish heat maps on where you're finding that you're responding to the most, or you're publishing where you're taking people to, whether it's an emergency room or some other place. That's also being collected and published as well, right?

SAMANTHA RABINS: Correct.

COUNCIL MEMBER CABÁN: Great. Thank you. And then my last question, and I'm sorry, I can't, because I also visited the Portland Street Response Team, and so I can't remember if this was an example given by you guys over in Denver or them, but when a team goes and interacts with an individual and asks them, because you have water, food, clothing, ask

2 them what they want and where they want to be. There
3 was a story that was told that was like, well, we
4 just asked them, and if they have a favorite tree in
5 a favorite park, we'll go take them there, and we'll
6 say, hey, do you need clothes, do you need water, do
7 you need coffee because if that's where you feel
8 safest, we'll take you there, and then also it's a
9 way to be able to continue to re-engage, and so my
10 question for you, and anybody can chime in here, is
11 what is the overall public health and public safety
12 policy of your municipal governments because ours has
13 not been the friendliest to folks who are at the
14 intersection of homelessness and mental health
15 struggles, and so it might not actually be the safest
16 thing to bring somebody to sit in a park or something
17 like that unfortunately, it should be, it should be,
18 and so I'm just wondering sort of what the
19 conversations are like and what the policies are
20 around some of those things.

21 SAMANTHA RABINS: At STAR, again, we're
22 providing the right response at the right time, and
23 we're ensuring that people go to the place that's
24 safest for them and to meet their needs. We do work
25 closely with our STAR Community Partner Network,

2 which is a group of organizations in the community
3 that we will refer people to with their consent so
4 that we are providing that follow-up wraparound care,
5 so we're not just dropping someone off, let's say, at
6 their favorite tree, we're also then providing
7 additional supports for individuals, no matter where
8 they land in the community, and we also work closely
9 with our first responders in Denver. We work closely
10 with police department, fire department, and our
11 emergency medical services as well as our local
12 hospitals, to ensure, as best as we are able, that
13 needs are being met of individuals. If we can't
14 provide them a safe, you know, what providers may see
15 as a safe space, i.e., you know, a four walls and a
16 roof over their head every single time we make
17 contact with someone.
18 ELLIOTT JONES: And Elliot here, I'll jump
19 in. A little jealous that Samantha's camera's on,
20 because I want to see y'all too, or I want you to see
21 me. But similarly, the city has had to come to grips
22 that not everybody that we get a call for is a mental
23 health crisis and they need to go somewhere. Many
24 people are simply desperate. If you've had two or
25 three days where you haven't had anything to eat or

2 drink or are sleeping outside in the cold, anything
3 can set you off so what we find, it's valuable to
4 make contact, it's valuable to build trust, because
5 these people are often using decades of trauma around
6 trusting the system, and when we are finally able to
7 get through to you, we're waiting for that one
8 opportunity, that one moment of clarity or shared
9 reality where we can make an appropriate resource
10 connection, and that really is happening now a little
11 over a third of the time, but we kind of need that
12 rate. There are not enough beds. There are not enough
13 resources available if everybody raised their hand
14 that needs help, wanted help so you really have to
15 trust these teams to develop and manage these
16 relationships to find out what's good in the moment
17 and set themselves up for the next visit where they
18 can hopefully break through a little bit further and
19 get people the help they desperately need.
20 COUNCIL MEMBER CABÁN: Thank you so much.
21 Thank you.
22 CO-CHAIRPERSON LEE: Thank you. I actually
23 had a really quick question for all of you as well,
24 and I don't know if we're going to get the answer
25 today, but I guess this goes to just the differences

2 in laws state by state because a lot of the
3 jurisdiction of how mental health services are
4 delivered, it varies state by state, and so I'm just
5 wondering, because I would love to hear from you, and
6 maybe this is just like a longer separate meeting
7 that we should have with you all, because I'm curious
8 to know how laws across various states are similar,
9 which are the challenges and which are not as
10 similar, and also how does that impact services like
11 B-HEARD, like we're talking about today, in
12 coordination with other agencies because I think that
13 there are definitely lessons that we can learn from
14 other cities for sure, and then maybe perhaps using
15 that to figure out how we work through some of the
16 challenges in a city like New York, and so I was just
17 wondering if any of you were familiar with how the
18 various different state laws across the country can
19 impact this type of program?
20 ELLIOTT JONES: Well, I could jump in
21 really quickly. In California, a mandate came out
22 from the Governor that something had to be done about
23 the homeless encampments. That coupled with many
24 cities outside of Oakland trying to throw laws on the
25 books, anti-camping laws, you can't sleep here

overnight, all of this puts pressure on cities to come up with a solution and, if you're connected on public transit, sometimes you have to be prepared to deal with a bunch of people coming into your border after they've been pushed out of a city they may have become unhoused in or are experiencing challenging. That all being said, even the best laid intentions can sometimes have the worst outcomes. So as we're doing community sweeps and encampment clearings, we're working closely with other partners in our Health and Human Services Department to make these service connections and, as people get into housing and supportive housing or other programs, this allows us to focus on who's remaining and the specific challenges that they're having. One core tenet about MACRO is nothing is forced. We don't force you to do anything, it's all voluntary. So really building up people and getting them to a place where they're ready to accept services is what has worked for us and you need time for that, and sometimes the cities don't give you that, but if you come up with a plan, you stick to the plan, you can get ahead of some of these external forces that may impact your city.

CO-CHAIRPERSON LEE: Great. Thank you. Any others?

SAMANTHA RABINS: I think just to add to that too, we have partnerships with, like I said, all of our first responders in Denver, partnership with mayor initiatives and groups that are working towards navigating this new landscape, and then at Wellpower, we also, we've worked with our STAR Community Partner Network, which is that group of community organizations to get people after we have buy-in after that initial crisis response, to get people then connected to long-term services to help mitigate some of the needs that were expressed, and then we also have, we're also able to accept people with all types of Medicaid and other insurances, and so we work with that insurance group as well to make sure that care is being able to be accessed by individuals in our community.

CO-CHAIRPERSON LEE: Great, thank you. Thanks to this panel.

Anyone from Admin still here by any chance? Oh, yay, okay, thank you.

Sorry, so now we're going to move back to in-person testimony and, sorry, I made a mistake. We

have another panel on Intro. 532 before moving back to the oversight topic so, really quickly, if we could bring up Nicholas Tishuk, Clarisa Alayeto, and Erin Acosta.

CLARISA ALAYETO: Thank you, Chairs and Members of the Committee. My name is Clarisa Alayeto. I manage Community and Government Affairs at DREAM, formerly Harlem RBI. DREAM has been serving the East Harlem and South Bronx communities since 1991, and today we work with nearly 3,000 young people across four schools. Our students come from diverse backgrounds, including a high percentage of students with IEPs, multi-language learners, and most recently families seeking asylum. Our students are public school students and they deserve the same safe, secure learning environments as all students in New York City but, unfortunately, charter schools in private spaces like DREAM are currently left out of the City's security guard funding. We support Intro. 532, but we urge the City Council Members to amend the bill and to include charter schools in private spaces like DREAM. Right now, we're the only public schools left outside of the City's security protection, despite facing similar challenges. The

lack of funding and security guards means that DREAM has to divert money from critical programs, including mental health services, athletics, arts, and additional supports for students with IEPs. By securing funding for school safety, we can reinvest in what matters most, our students' education and wellbeing. We urge you to prioritize the passage of Intro. 532 and ensure that all students, no matter where they attend school, are equally protected and supported. Thank you.

ERIN ACOSTA: Hello, I'm Erin Acosta, the Director of Family Engagement and Communications at Growing Up Green Charter Schools. I'm also an alumni parent of the school and a longtime resident of Astoria, Queens. I respectfully submit the following testimony on behalf of the students and families of Growing Up Green. Thank you all for your attention. I have submitted my written testimony online, but I'll summarize here. Growing Up Green has been a part of the Queens community since we opened our first school in Long Island City in 2009 followed in 2015 by GUG2 in Jamaica, Queens. We serve over 1,400 students in grades K through 8. We're not co-located, just like DREAM, with another public school. We pay rent for

2 each of our buildings. Our population is very diverse
3 and reflects the neighborhoods we serve. We welcome
4 all types of learners, including students with IEPs,
5 multi-language learners, and most recently, we've had
6 many students whose families are asylum-seekers. All
7 of our students are public school students and have a
8 right to a safe and secure learning environment.
9 Intro. 532, if amended, should include these public
10 school students. We have had security issues in both
11 our Long Island City and Jamaica communities. Most
12 recently, there was a knife incident outside of our
13 building on 161st Street in Jamaica. Our families are
14 very, very, very concerned, and their children
15 deserve a safe learning environment, just like every
16 other kid in New York City. Currently, because GUGS
17 is excluded from the security guard funding, we have
18 to take that funding out of our per pupil to pay our
19 security guards so I urge you all to please include
20 us and protect all the children in New York City.
21 Thank you.
22 NICHOLAS TISHUK: Hey, everybody. Good
23 afternoon. My name is Nicholas Tishuk. I'm the
24 Executive Director at Bed-Stuy New Beginnings Charter
25 School in Brooklyn. We serve over 700 students and

families in our community, and as a neighborhood resident, it's a great school. Come visit anytime, no matter who you represent. I did submit testimony so I just want to kinda summarize my thoughts in a simple message and to echo my colleagues here and also echo the colleagues who spoke earlier from the other types of schools. The governance model that the parents choose to send their children to should not determine whether they access this funding. Whether it's a public school in district space or a charter school co-located in district space, whether it's a private school, whether they're religious, whether they have a specific vision or model, whether they're a charter school, private space such as mine or my colleagues here, it really shouldn't matter. We have our students' best interests in mind as educators, and that should really be what demonstrates the needs, and I also think the smaller schools should also access that funding too by the way. I think that the idea that anyone in the city has a disproportionate access or lessened access due to any of these factors is really unfair. I think it's great that there's schools in New York City that you pay 40,000 dollars a year and they're amazing, they're phenomenal, get

access to this funding, but we should too, and it shouldn't be about governance, shouldn't be it's charter versus district versus private versus religious. It should really come down to the needs of our kids. In our school, 96 percent of our kids are eligible for free or reduced lunch, and 20 percent are McKinney-Vento eligible, meaning they're homeless, in transitional housing, in the shelter system, or doubled up. They deserve the same opportunities that everyone else is getting through this program. I think it's a great program. Please expand it, please amend this bill so we can access this funding. If you have any questions, I'm happy to answer them.

CO-CHAIRPERSON LEE: Great. Thank you so much, everyone. Thank you. I don't think anyone, no one has questions, right? Do we, guys? Okay. Thank you so much.

Okay, and so next we're going to go back to in-person panels so we have Grace Nichols, Joelle Ballam-Schwan, Jonathan Chung, which I know that name, Ray Schwartz, I know that name too, Jim Bohovitch, and Ramon Leclerc.

And it's awesome to see all you guys' familiar faces. Yay, thanks.

RAMON LECLERC: Good afternoon, Council. My name is Ramon Leclerc. I'm representing New Alternatives for Homosexual LGBTQ Youth. Let me say first that police are antagonists and bullies who show up with guns, batons, riot gear, and other paraphernalia to intimidate people going through mental health crises. I've experienced my director call 9-1-1 for a schizophrenic client who was having a hallucination that they were saving a child and throwing a book bag across the dining hall who needed to be on medication who was not medicated for a while, and riot police in full, even though my director expressly said the client was nonviolent, just needed to get to a hospital ASAP, police showed up in full riot gear, causing an adverse reaction from other clients in the dining hall, which is not fair and could have been a deadly situation if I had not stepped up and removed those clients from that hall. Also, unprofessionalism runs rampant within NYPD and the EMS systems. One time we had a client who we hadn't seen who was street homeless and schizophrenic who needed to be medicated. My director

once again called 9-1-1 to get this person to the hospital. The police show up first and then EMS shows up, asks the officer what's going on. The officer nonchalantly responds, oh, somebody's off their medicine, and EMS's response was, me too. It blew my mind. Excuse me for going over, I just need to get this out, but the client ended up leaving and we barely see the client so it's a major concern. There needs to be some sort of oversight and training or just remove the police. I'm sorry.

CO-CHAIRPERSON LEE: No, thank you, Ramon, and thanks for joining the call the other day as well and sharing your story there too on the roundtable. I really appreciate that, so thank you, and we'll come back to you, but Jonathan.

JONATHAN CHUNG: Thank you. Good afternoon, Chair Lee, Council Member Cabán, and all the distinguished Members of the Committee. Thank you for holding today's really important hearing. My name is Jonathan Chung. I'm the Director of Public Policy and Advocacy for the National Alliance on Mental Illness of New York City, or NAMI-NYC, and a steering committee member of Correct Crisis Intervention today. While NAMI-NYC appreciates the goals of the B-

2 HEARD program and the City's attempt to shift crisis
3 response to social workers and EMTs, we have great
4 concern with how the program is being implemented and
5 with the current composition of the crisis response
6 teams. We have made clear to the City Council and the
7 Administration that it is extremely important to
8 fully fund a mental health crisis response program
9 that is citywide, operates 24 hours a day, seven days
10 a week, includes peer responders, and has no police
11 involvement. What we advocate for is not currently
12 embodied in the B-HEARD crisis response program
13 that's coordinated out of the Mayor's Office of
14 Community Mental Health. These changes must be made
15 as soon as possible to drastically improve the
16 program. Two key goals of the B-HEARD program are to
17 increase connection to community-based care and
18 decrease hospitalizations. Yet just 6 percent of
19 people who receive a B-HEARD response to a mental
20 health crisis are transported to a community-based
21 healthcare or social service location, and nearly 60
22 percent are still transported to the hospital. The
23 program is failing to meet its goals, and in turn,
24 failing vulnerable New Yorkers in need of help. There
25 must be more transparency around the B-HEARD program

2 to inform best practices and investments in crisis
3 response. We're thankful to Council Member Brannan as
4 well as Council Members Schulman, Narcisse, and Lee
5 for introducing 1019 that will help in this cause.
6 The City must commit to working more
7 closely with community-based service providers and to
8 greater transparency. As a result of the City's poor
9 allocation of resources, 20 people who should be
10 alive are dead, and their family and loved ones are
11 left grieving and searching for answers. Having a
12 mental illness is not a crime and should not be a
13 potential death sentence. We can and must do better
14 than this.
15 CO-CHAIRPERSON LEE: If you could just
16 wrap it up.
17 JONATHAN CHUNG: I will wrap it up. We
18 strongly urge the Administration to properly expand
19 the B-HEARD program citywide with the specific
20 proposals outlined in our testimony. And again, it's
21 very important that peer crisis workers are included
22 because they're highly capable, equipped to conduct
23 the psychoeducation and outreach necessary to engage
24 folks having a mental health crisis. Thank you again
25 for holding this important hearing and please use

2 this as a resource for anything you may need in the
3 future.
4 CO-CHAIRPERSON LEE: Thank you.
5 JIM BOHOVITCH: Good afternoon, Council
6 Members and Chairs. Thanks for allowing me the
7 privilege to speak today. My name is Jim Bohovitch.
8 I've been a peer specialist for 10 years. I've had
9 bipolar disorder and PTSD for 30-plus years. I
10 currently work on an IMT team at Community Access.
11 I'm a steering committee member for CCIT. I've worked
12 on an inpatient unit at Kings County Hospital. I've
13 worked in Kansas and Cleveland, Ohio on mobile crisis
14 teams and doing community work. I just wanted to talk
15 about a few things that I heard today. People seem to
16 have questions about what de-escalation is and what
17 techniques are. Doing de-escalation is all about
18 having, it's like a skill, it's an art, and it's
19 having a positive attitude. You try to be an opening,
20 accepting person, and you're calm, you're collected,
21 you're chill even, and the most important skill is
22 absolutely listening. You just listen, listen,
23 listen. Once you get the person talking about what
24 they're going through, the de-escalation will begin.
25 They'll start to feel more calm. They'll talk about

what their issues are. They're letting out their emotions, and that's how de-escalation works. As peer specialists, we try to provide hope. That is difficult to explain in two minutes, like how that works, but it's a real part of what we do. De-escalation techniques, you also follow your gut instinct, see where the person is, and follow their lead. Just to be clear, motivational interviewing is not a de-escalation technique. And also, the mental health crisis is incredibly massive and pervasive in America, and especially here in New York City. Chair Lee, I would like to volunteer to help you with data analysis pro bono. One of the things that peers do is we try to get people in different situations to talk about different things. Last week, I cooked lunch with a participant of ours, and the conversation was incredible. And yeah, if you have any questions about my experiences, please let me know.

CO-CHAIRPERSON LEE: Great, thank you.

JOELLE BALLAM-SCHWAN: Hi, my name is Joelle Ballam-Schwan. I'm with the Supportive Housing Network of New York. We're a statewide membership and advocacy organization representing the providers of supportive housing. I'm also part of CCIT-NYC so

2 thank you so much for holding this hearing today.
3 Mental health crisis response is of critical
4 importance to both me and my organization. I've lost
5 close loved ones to mental health crises, and the
6 supportive housing community has an increasing need
7 for a peer-led, non-police mental health crisis
8 response system. Supportive housing, as you know,
9 permanent affordable housing with onsite voluntary
10 services for those who've experienced homelessness
11 and face systemic barriers to accessing and
12 maintaining permanent housing, which includes folks
13 living with serious mental health concerns.
14 Nationwide, the pandemic exasperated mental health
15 crises, and as a result, the past few years, the
16 majority of our members have reported an increase in
17 the incidence and intensity of mental health concerns
18 amongst tenants. Staff and tenants are in need of a
19 resource to call upon to ensure that an individual in
20 crisis can be met with a person-centered approach,
21 like Jim was talking about, rooted in genuine
22 connection and communal well-being. B-HEARD, as it
23 currently operates, is not providing that. B-HEARD
24 response teams fail to include peers, people with a
25 mental health experience and, across the country,

1
2 mental health crisis response systems led by trained
3 peers have proven more successful than police-led
4 responses. Where B-HEARD is operating, response teams
5 are only responding to 29 percent of mental health-
6 related 9-1-1 calls, leaving police to respond over
7 70 percent of the time. We have seen time and time
8 again, police are not equipped to handle mental
9 health crises. Since 2015, at least 20 people have
10 had fatal encounters with the NYPD during a mental
11 health crisis. 85 percent were people of color. In
12 order to operate outside of the police system, B-
13 HEARD should be dispatched at 9-8-8 versus 9-1-1. B-
14 HEARD also only operates 16 hours a day, as we've
15 heard, and must be available 24-7 and of course, it
16 should be fully funded to expand its operations
17 citywide. So B-HEARD is a very important step in the
18 right direction, but these significant changes must
19 be implemented as soon as possible. With the recent
20 killing of 19-year-old Winn Rosario, we must all
21 really say enough is enough. Thank you so much.
22 RAYMOND SCHWARTZ: Two minutes. Good
23 afternoon. Thank you, Chairs Lee, Salaam, Narcisse,
24 and Ariola, and all the other Members of the
25 Committee. My name is Ray Schwartz, and I am a

1
2 resident of New York City and have worked in mental
3 health services in both public and non-profit sectors
4 as an employee and a member of non-profit boards in
5 the mental health field. I am here to support and be
6 part of the CCIT advocacy efforts. My experience and
7 observations from more than 40 years in the mental
8 health field still leave me puzzled as to why there
9 is a public safety criminal justice response to a
10 public health need. While B-HEARD has been the New
11 York City government response to altering how a
12 mental health crisis is responded to, their last-
13 minute data dump, when analyzed, still has the police
14 responding to more than 70 percent of 9-1-1 calls.
15 Other localities are doing much better. Stereotyping
16 and bias about people living with a mental illness is
17 suppressing the development of a fully implemented
18 non-police response to mental health crisis calls.
19 The last Friday's data dump is an attempt to provide
20 meaningful data requires real scrutiny. I and my
21 colleagues from CCIT are willing to meet with you and
22 staff to review and use the data to identify what
23 information is missing, unexplained, and questionable
24 in order to accelerate the transformation of the
25 City's mental health crisis response so it is focused

2 to addressing public health need and permits the
3 police to use their available resources to address
4 public safety. I did include in my testimony some of
5 the comments and questions about the data, which I
6 hope you guys will be able to review and get us
7 engaged and participating. Thank you.
8 GRACE NICHOLS: My name's Grace Nichols,
9 and New York's my hometown. I went to high school
10 over here at Stuyvesant, and I come to you today,
11 drove in from Maine. After getting my law degree, I
12 now work for the Maine Human Rights Commission. And
13 25 years ago, despite the fact I was a science
14 teacher and a mother and pacifist, after a
15 misunderstanding with a social worker, the police
16 came for me and dragged me off to a mental hospital
17 where I both witnessed and experienced human rights
18 violations that I did not think were legal in the
19 United States. And when people with disabilities are
20 subject to the types of police brutality that is a
21 national crisis in public health, it's not just New
22 York, but when I heard that New York was having this
23 degree of difficulty in respecting human rights, I
24 had to come down and testify today. Now, I represent
25 a coalition named New York Act Up. We are a historic

group that has provided peer support for people living with HIV and their allies for over 47 years. We're famous in this city for confronting the City when our blood was on your hands, and we stand in solidarity with our sisters and our brothers in the mental health rights and recovery movement. I have a statement here that we consent to and Act Up members live in every borough. We have over 1,000 members. Act Up New York supports funding a Peers Not Police mental health crisis response in New York City to stop NYPD violence, and we know that all people with disabilities are in danger when the status quo continues. We rely on you, our city Council, to protect our safety and civil liberties. In the last eight years alone, New York City police have murdered 20 New Yorkers in their botched attempts to help them during a mental health crisis. These killings, in which the fear of people with mental health diagnoses intersects with racial profiling, are unacceptable and preventable. We are calling on you to act as a voice of the people most in need of protection. Act Up has served the HIV-positive community since 1987 using our own peer support and direct action model, defending a vulnerable population against stigma,

governmental neglect, big pharma profiteering, and lack of treatment access. We have fought against civil rights violations of all kinds. We know that any New Yorker can experience crisis and that people living with HIV are impacted by your choice in how to address a crisis. We also know that black and brown New Yorkers, as well as impoverished New Yorkers, are most at risk for a violent police response. People with HIV are overrepresented in each of these groups. We stand with Correct Crisis Intervention Today and their Peers Not Police model. We know that the presence of trained peers as first responders to New Yorkers in crisis saves lives, saves dollars, and also provides jobs to caring, trained people with lived experience of mental health crisis.

CO-CHAIRPERSON LEE: Sorry, Grace, one second. Just because I have to give as much equal time as possible.

GRACE NICHOLS: Yeah, yeah, yeah. Okay.

CO-CHAIRPERSON LEE: If you could sum up in one or two sentences.

GRACE NICHOLS: I will, I will.

CO-CHAIRPERSON LEE: And hopefully you have the rest of that in your written statement that you're submitting.

GRACE NICHOLS: So we recommend full funding 24-7 for a peer-led, peer-centered model, and we also ask, given that the mental health crisis is intersectional with physical health, intersection with the LGBT community, intersection with racism and classism, that you incorporate physical health peer support into your thinking on this. Act up, fight back, fight stigma. Thank you.

CO-CHAIRPERSON LEE: Thank you. Any questions? I think Council Member Cabán and I are the only ones left so do you have any questions?

Okay. I just want to say thank you to all of you especially, and just to reiterate, peer, you know, and more supportive peer services is important to me personally but also to the Speaker and other Council Members, which is why we wanted to make sure to include that in the first step of our roadmap, because we see how important it is, whether it's in the criminal justice system, whether it's in just, you know, your neighbors who are experiencing a crisis or family members, it is super, super

2 important so I just want to commend you all for the
3 work that you're doing, and I'm glad that so many of
4 us are associated with NAMI New York City, as a
5 former board member myself, so I just want to really
6 say thank you to all of you for the work you're
7 doing. Jim, I definitely felt more calm with you
8 speaking, and we have to meet people where they are,
9 right? We have to meet people where they are so, yes,
10 definitely. Can you come talk to some of our
11 constituents that are upset about their potholes and
12 stuff? No, I'm kidding. Okay, thank you so much.
13 RAMON LECLERC: (INAUDIBLE) don’t follow
14 up is because (INAUDIBLE) that makes them not want to
15 show back up (INAUDIBLE) over and over and over again
16 (INAUDIBLE)
17 CO-CHAIRPERSON LEE: Thank you so much,
18 Ramon, and that is something we talked about
19 yesterday on our round table panel with youth and
20 runaway homeless youth so thank you so much for
21 reiterating that.
22 Okay, so next panel. We have Bella
23 Soyoung Park, Mo Razvi, I saw him earlier, I don't
24 know if he's still here. He had to leave, right?
25

2 Okay, okay. Amber Song, Alison Wilkey, Cassandra
3 Kelly, and Kimberly Saltz. Are you with COPO also?
4 REVEREND TERRY TROIA: (INAUDIBLE)
5 CO-CHAIRPERSON LEE: Okay. Can you give us
6 your name? Sorry, actually, you could start first,
7 but if you could give your name for the record and
8 the organization again, just so we have it.
9 Oh, wait, I think you need to turn the
10 mic on. Just push the, press the button.
11 REVEREND TERRY TROIA: My name is Reverend
12 Terry Troia, and I work for Project Hospitality.
13 CO-CHAIRPERSON LEE: Oh, did you also fill
14 out a slip as well?
15 REVEREND TERRY TROIA: I did.
16 CO-CHAIRPERSON LEE: Okay, okay, perfect.
17 So we'll take you off that one and then put you on
18 this one. Okay, go ahead.
19 REVEREND TERRY TROIA: Hi, my name is
20 Terry Troia, and I work for Project Hospitality in
21 Staten Island. We serve street homeless and unstably
22 housed persons. A majority of the people we serve
23 have lived experience with behavioral health issues.
24 I'm here to share with you the story of a Staten
25 Island man living with mental illness. In need of

2 immediate mental health services, a 9-1-1 EDP call
3 was made. The man was transported to RUMC Hospital,
4 at which point upon exiting the ambulance, he decided
5 to leave the site and not enter the hospital. I am
6 not clear on what transpired at that point, but here
7 is how the interaction between the man and NYPD
8 ended. The man's head was pushed into the dirt so
9 deeply with such force where his head was held until
10 he was non-responsive and ultimately declared dead.
11 The autopsy revealed soil in the man's throat. He was
12 suffocated to death. 9-1-1 was called because a man
13 in crisis needed immediate mental health attention
14 and he died before he could get help. He was ill, he
15 needed healing, he ended up dead. We need mental
16 health professionals and peers who are trained both
17 in mental health crisis and de-escalation to be the
18 lead for mobile crisis teams, an integrated team of
19 trained peer professional collaboration that includes
20 NYPD, FDNY, and EMS. B-HEARD needs to be everywhere
21 in New York City, including Staten Island, and New
22 York City needs a public health response to a public
23 health need, a peer mental health expert, joint-led
24 integrated mental health crisis response team, and
25 these teams must be fully funded and must work as an

integrated effort to de-escalate, offer positive person-centered, trauma-informed crisis intervention services, while providing for both the protection of human life and respect for human life, with the ultimate goal of providing the person in need with life-saving services. Thank you.

BELLA SOYOUNG PARK: Hi. Thank you, all the Council Members and Chairs, for the opportunity to testify today. My name is Bella Soyoung Park, bilingual mental health counselor and case manager, and I'm here on behalf of the Korean American Family Service Center, or KFSC, as part of this Asian American Mental Health Roundtable. At KFSC, we work to empower immigrant survivors of gender-based violence with a focus on culturally and linguistically competent services. Our clients are often among the most vulnerable populations, facing multiple barriers to accessing the support they need due to language, culture, and stigma, particularly in times of mental health crisis. KFSC stands in strong support of expanding programs like B-HEARD, which align with our core belief and should be under the assumption that mental health crisis should be met with care, compassion, and cultural understanding by

trained professionals, not by law enforcement alone. During the times when many of our survivors struggle with mental health challenges, including severe trauma often resulting from their interaction with police officers, having responders like us, who can understand their cultural nuances and can communicate in their own languages, has been essential to ensuring the safety and proper care. So, with all of these being said, we urge the City to provide the resources needed to equip B-HEARD programs and teams with cultural competency and linguistic access and to fund community-based organizations like KFSC, who have long been trusted providers of care in immigrant communities. Our clients deserve a response that prioritizes their mental health and respects their cultural background, ensuring they're treated with dignity and receive the care they need. We hope to see the City further invest in this lifesaving program and partner with organizations like ours to create a more inclusive and responsive mental health care system. Thank you for your time and consideration.

AMBER SONG: Hi there. Thank you to the committee Chairs and Members of the Committee for the

opportunity to provide testimony. I'm Amber Song. I am a Senior Program Coordinator at the Asian American Federation, where we represent the collective voices of over 70 member non-profits that serve 1.5 million Asian New Yorkers. Winn Rosario, a Bangladeshi teenager in Queens, was in a mental health crisis and called the police. We all know what happened next. Within minutes, he was dead, shot by the NYPD. The recent tragedies of Winn, Victoria Lee in New Jersey, and countless others show that police shouldn't be the only ones to respond to crises. Instead, it's better for mental health workers and someone from the community to respond, which is why we applaud B-HEARD, but we found that it hasn't targeted the Asian community. So how can we better meet these needs? We urge the City Council as well as Members of the relevant Committees and City agencies, to consider the following recommendations. One, to equip B-HEARD teams with the linguistic and cultural competencies to serve the Asian community through translated information in common Asian languages and staff who understand Asian cultures and speak Asian languages and, two, invest in organizations that provide in-language and culturally competent services to the

2 Asian community. Our mental health partners provide
3 in-language mental healthcare in culturally
4 appropriate ways, and they receive referrals from
5 mainstream agencies and hospital systems that put a
6 strain on our partners' already limited capacities
7 since they do this work with no dedicated mental
8 health funding. The City should provide funding to
9 these organizations to provide preventative mental
10 health care before mental health issues turn into
11 emergencies, and the City should consult with them to
12 make sure the B-HEARD program meets the Asian
13 community's cultural needs because these
14 organizations are trusted among the community. We at
15 the AAF will continue to do our part through
16 advocacy, research, and programming. We lead the
17 Asian American Mental Health Roundtable, a group of
18 12 Asian-led, Asian-serving organizations, some of
19 who are testifying here with me today, and together,
20 we work together to tackle challenges, find
21 solutions, and share resources to improve access to
22 culturally competent mental health services for Asian
23 Americans. We look forward to working with the City
24 as it creates innovative solutions to address and
25

1
2 support New Yorkers experiencing mental health
3 crises. Thank you.
4 KIMBERLY SALTZ: Hello, good afternoon,
5 and thank you for this opportunity to testify. My
6 name is Kimberly Saltz. I'm a law fellow at the Legal
7 Defense Fund. New Yorkers need to have a meaningful
8 alternative to law enforcement when experiencing
9 behavioral health emergencies. B-B-HEARD in its
10 current state fails to provide New Yorkers with the
11 community-based response that is necessary to prevent
12 police encounters, and it further entrenches officers
13 into mental health crisis response in New York City.
14 People with serious mental health and behavioral
15 health disabilities are far more likely to be the
16 victims of violent crime than the perpetrators, but
17 these individuals are significantly more likely to
18 experience police violence than their peers without
19 such disabilities. Crisis intervention training and
20 co-responder models are not an effective solution to
21 police violence. Law enforcement has a fundamentally
22 different goal and different priorities than mental
23 health providers. Law enforcement's mission is to
24 enforce laws. Mobile crisis responders, including
25 clinicians, social workers, and peer workers, do not

2 involve police and have the professional expertise
3 and training to safely and effectively engage with
4 someone in a mental health crisis. Their mission is
5 to resolve the incident, identify and understand the
6 underlying issues, and connect the person
7 experiencing crisis to the additional services they
8 may need. These services can change lives, but only
9 if they're effectively funded and effectively
10 deployed. The City of New York has an obligation to
11 avoid putting New Yorkers at risk through
12 criminalization, through police encounters, simply
13 because of their mental or behavioral disability or
14 because they are in crisis. We urge City Council to
15 invest in true community-based responses to calls
16 involving people with mental health crises. Thank
17 you.
18 CASSANDRA KELLY: Good afternoon, my
19 name's Cassandra Kelly and I'm an attorney at the
20 Legal Aid Society's Criminal Law Reform Policy Unit.
21 At the Legal Aid Society, we see the profound
22 consequences of over-policing, especially in
23 generally under-resourced communities that so many
24 New Yorkers we represent come from. A 9-1-1 call for
25 mental health assistance is often met by cops with

2 guns who have no insight into how to de-escalate the
3 situation or connect that person to recovery-based
4 mental healthcare and support. Police have killed and
5 injured too many of our community members during
6 these encounters and they are almost never held
7 accountable. If people survive these police
8 encounters, they are routinely thrown into the
9 criminal legal system. They meet our lawyers and our
10 social workers in filthy City arraignment booths,
11 traumatized and further decompensated by their sudden
12 and sometimes violent arrest and detention. Our
13 lawyers have to explain to these New Yorkers the
14 impossibly inhumane situation they are in, that their
15 mental health crisis resulted in their arrest, and
16 that Legal Aid must now fight to keep them off the
17 irreparably dangerous Rikers Island. This should
18 never be the path for our neighbors in crisis and in
19 need of care. It is essential that we remove the NYPD
20 from mental health crisis response once and for all.
21 Continuing to send police to respond to mental health
22 crisis sends a message that the City does not care
23 about the lives, safety or dignity of people living
24 with mental illness and, given the NYPD's documented
25 history of racial discrimination and violence, the

2 threat to the lives of black and brown New Yorkers
3 with mental illness is especially high. The criminal
4 legal system causes harm and is not the answer to
5 public crisis. Instead, we need to invest in a non-
6 police public health-based response to mental health
7 crises that use harm reduction principles, centers
8 peers who understand and live with mental illness as
9 frontline workers and ensures that New Yorkers get
10 immediately connected to recovery-based mental health
11 care and support. We must also invest in robust
12 community-based mental health services that help
13 prevent escalation in crisis by providing daily
14 affordable access to mental health services and
15 additional funding and support for assertive
16 community treatments like ACT. In our written
17 testimony, we expand upon these objections to the B-
18 HEARD program and our suggestions for investment, but
19 I will refer you to the analysis provided by our
20 friends at Communities United for Police Reform who
21 have analyzed the gaps and identified solutions that
22 will move us out of a carceral approach to crisis
23 situations and into a public health-based mental
24 health crisis response. Thank you.
25

2 ALISON WILKEY: Good afternoon, my name's
3 Alison Wilkey, and I'm the Director of Government
4 Affairs and Strategic Campaigns at the Coalition for
5 the Homeless. Thank you for the opportunity to
6 testify, Chair Lee and Council Member Cabán.
7 I want to make four points today. First,
8 there was a lot of talk by the Administration about
9 the availability of mobile crisis teams through 9-8-
10 8, but the mobile crisis team website says
11 specifically that they will not respond to people who
12 are street homeless so, if people are living on the
13 street and have a mental health crisis and they're
14 not in the B-HEARD area, like say in Times Square,
15 which also came up, they will get no other option
16 other than a police response, and that is a big gap
17 in being able to have some kind of response that is
18 squarely in the mental health system and outside of
19 the uniformed services.
20 Second, I've been looking at the data
21 that was released on Friday and, if we're looking at
22 whether B-HEARD is effective at its goals and
23 actually having a non-police response that connects
24 people to care, you kind of have to look at the full
25 universe of calls so there were, in FY-24, 51,329

mental health calls. Of that, only 40 percent were found B-HEARD eligible, which is a really big drop. Of that total number of 51,000, B-HEARD dispatched a team in only 29 percent of those calls, and then of that total number of 51,000 calls, they only came in contact with a person in 14 percent of those calls, and I didn't hear an explanation today about why there's such a huge difference in them not actually coming into contact with someone when they actually do respond.

The third point I'll make is about the outcomes. I think other people have pointed this out, that in 57 percent of the cases where they respond, it results in someone being transported to the hospital. That number is egregiously high. In a similar program in Toronto, that figure's 8 percent, and in the Portland Street response team, that number is 2.5 percent so the number of people going to the hospital is incredibly high, and we don't know, and they couldn't tell us whether those are involuntary or voluntary transports.

Just the last point that I'll make very quickly is that I have concerns about the algorithm that they're using, and whether there are racially

2 disparate outcomes on that. Even in health settings,
3 algorithms have been shown to be racist and biased so
4 I have concerns about whether that is resulting in
5 the really low number of cases being found eligible.
6 We stand with other CCIT in calling for a peer
7 response that is truly outside of the uniformed
8 services and police.
9 CO-CHAIRPERSON LEE: It's interesting,
10 because actually when I was at KCS, we were part of a
11 grant where we looked at how questions were being
12 asked to, like the PQ-9 that everyone uses to assess
13 mental health diagnoses. Even that, right, it's a
14 very Western way of asking questions, right? So we
15 actually worked with some funders to rejigger the
16 questions so that it's more friendly to different
17 cultures because they're not going to answer in the
18 right way, right? If you just ask them bluntly, oh,
19 are you experiencing a mental, you know, like they're
20 not going to respond in the same way so to your point
21 about the algorithms and the trainings, I'd be
22 curious to look that more, and that's a good point.
23 I just want to thank all of our advocates
24 who are here today. Obviously, for the AAPI
25 communities, we've seen a lot of incidences happening

that could have been better handled for sure and so, you know, and the language access and the legal aspect of things is always a need so I just want to thank you all for your advocacy.

Council Member Cabán.

ALISON WILKEY: Yes, thank you.

COUNCIL MEMBER CABÁN: Just thank you for your testimony and the work that you're doing, and thank you for crunching those numbers over the weekend.

I think some of the things that I've heard from y'all and others kind of synthesizing it a bit, a big one on the hospitalizations is that what we've seen in some of these other cities is that the reality is they simply have more places to take people, more places, more diverse settings that are meeting a whole host of different needs, and what we found from looking at the data from lots of different cities and the information that they're reporting is that the more places they have to take folks that are not in emergency room or a precinct, the more successful the program is in the long-term, and that also, while we saw here in New York City that the emergency calls are trending up, that actually the

2 best metric for success for alternate responder
3 program is for there to be less 9-1-1 calls overall,
4 because that means that the preventative
5 infrastructure and the continuum of care
6 infrastructure is strengthening, and also that that
7 alternative response is being effective in connecting
8 folks to a continuum of care, and so I just wanted to
9 take the pieces of information that folks have been
10 sharing with us and kind of put that together a
11 little bit so thank you.
12 CO-CHAIRPERSON LEE: Awesome. Thank you so
13 much, everyone.
14 Okay. I wish I had prizes to give away
15 for the folks that are still sticking around with us.
16 Okay, so next panel, we have Dr. Victoria
17 Phillips, Victor Herrera, Arlene Machado, Sasha
18 Myrie, Leah Faria, and Sakeena Trice. I hope I'm
19 saying these correctly. Correct me if I'm wrong.
20 Sure. Absolutely. Okay.
21 COUNCIL MEMBER CABÁN: Is there anything
22 we can do to support you? Would you like some water?
23 All right, you got this. Take your time.
24 ANNALICIA WILLIAMS: Just wanted to, hi,
25 I'm sorry, I'm so sorry. Good afternoon, my name is

2 Annalicia Williams, and I'm here to advocate for
3 people who have been affected by NYPD and their
4 actions and for people whose mental health has been
5 affected due to similar experiences. As a young black
6 woman in America who's living with mental health
7 struggles and suffers daily, I respect when calling
8 for 9-1-1 for help due to my health that I would be
9 treated with deference and respect and be treated
10 swiftly. However, that was not my experience and on
11 multiple occasions due to NYPD and one occasion due
12 to FDNY. On the occasion I had an interaction with
13 FDNY, I was physically assaulted due to having a
14 panic attack and refusing to walk to the ambulance.
15 Because I felt dizzy and because I couldn't breathe
16 which later was discovered that my oxygen had dropped
17 to an 89 percent and I had arrhythmia. I also, when I
18 arrived at the hospital, had a stroke in my right
19 eye. Due to my medical history that was documented in
20 the system where EMS had information of my past
21 arrest records and my past health records of my
22 mental health and physical conditions, I was choked,
23 slapped in my face, and my glasses were broken by
24 FDNY paramedics and EMS which my mother later then
25 found my glasses broken on the staircase. I was, I'm

sorry, being arrested due to mental, I was arrested, besides FDNY, I'm sorry.

CO-CHAIRPERSON LEE: Take a deep breath.

COUNCIL MEMBER CABÁN: take your time, you got it.

ANNALICIA WILLIAMS: Later that night I was arrested by NYPD due to false accusations and later taken to the hospital. Besides FDNY on multiple occasions I have been verbally, emotionally, and even physically abused by NYPD. However, that was not the most traumatic experience. Unfortunately, it's sad for this to be said because going through severe mental illness can already be traumatizing. Being arrested due to mental breakdown on what was called resisting arrest caused me to be arrested and wrongly accused as well as wrongly accused of assaulting officer was showed on the body cam that I did neither. Neither me or my family was notified I was arrested until I arrived at the hospital where I was told I was being admitted for 48 hours under watch and was arrested in psych and handcuffs. This experience was severely traumatic as I could not use the bathroom without a male police officer having me under watch and watching me while using the restroom.

2 I couldn't shower while at the hospital and couldn't
3 change or use the bathroom without a male officer
4 being in the same room as me or the same bathroom as
5 me. I was not even given a female officer at any time
6 and was constantly anxiety ridden. Unfortunately, I'm
7 not the only person who's experienced being
8 wrongfully arrested, and I hope to spread awareness
9 to my experience and others. I faced being forcibly
10 guilty to a felony which I did not, sorry.
11 COUNCIL MEMBER CABÁN: You've got this.
12 ANNALICIA WILLIAMS: To a felony which I
13 did not fortunately accept and kept fighting for my
14 innocence. Please take this experience as a motivator
15 to continue fighting for the rights and health, thank
16 you, health of people who've been demised and
17 detained wrongly by law enforcement and treated
18 unfairly by FDNY. I hope for New York and the City to
19 place more programs for people, families, and
20 citizens to feel more safe and provide better care
21 and protection to people with mental health
22 conditions. I surely believe that people with mental
23 health conditions is part of the vulnerable
24 population and should be treated as such. The City
25 should have more peers in communities in law

enforcement with no training or minimum training. Thank you.

CO-CHAIRPERSON LEE: Thank you so much for sharing it, Alicia.

CHAMBERS: (APPLAUSE)

CO-CHAIRPERSON LEE: Yes. I think that actually deserves a clap. I don't know if we're allowed to, but okay, I'm going to clap. Thank you, and thank you to both of you for being supportive.

SASHA MYRIE: Good afternoon, everyone. My name is Sasha Myrie. I am a mother and an advocate for my daughter who's sitting beside me, and I'm a New York City resident. I'm also a civil servant. I also work with the vulnerable population and I also live with someone who needs my support. On June 18, 2023, at 11.43 p.m., I made a 9-1-1 call for a mental crisis in which my daughter was experiencing. She was attempting suicide. I made the call for help, a call that I will always live to regret. At 12:21 a.m. on June 19, 2023, 37 minutes after a call that I made, more than a dozen officers arrived at my mother's home and, two minutes later, FDNY EMS workers showed up. What I thought would be help became a living nightmare that has caused my daughter trauma ever

2 since and, once again, and for me, trauma. When
3 officers arrived at the scene of my mother's home,
4 you would have thought there was a crime in progress
5 that required more than a dozen officers and a
6 handful of patrol cars that blocked an entire one-way
7 street. A crime did not occur. My daughter was
8 treated inhumane, dismissed, and was violated by the
9 people who are supposed to serve and protect
10 civilians, including those who are having mental
11 crisis. My daughter was emotional, and her cries
12 became screams for help when officers ran into my
13 mother's tiny corridor of her Bronx apartment. I'm
14 sorry, I'm going to skip right through because time
15 is limited. While I did not witness…
16 CO-CHAIRPERSON LEE: It's okay, continue.
17 SASHA MYRIE: Sorry. While I did not
18 witness my daughter assaulting any officer, I was
19 there. My daughter did not have her rights read. She
20 was not told she was being arrested. Until we arrived
21 at the hospital, still she was not informed by
22 officers of the arrest. She was hospitalized for four
23 days. In CPEP, while she was handcuffed, hands and
24 feet to a bed like a caged animal, unable to use the
25 bathroom, given bedpans to urinate and defecate,

1
2 while a male officer would be in the room at all
3 times. Male officers were present when she needed
4 hygiene care from nursing staff. She was exploited.
5 She was humiliated. She was being punished for her
6 disease in the most inhuman way possible. She was
7 denied any contact with me or loved ones for four
8 days. Not one phone call was made from her. Fast
9 forward. My daughter faced a felony assault charge
10 that was brought up against her on June 23, 2023. I
11 requested FOILs from NYPD multiple times. This
12 morning, I looked at my email to see the confirmation
13 receipts. I've never received any body cam. My
14 daughter spent more than a year fighting to not take
15 a plea deal. Something that is obvious in our
16 community to cover the problem. My daughter was
17 proactive and assertive of not taking a plea deal. We
18 went through two Legal Aid lawyers to a court-
19 appointed attorney who still insists these things can
20 get tricky. She was coerced in the criminal justice
21 system. It wasn't until August 14, 2024, not so long
22 ago, two days before her last hearing that I finally
23 received the body cam of more than a dozen officers,
24 and it is horrendous, it’s an outrage, and it's a
25 crime because what I watched on more than a dozen

2 body cams, it took a lot of strength because I'm even
3 more traumatized today because I wish two things. I
4 never made that 9-1-1 call, and I wish I never had to
5 watch those body cams because she didn't hit a
6 officer but she was physically abused that day, and I
7 filed with CCRB and everything was unfounded and
8 unsubstantial and they refused to open an
9 investigation that I've requested. It's not funny how
10 today, finally I'm able to access records. So I'm not
11 going to continue to turn a blind side because on
12 August 14, my daughter did take an ACD, a weird ACD.
13 She didn't have to have any departments of community
14 service or anything that the judge questioned the DA
15 and the prosecutors in the room how is it that this
16 defendant is offered an ACD? What the judge didn't
17 understand is that he was not going to be able to
18 hear her story because it was lies. I saw everything.
19 My daughter was brutalized that day by police
20 officers. I witnessed a police officer ready to pull
21 his gun in front of me. My mother terrified, a senior
22 citizen terrified in her own home and became a child,
23 and she had to face a felony charge. And guess what?
24 She has to wait another five months before she's
25 cleared of that felony charge. Our people who are

facing mental crisis in community are being discriminated. They're being brutalized. Not all of them end up on the news deceased. Some of them live with a lifetime of trauma. I know. The job I do, I'm hearing it. It's a shame. When you hear Ms. Myrie, I couldn't call 9-1-1, I was afraid, I was having crisis. Now we're having people having to make the decision, and we as family and caregivers and loved ones are making decision because when we're trying to save a life, 9-1-1 is out here to destroy a life forever. Thank you for your time.

CO-CHAIRPERSON LEE: Thank you so much. Thank you so much for sharing your stories, both of you.

And this is exactly why we're here today because we need to figure out how to make 9-8-8 more prevalent so that these situations don't happen as well as to make sure that B-HEARD is as effective as possible so I just want to thank you both for sharing your stories.

SAKEENA TRICE: Wow, I'm extremely moved right now. Thank you. My name is Sakeena Trice. I am a Senior Staff Attorney. I work for the New York Lawyers for the Public Interest. I work in our

Disability Justice Program. Well, thank you, first off, for the opportunity to present testimony on behalf of NYLPI regarding the City's B-HEARD program. This spring, NYPD officers in Queens fatally shot Winn Rosario, a 19-year-old, while he was experiencing a mental health emergency, for which he called for help. Again, Winn called for help and was shot by NYPD officers. How many more individuals must die at the hands of police before we finally adopt a more humane, a person-centric approach to mental health crisis, one that is free of discrimination? This is an important issue because people are being abused, people are dying, particularly people of color, people that look like me. NYLPI is deeply concerned about the City's practices related to responding to mental health emergency. We urge City Council to mandate significant changes to B-HEARD as it is a deeply flawed pilot program, which merely purports to be a non-police response to people experiencing mental health emergencies, but in effect, it is part of the long tradition of policing, criminalizing, and under- and mis-serving people with mental disabilities. Funding B-HEARD in its current guise diverts money from what we truly need, which is

2 a true non-police response, one that dispatches a
3 team of peers, those with lived experiences, and
4 emergency medical technicians who are not City
5 employers. We need 24-7 operating hours. All calls
6 need to be routed through 9-8-8, and above all, we
7 need a system that prioritizes the self-determination
8 of those with mental disabilities. Thank you.
9 CO-CHAIRPERSON LEE: Thank you.
10 ARLENE MACHADO: Good afternoon, Chair Lee
11 and Council Members. Thank you for the opportunity to
12 testify today on behalf of the Center for Justice
13 Innovation. My name is Arlene Machado, and I'm a Case
14 Manager for the Bronx HOPE Program, Bronx Heroin
15 Overdose Prevention and Education Initiative of Bronx
16 Community Solutions, which addresses substance use
17 and a harm reduction model at the precinct level,
18 providing the opportunity for rehabilitation rather
19 than jail or options that fail to address the
20 underlying issues. Over the years, I've been a
21 witness to the desperate need for mental healthcare
22 for the people that we service. Mental illness and
23 substance use go hand-in-hand. It's rare that we meet
24 clients who don't have a history of mental health
25 disorders. Typically, most clients usually use

2 illicit substances because they don't have the access
3 to proper mental healthcare services. They face
4 barriers, like having to wait too long to see
5 providers, not having insurance, and not being able
6 to complete the various intake assessments. Their
7 health insurance just isn't accepted at the clinics
8 that they've been referred to or that they're heard
9 about. It's frustrating for us as case workers,
10 clinicians, social workers, etc., to sometimes find
11 the adequate care for our clients. Imagine how hard
12 it is for the people that are actually waiting for
13 the care. I wasn't always a case worker. I began my
14 career as a peer specialist. My goal has always been
15 to help and support the clients that have struggles.
16 As a peer, I was able to connect with people that I
17 serve, not in a clinical sense, but in a way that
18 related to the realities that they were facing. I was
19 a person somebody could speak to without the fear of
20 judgment. I was a voice for people who weren't loud
21 enough to be heard. My past life experiences were no
22 longer just a piece of trauma that I carried around.
23 They became valuable tools of knowledge to be passed
24 on so that others can have the opportunity to know
25 better and do better. I say all of this to highlight

2 the value that peer specialists bring to the work and
3 the lives of our clients. Our data shows how
4 impactful peer engagement can be and how our clients
5 are likely to complete programming if they are
6 connected with a peer specialist immediately after
7 being arrested. Mental health responses such as these
8 are so integral to rehabilitation and connection to
9 community. Thank you for your time.
10 VICTOR HERRERA: Good afternoon, Madam
11 Chair and Committee. My name is Victor Herrera,
12 leader and member of Freedom Agenda, Close Rikers,
13 former jailhouse lawyer, mental health advocate, and
14 street lawyer for Sensible Policies, DBA GAP
15 Solutions. In almost every home, I am quite positive
16 that there is a concern related to a person
17 experiencing emotional crisis or trauma. However,
18 those of us that have no home or returning citizens
19 are the target of structural racism, don't have such
20 luxury as access to the resources necessary to be
21 appropriately treated. I urge the City Council to
22 revise the NYPD patrol guide language, demanding the
23 NYPD and NYC Department of Health and Mental Health
24 need to end the stigma and criminalization of people
25 experiencing emotional crisis. My own experience of

2 being the subject of the patrol guide for
3 illegitimate purposes to cover up misconduct by two
4 agencies, DHS Police and NYPD, and the Health and
5 Hospital Corporation response to NYPD practices that
6 resulted in harm to my mental health is the reason I
7 survived post-traumatic stress disorder today. Today,
8 people who have no resources are treated with
9 dangerous consequences, injury or death. No to EDP.
10 No to NYPD as first responders or co-responders. Yes
11 to expanding B-HEARD and funding of mental health
12 resources. What I have learned as a client of CUCS
13 IMT is coping skills that many in the community are
14 deprived of on account of no funding sources. DOHMH
15 and the City must do more for the at-risk community
16 and address the epidemic as a serious public health
17 concern. We've had too many police responding with no
18 de-escalation skills or training. Hence, the subway
19 shooting cannot be exempt as it was clear the
20 individual was experiencing a crisis when he asked
21 the officer to shoot him. The fact that these kinds
22 of concerns are ignored raises serious questions
23 whether it's deliberate or negligent in this City
24 doing more for the at-risk community members who
25 deserve treatment, not bullets. Innocent bystanders

being in the path of what is clear inadequate responses to people experiencing emotional crisis. Yelling out or threatening a person experiencing an emotional crisis is not de-escalation. More provocation and deliberate to create the idea the NYPD patrol guide definition of threat to themselves or others to justify lethal force. Thank you.

CHAPLAIN DR. VICTORIA PHILLIPS: Peace and blessings, everyone, all Chairs and Council Members. I'm Chaplain Dr. Victoria Phillips, aka Dr. V and today I'm speaking from several volunteer and contracted positions. B-HEARD had a pilot prior to the pandemic, right? I believe it was focused more on the Upper East Side. Now there are 31 in police stations out of 77. These numbers are disrespectful. Expand to all communities, not just those ZIP codes the City favors. We are all New Yorkers. That's like having an officer on tour in our communities without being CPR certified or firearm trained. 9 a.m. to 1 a.m., this is B-HEARD hours of operation. As a doula, I know our society doesn't tell its mothers' wombs what time to deliver their children. Do we monitor the hours unexpected fires should break out? What time is appropriate for a car accident to occur? So

2 why am I saying all these things? Because we don't
3 ignore the basic human need and right around the
4 clock to physical care so why are we doing it for
5 mental health treatment? I worked in nursing in
6 regular ER and in the ER for mental health, which is
7 known as CPEP, Comprehensive Psychiatric Emergency
8 Program, for many, many years. The system is failing
9 us, the most vulnerable populations. I've said Mr.
10 Carter's name on this record previously because our
11 City agencies failed him as well. The shelter system,
12 the hospital system, the police department, the DA,
13 the judge, the Department of Corrections, where he
14 died less than 72 hours upon arriving on Rikers
15 Island. 68 percent of those with mental health
16 concerns do not receive the mental health treatment
17 they need while incarcerated. On this point, let me
18 also state on the record, hospitalization can also be
19 a form of detainment. As an Army brat who grew up
20 listening at my bedroom door to the lasting trauma of
21 deployment assignments discussed by my serving
22 parents and their platoon members, I'm programmed to
23 hear the cries of others, to advocate, create, and
24 implement lasting change that can only begin by us
25 all holding ourselves accountable, elected officials,

2 community members, and all peers accountable every
3 day. As clergy, I know no one escapes, can I just get
4 a few? As clergy, I know no one escapes crossing
5 paths with mental health concerns, from the law
6 enforcement officers who personally ring my crisis
7 line in the middle of the night, to principals who
8 are referred to me by superintendents. Invisible
9 disabilities, mental health concerns, developmental
10 delays, et cetera. As a brain surgery survivor, I
11 personally know no one has patience anymore,
12 including service providers and medical and mental
13 health care. Police often enter our communities
14 already put off. Yes, B-HEARD needs additional
15 languages, but also make sure those who use sign
16 language and any other means to communicate have
17 access as well. Let me be clear, cultural humility is
18 key. Our City has zero excuses to not meet the
19 demands of its residents. We are the people. Officers
20 need to use person-centered language and should fall
21 back on these radio runs. My community knows NYPD
22 leaves all calls that they respond to, regardless of
23 what you heard on the record today. The answers and
24 examples given today were full of fluff. Lastly, I'll
25 finish by saying from a public safety perspective, I

2 can recall working at the largest SRO in the nation.
3 My client with known substance abuse had a gun in my
4 office. He didn't point it at me, nor was it actually
5 loaded, but I didn't know that in the moment. And I
6 say that because it was early evening, one of the
7 late nights that I was giving medication and
8 literally minimum staff. I had to utilize all de-
9 escalation tools and trainings that were given to me
10 to keep myself safe. And guess what? He ended up
11 handing me his gun and that's how I found out it
12 wasn't even loaded. In one other example, very
13 quickly, years later in 2011, I was held hostage in a
14 MICA shelter. We had just opened up. I had no working
15 phone in my office and not one security officer made
16 rounds to the ninth floor for over two and a half
17 hours. My high needs client who was recently released
18 after 30 years said I reminded him of a woman who he
19 had previously raped and stabbed by Fordham
20 University. By the time security had appeared, I had
21 my client sitting on the floor in front of my door.
22 The excuse later was security was short-staffed. I
23 say all that to say de-escalation training is a must,
24 but more importantly is holding those accountable to
25 actually use it. Too many times police resort to uses

of force when it isn't necessary. I know my examples are extreme, but even in those moments, life can be preserved and still should hold value. Nine million calls were stated today from the date of 2023, and one of the Department members said only 1,700 uses of force. Out of 174,893 calls that they responded to last year, divide that by 1,700, that equals 102.87 so out of every 102 people, a use of force was actually done. And CCIT training should be 100 percent at this point, and it also should not be rushed nor overlooked. The curriculum facilitators should have time to flesh out concerns, questions, and be held accountable for their own biases they might bring to the trainings. And if classes doubled in size, has the time doubled in size to deliver the message and materials? Peace and blessings.

CO-CHAIRPERSON LEE: Thank you, Dr. V. Thank you to this panel.

Did you want to say anything? No, okay.

I want to highlight that all the examples of what you all are bringing up, and by the way, I have a family member and friends, by the way, that have experienced similar incidences where they had mental health crises and were, you know, in

situations they were found homeless, and so I want to commend everyone here, and also, you know, being the Chair of Mental Health Disabilities and Addictions, right? Those things need to, we should respectfully address each one and not make assumptions, but also at the same time, our system is not set up to fully treat someone as a whole person and a whole being so if I have a substance use and a mental health issue, a lot of times I have to walk through separate doors to get treatment, and the folks are not talking to each other so I just want to thank you all for your continued advocacy, and thank you so much for being here and I love that your mom is also being here to support you, and that really is so huge and so I just want to say thank you for waiting and for sharing your story. It is so much appreciated. Of course, for all of you, and Dr. V always bringing the fire, I love it.

VICTOR HERRERA: I just wanted to emphasize one thing in regards to the daughter going through the experience, because this thing with people experiencing emotional crisis, I'm not using EDP anymore. I want to change that. It's real because I was reported as emotionally disturbed nine times,

okay? Five out of those nine, I was forcefully injected with an antipsychotic drug, okay? Now, just to be clear, okay, that the practice of the NYPD patrol guide is clearly open for abuse. They intend to use it as a criminalization type of approach to individuals experiencing an emotional crisis, okay? Nine times, held against my will, lost two jobs, lost my car, had to sue them in federal court, and broached the subject of acting in concert theory against private corporations, non-profits involved, okay? And this practice, this is ridiculous. And hearing this story continue today. Even last year, I experienced it. Pulled over in my car, okay? Queens General Hospital, even after I explained it to them, don't do this, they still injected me. The Hospital Corporation needs to be also held accountable because they work in psychiatry, I'm traumatized. I'm scared to go to a hospital to get treated, and this is where people go hoping to get treated and get well, and this is the trauma that people like us are going through because FDNY, NYPD, and the Health and Hospital Corporation are in collusion. The patrol guide and the use of force for NYPD patrol guide, the language has to be changed in order to de-escalate

these matters in regards to the mental health community. Thank you.

CO-CHAIRPERSON LEE: Thank you for sharing that.

CHAPLAIN DR. VICTORIA PHILLIPS: All day today, everybody kept saying that like substance abuse is something different. It is part of the DSM-5. It is still a mental health concern.

CO-CHAIRPERSON LEE: That is so true.

Okay, so next we're going to have the next panel. Helen Skipper, Roland Pierre, Michael Nugent, Alexandra Nyman, Monica Harris, and Kayla Hackman.

LEAH FARIA: Okay. thank you, Chair Lee, Council Member Cabán, and the rest of the Council for giving us the opportunity. You stated earlier, thank you to us. Thank you to you. My name is Leah Faria, and I am the Director of Community Engagement for the Women's Community Justice Association. I'm here today to testify in support of CCIT, Correct Crisis Intervention Today, a coalition of advocacy groups and other community organizations that consist of hundreds of community stakeholders working to transform how New York City responds to mental health

crisis. The Women's Community Justice Association advocates with and on behalf of women and gender-expansive people impacted by mass incarceration, and as such has had a front row seat for the criminalization of mental health crisis. Rikers Island is currently the largest mental healthcare provider in the state of New York, and over 80 percent of the women and gender-expansive people incarcerated there have a mental health concern, stark testament to the lack of appropriate response to New Yorkers in mental health crises. When law enforcement responds to a call about an individual in a mental health crisis, involvement of the legal and carceral system become far more likely, often at the cost of the care that person actually needs. Far too many individuals have been killed by police officers while experiencing a mental health crisis in New York City. After decades of advocacy by CCIT, NYC, and others, we appreciate New York City's attempt to shift crisis response through its Behavioral Health Emergency Assistance Response Division, B-HEARD, pilot. Responding to mental health calls with health professionals instead of law enforcement is essential. About a quarter of all fatal police

2 shootings in the U.S. involve someone experiencing a
3 mental health crisis. However, we have significant
4 concerns with the program's current structure and
5 outcomes to date. The current B-HEARD structure is
6 fundamentally flawed and still very much relies on
7 NYPD B-HEARD teams. Our only dispatch through 9-1-1
8 rather than 9-8-8, the new federal three-digit number
9 for mental health crisis calls. 9-1-1 does not accept
10 requests for a B-HEARD team response. Other issues
11 pertaining to scope of service include that the
12 program is not citywide or 24-7, leaving far too many
13 citizens with police as first responders to their
14 mental health concerns. We have seen time and time
15 again, most recently with the death of Winn Rosario
16 that it is entirely inappropriate to send police in
17 response to mental health crisis calls, and their
18 presence only creates deadly escalation. CCIT NYC
19 calls for police to be completely removed as first
20 responders to nonviolent mental health crisis calls
21 and for peers, people with lived mental health
22 experience, to be a mandatory element of B-HEARD
23 teams. Response teams that include people with lived
24 experience will help achieve the B-HEARD pilot goals
25 by shifting the model to a person-centered approach

rooted in genuine connection and communal well-being. Two key goals of B-HEARD are to increase connection to community-based care and decrease hospitalizations. Yet just 6 percent of people who receive a B-HEARD response to a mental health crisis are transported to a community-based healthcare or social service location, and nearly 60 percent are still transported to the hospital. Peers have the skills and expertise to advocate for connection to community-based care and avoid unwanted and unnecessary transports to hospitals. Although B-HEARD's geographic bounds have expanded some since its inception, and it is responding to a higher volume of overall calls, the number of calls directed to B-HEARD are not keeping up with the rate of the program's expansion. The most recently available data shows that only about one in four people who place mental health crisis calls in a qualifying area get a B-HEARD response. In an interview with New York One, the program openly stated that teams only respond to a mere three to five calls per day. Finally, we need more transparency around B-HEARD program to inform best practices and investments in crisis response. There has been no new data reported this Fiscal Year.

2 The City must commit to regular reporting. Of course,
3 in order to continue to make progress towards its
4 goals, the B-HEARD pilot will require sustained
5 investment in the budget, starting with fully
6 restoring the B-HEARD Program to Eliminate the Gap
7 cuts in the adopted budget. We look forward to
8 working with the Chairs and Members of these
9 Committees to improve B-HEARD and ensure that New
10 Yorkers experiencing a mental health concern crisis
11 receive the response they deserve.
12 CO-CHAIRPERSON LEE: Thank you. And just
13 as a reminder, because I hate being bad cop, help me
14 out, please, because feel free to summarize, because
15 we do have all the written testimony that we're going
16 to read, so I want to definitely hear what your main
17 points are, main concerns, so please feel free to
18 summarize. Thank you.
19 HELEN SKIPPER: Good afternoon. My name is
20 Helen “Skip” Skipper. I'm the Executive Director of
21 the New York City Justice Peer Initiative. Once
22 again, I find myself sitting in the Council Chambers,
23 which is empty. I don't have a lot of Council
24 Members. I definitely don't have the sea of uniforms
25 that were sitting here, because we had DOHMH, we had

2 the NYPD, we had the Fire Department. No one is here
3 so I would officially like to take this time to
4 protest how we do these hearings because the people
5 that sat here need to hear what we have to say, and
6 we've been here since 9 o'clock. I sit here in all of
7 my intersectionality and identities. I spent 25 years
8 cycling through the criminal justice system, through
9 the behavioral health system, through crises, but I
10 also sit here as a peer, moving lived experience to
11 lived expertise. I also sit here, my other identity
12 as the Vice Chair of the New York City Board of
13 Correction. What are we doing? Peers can train CIT.
14 They can train B-HEARD. And yes, I know, because I'm
15 one of them. I'm one of the trainers. Yet we're not
16 good enough to work in this program. This program is
17 only available in communities that are marginalized
18 and oppressed. So what does that mean? The more
19 affluent areas of New York City do not suffer from
20 mental health crises? I think not. There was a lot
21 being said today, a lot, and you guys know me, and
22 you know I'm unapologetically peer. I train justice
23 peers who have lived experiences in behavioral health
24 concerns, and also the criminal justice system. I did
25 not get to where I am without being unapologetic and

2 without using my lived experience. When will the City
3 buy in to the fact that the lived experience that we
4 have, we're not begging for a seat at the table. We
5 are the table. These programs will not run
6 effectively and efficiently without incorporating
7 lived experiences. You heard from people from other
8 locations across the United States. They all talked
9 about, yes, we have peers. Peer support is an
10 empirical based, and I speak of that because as a
11 criminologist, as someone who is entering into a PhD
12 program, in the fall, empirical research means that
13 it has been studied, looked at, dissected from rooter
14 to tooter, from A to Z. What is the problem with
15 incorporating this into our crisis response? What is
16 the problem with incorporating lived experiences into
17 the criminal legal system transformation? I ask that
18 B-HEARD be expanded 24-7 because, as my sister said,
19 you don't have a crisis at 4 o'clock on a Thursday.
20 They often come like thieves in the night. We need to
21 expand this program. We need to expand this program
22 into all areas of the city because in the South
23 Bronx, we have crises. Guess what? They have them on
24 Fifth Avenue too. I don't understand what their
25 problem is, but I'm going to thank you, Chair, and

thank you for letting me just go off topic and just talk, but please, can we switch this around? When there's a big hearing like this, can the public speak while the officials are here to hear what we say? They run the programs that we consume.

CO-CHAIRPERSON LEE: Right. So just so you know, actually, this is a conversation that several Council Members, a lot of us have had in terms of how we can try to switch it so we hear you on that point, and so we'll see. I don't want to speak out of turn, obviously, but yes, we hear you.

HELEN SKIPPER: Thank you.

ALEXANDRA NYMAN: Thank you. Hi, my name is Alexandra Nyman. I am a peer, I'm a recovery coach, I'm a NAMI NYC advocate, I'm a member of CCIT NYC, and I'm the founder of the Break Free Foundation where we provide scholarships for people living with substance use disorders to attend an inpatient outpatient facility at little to no cost to them to remove the financial barrier of entering into recovery. I guess, as you can hear, I wear a lot of hats, but my favorite hat is that of a trainer of trainers. As a recovery coach, I have the distinguished honor of being able to train the next

1
2 generation of coaches. And we've talked a lot about
3 the work of a peer, but I don't think we've really
4 talked about what goes into becoming a peer. And so
5 to become a CERPA, a Certified Recovery Peer Advocate
6 in the state of New York, you need to undergo an
7 exam, and prior to that, you undergo training. Your
8 foundational training is 60 to 70 hours, which can
9 take you two weeks to accomplish, and then on top of
10 that, once you pass your exam, you can then go on and
11 you do 500 hours, which if you're doing that full
12 time, it can take you anywhere from three to four to
13 six months. For the Behavioral Health Peer Track,
14 it's an exam, it is classes that take around two to
15 three months to complete and 2,000 hours of reviewed
16 work, supervised work, which can take a year and a
17 half to two years, and I think it's absolutely
18 ludicrous that we're expecting the Committee before
19 us that are involved in B-HEARD to think that they
20 can understand de-escalation, understand how to meet
21 someone where they're at, because, oh, well, we watch
22 a 45-minute video and then we quiz them like 15
23 minutes before their shift and they're so well-versed
24 now. I would also like to echo what my colleague had
25 said, because I think if the members who had spoken

2 before us could really understand what goes into
3 being a peer and becoming a peer and all of the work
4 that we put into it, they would understand that they
5 shouldn't be requesting less funds. We need more
6 funds. The average peer recovery worker in New York
7 City makes between 40 to 45,000 dollars a year. I've
8 worked with so many incredible peers at the recovery
9 center that I was at, and half of them work two full-
10 time jobs as peers to make ends meet. On top of that,
11 they also worked part-time jobs. That is insane. We
12 have created a system where we desperately need these
13 workers, and yet we wonder, oh, why do they not want
14 to come and work within this field, it’s so great
15 and, yes, it is the most rewarding thing that you can
16 do as a person in recovery. Being able to give back
17 is incredible, but not being able to live can lead to
18 its own behavioral health issues. So to recap and to
19 conclude, what I am asking for is increased wages for
20 the peer workforce as well as to push back on what we
21 heard from the panel, which was ridiculous, that, oh,
22 we just, we don't know if we're going to expand the
23 scope, like I don't know as well as to remove police
24 from all mental health crises. In my two years of
25 working as a peer, where I, me, my colleagues, and my

staff have had violent encounters, encounters with weapons, I've never thought, like, let me grab a gun, I'll feel so protected. I have always been able to help that person de-escalate and to then hand them off to community-based care, and they're still alive and thriving today. I would also like to ask that New Yorkers in crisis to receive the compassionate care that they need, not confrontation, and for us to finally take this from being a public safety issue to a public health issue. Thank you so much for your time and for staying to the bitter end.

MICHAEL NUGENT: Hi. My name is Michael Nugent. I work for Baltic Street Wellness Solutions, which is the largest peer-run organization in New York State. I want to say three main points. 20 people dead in the past, you know, since 2015 is unacceptable, but there's a problem also of involuntary treatment, people being forced into involuntary treatment, the thing that people have alluded to in terms of hospitalizations that result from these calls to 9-1-1, and I think if you're talking about de-escalation, if you're talking about people having choice and being able to make informed decision, if you're able to do your work properly

2 when a person is in crisis, then you're able to kind
3 of de-escalate and there's not a need for
4 hospitalization, right, so I think the person from
5 Health and Hospitals was talking about kind of like
6 they need to do their assessments and this and that
7 so they could determine the treatment, but the person
8 may not want to go to treatment, right, and the thing
9 shouldn't be treatment so we don't want the forced
10 hospitalizations either, basically, which is what
11 they are, forced treatment. That's one point.
12 The second point is my program at Baltic
13 Street, I'm the Director of Employment Services and
14 Education Services, and those are the community-based
15 services that we're talking about here that people
16 need. We want people who are in crisis to be referred
17 to us and basically to deliver those services to
18 people who need them, who we can use our peer
19 experience to help get through college. You know, the
20 number of people who actually don't finish college
21 who are diagnosed with so-called SMI, I think it's 85
22 percent of them, if I'm not mistaken, and that's too
23 high. And you know what I'm saying? That's something
24 that peers can also be involved through supported
25 education in solving.

2 The last point is basically, we support,
3 as Baltic Street, peer-led response to mental health
4 crisis. Members of our executive team sit in the
5 Mayor's Office team that communicates about B-HEARD
6 and sums it up, how it's going, but we do advocate
7 for a peer-led response and more peers involved and
8 we're strong on that. That's what we want. And yeah,
9 those are the three main points so thank you for
10 letting me speak.
11 KAYLA HACKMAN: Hello, my name is Dr.
12 Kayla Hackman. I'm a resident of New York. I have
13 been for over a decade. I wanted to thank everybody
14 that stayed to the end. Thank you. It's your job, so
15 you should be here. I'm saying that for the people
16 who aren't.
17 I'm here wearing two hats. I'm a medical
18 doctor who has worked in a psychiatric hospital and
19 I'm also an individual who has psychosis. The unique
20 perspective that I have compels me to speak out about
21 the critical state we find our City's emergency
22 services in at the moment, especially the
23 interactions with individuals experiencing mental
24 health crises, particularly those experiencing
25 psychosis. Being mentally ill or psychotic is not a

crime. The current state of affairs is deeply concerning and having attended and taken a day off of work to be here, I find it even more concerning how no one seems to care. The tragic cases of Shereese Francis, Eleanor Bumpurs, and multiple others highlight a systemic problem in how we respond to mental health emergencies. The incidents highlighted during this session underscore the urgent need for reform in our approach to crisis intervention. As someone who has been in both positions as a provider and a patient, I'm intimately familiar with the challenges of our current healthcare system. My perspective is not just professional but personal. I have experienced firsthand trauma at the hands of the NYPD who forced me from my own bed and took me against my will to Bellevue. While institutionalization can be a miserable experience, especially at Bellevue, and while I understand that it may seem challenging to convince people to willingly submit to it, it is eminently preferable to go to the hospital than to face the tragic outcomes we have heard today. Few people are more qualified to help get mentally ill people the treatment they need than the people who have been there and gotten better

2 themselves. Psychosis is not a death sentence. Mental
3 illness is not a death sentence. Peer-led policy is
4 the only way forward. I'm here in support of the
5 testimony that's been provided today. I'm deeply
6 concerned about the use of algorithms to triage
7 people. I'm deeply concerned about many things. I
8 echo everything everybody here has said today, and I
9 just really want to say how much I feel like I'm in
10 despair right now because there's just nobody here
11 who wants to listen to this. I know that you're
12 listening to this now, and I appreciate it, but you
13 know what I mean. Thank you.
14 CO-CHAIRPERSON LEE: Yes, thank you so
15 much, and sorry, before you guys move. I just had a
16 really quick question for you, Helen, because we had
17 a joint hearing one time with the Veterans Committee,
18 right, and it was specifically about veteran
19 treatment courts because they hadn't had a hearing
20 since 2015, and there was one person there. He is the
21 only peer specialist that works with the treatment
22 courts, and I was amazed at how much he does to help
23 veterans, to help the system and the folks that work
24 in the criminal justice system to understand the
25 importance of how to stop someone from having to go

to Rikers versus getting that treatment that they need, and so I guess my question is, when you look at the larger treatment court system, and I ask you this in your Board of Corrections role, what is the biggest barrier that we're facing because, in my mind, I just didn't understand why we wouldn't have so many more peer specialists that are part of that, and so if you could sort of allude to what the challenges are there.

HELEN SKIPPER: Let me speak on that also in my role as a member of the Treatment Not Jail Coalition. We're fighting with OCA to approve the legislation. There are pockets of pieces of information here and there where OCA is not backing down from. We're trying to amend what we can without losing the essence. The Treatment Not Jail Coalition is just simply changing the gatekeepers who allow people into treatment, and I myself, I could have been one of them. I spent 25 years going in and out. I came in addicted to drugs, suffering from an unchecked mental illness with criminality because of the drug addiction and the mental illness, but because of my record, I was always not given a program, which means I was criminalized and went to

jail, rinse and repeat for 25 years. If we allow people who need the support to access the support, you'd be amazed at some of the findings. Recovery is real, second chances is real. Give people an opportunity to succeed. Give them what they need, and what we don't need is criminalization, and you know, I'm involved in a fight with OCA too because I keep going up to them saying, hey, would you hire me? You know, and I always hear yes, but we all know that that is not the case, so we need peers in the criminal justice system. We need peers in treatment court. Who better than to model and mentor and show that resiliency works? You've heard my story before, and it's not an individualistic story. I mean, it sounds hot because the way I tell it, but other people have the same story. You know, we came through, we persevered, we stood tall, and then we got tired, and we got access to recovery, and we leaned into recovery, and we used that to spread our wings and push forward. That happens all over, but when we try to come back into these systems that have damaged us, that has traumatized us, we're always stopped. Why? Like, we should be the ones to be able

1
2 to walk back in there and say, look, if I did it, so
3 can you.
4 CO-CHAIRPERSON LEE: Thank you.
5 Okay. Thank you guys so much.
6 Next panel is Tamara Begel, Mark Laster,
7 Priscilla Gorem, Jenna Schugart, Aaron Miner,
8 Katherine Bajuk.
9 TAMARA BEGEL: Hello. My name is Tamara
10 Begel, and I am an independent advocate for people of
11 all ages who experience mental health crises and/or
12 developmental disabilities. I started out in the
13 education system and watched the preschool to prison
14 pipeline myself as my clients could not receive the
15 care that they needed because the services were not
16 there or were not instituted appropriately. I also
17 testify as a person who has had mental health crises
18 and as a mother who is raising a child with mental
19 health crises and developmental disabilities. We must
20 expressively write into the system, into every law
21 that we publish children and adults with
22 developmental disabilities and training for the
23 individuals who deal with those crises. It is
24 imperative that, if we don't write them in, that they
25 don't, that training does not occur, and they don't

2 get added in. Not only that, it is imperative that
3 there is a pipeline. We talk about the preschool to
4 prison pipeline. The number of individuals with
5 mental health disorders that are in our jails is
6 three times more than the average population. Not
7 only that, but it is proven in one of the NAMI series
8 from this past January, that incidents of mental
9 health is miscorrelated with violence. It's higher
10 for individuals who are drinking and individuals who
11 have been abused and individuals with access to guns,
12 three times higher. We need to change our language
13 and treat mental health as healthcare, not anything
14 else.
15 CO-CHAIRPERSON LEE: Thank you.
16 MARK LASTER: Hi. First, thank you all for
17 hanging in here. It's been a long day. My name is
18 Mark Laster, and I'm a graduate of the Citizens
19 Police Academy, Third Vice Chair of Queens Community
20 Board Six, and a licensed political social worker for
21 over 40 years. I'm here today to testify in support
22 of the testimony provided by the Correct Crisis
23 Intervention Today, NYC-CCIT, a coalition of advocacy
24 groups and other community organizations that consist
25 of hundreds of community stakeholders working to

transform New York City response to mental health crisis. My comments today reflect my personal opinion about the B-HEARD program and do not reflect on Community Board Six. I've been tracking the B-HEARD program since its launch in 2021. Soon after I read about the program, I was attending a meeting of the 112th Police Precinct Council's Build a Block meeting and asked the NCO officers running the meeting their thoughts about the B-HEARD program. The response I received is, what's B-HEARD? When I explained the program to these officers, they did not express a great deal of enthusiasm for it. On November 16, 2022, I attended a meeting with the Queens Borough President, Donovan Richards, Civic Engagement Committee, where Chief Gallin Frierson of NYPD Queens North and Chief Kevin Williams of Queens NYPD South attended. I asked both of them their thoughts about the B-HEARD program. The response I got was, what's B-HEARD? Since there are many other civic activists at the meeting, I asked if either one of them would reach out to me or if their staff would reach out to me so we could continue a discussion about it. Never heard from them again. Then on February 28, 2024, I attended the Queens Borough President's Town Hall

2 meeting where Captain Cordero of the 112th Police
3 Precinct was present. I asked him his opinion about
4 the success of the B-HEARD program, and his response
5 was, what's B-HEARD? So I was disappointed with these
6 responses, obviously. The disappointment escalated
7 significantly, however, when Winn Rosario died on
8 March 28, 2024. At CB6, we discussed passing a
9 resolution regarding this incident, but decided not
10 to when we heard about this hearing, which was
11 scheduled for back in June. As I've stated above, I
12 learned about the challenges police officers face
13 daily doing their job by attending the 14-week course
14 of the Civilian Police Academy. They have enough on
15 their plates that should not be primary responders
16 when, like the Winn Rosario case, a call comes in
17 that's clearly a mental health issue. This is why I
18 come here today to testify in support of the CCIT
19 recommendation. Thank you very much for listening to
20 my testimony.
21 CO-CHAIRPERSON LEE: Thanks, Mark.
22 JENNA SCHUGART: Thank you to the Chairs
23 and the Committee Members for holding this hearing
24 today. My name is Jenna Schugart, and I'm a Bushwick
25 resident and a mental health service provider. I

advocate for proper crisis response in our community by being a NAMI NYC ambassador. I am here to support the testimony provided by CCIT NYC. As a former counselor in a psychiatric group home, I'd like to share a real example of the impact of crisis response. This individual's name has been changed to protect her privacy. Sarah lives with schizophrenia. One day, Sarah locked herself in the bathroom and started screaming, banging her hands on her body and pleading for help. I called for 9-1-1, assuming a trained health professional would arrive. I explained that while she was experiencing a psychotic episode, she was not a threat to others and had no history of violence. Police showed up, handcuffed her, and took her to the hospital in the back of a police car. She was discharged hours later and proceeded to lock herself in the bathroom again and resume yelling, hitting herself and begging for help. I called 9-1-1 again, but Sarah refused to go with the police this time. I drove Sarah back to the emergency room myself and advocated for her treatment the entire time. Ever since Sarah got the support she needed, she has been living the past two years free of any psychotic episodes. I understand now that while she was in

2 crisis and having hallucinations, she needed somebody
3 there who could de-escalate the situation in an
4 appropriate way and advocate for her. Sarah's story
5 shows the distress that can be provoked by an
6 improper crisis response. By having mental health
7 professionals and peers answer these calls rather
8 than police, this whole situation could have been
9 avoided. CCIT calls for police to be completely
10 removed from nonviolent mental health crisis calls
11 and for shifting the model to a more person-centered
12 approach. This will require some investment, starting
13 with restoring the Program to Eliminate the Gap cuts
14 in the adopted budget. Thank you for listening to my
15 testimony. I look forward to a brighter future where
16 B-HEARD can ensure that New Yorkers experiencing a
17 mental health crisis receive the response they
18 deserve.
19 PRISCILLA GOREM: Hello. Thank you for
20 having me. Members of the New York City Council, my
21 name is Priscilla Gorem, and I've been a proud
22 resident of New York City for almost 25 years. During
23 that time, I've raised my daughter, who will graduate
24 from CUNY at John Jay in May. In addition to raising
25 a child here in the public school system, I completed

my undergraduate education in New York City at the New School, have worked for many non-profits and volunteered with various activist manifestations, all of which have given me an excellent education on the needs of our communities and the shortcomings of City government in meeting said needs. I am here to express my strong support for defunding the NYPD. My request today is not only because of the most recent mass shooting in the subway. For too long, black and brown communities have been over-policed, subject to racial profiling, and in too many cases have lost loved ones to police violence. These practices must end immediately. The only way to end the way the City agency acts with impunity, violence, and opacity is to drastically cut their budget. Beyond the NYPD's misconduct, Mayor Adams' scandals cannot be ignored. As the most recent architect of funneling public funds into the NYPD, Mayor Adams has betrayed the trust of the people of New York City. He has diverted critical resources that should have been used to uplift our neighborhoods, resources that instead have been deployed to brutalize our communities. This misuse of public funds is an unforgivable breach of leadership, and I call for his resignation. We need

2 City leaders who prioritize public well-being, not
3 those who perpetuate harm. By reclaiming the NYPD's
4 budget, we can invest in essential resources such as
5 education, affordable housing, mental health
6 services, and programs that truly address the needs
7 of our neighborhoods. It is time we end the cycle of
8 violence and start building a safer, healthier, and
9 more equitable city for all New Yorkers. Thank you
10 for your time and consideration.
11 KATHERINE BAJUK: I’m Katherine Bajuk, 30-
12 year public defender and mental health specialist at
13 NYCDS. My clients, all indigent, mostly black and
14 brown folks, due to bias, language barriers, no
15 insurance, stigma, often have un- or misdiagnosed
16 mental illness-causing crises. Accessing B-HEARD
17 through 9-1-1 over-involves untrained and
18 inexperienced with mental illness police there to
19 enforce the penal law, leading to escalation and
20 arrest. Note, 42 percent of our Assault II clients,
21 involving police, etc., are flagged with mental
22 illness. Incarceration. Note, 50 percent of Rikers
23 Island detainees have mental illness. Even death.
24 Note, Winn Rosario and too many others. Perpetuating
25 historically racist weaponization of psychiatry.

2 Note, a white supremacist devil in the details. See
3 my footnotes. Harming, not helping. Many would never
4 even be clients if we followed CCIT's recommendations
5 and removed police from non-violent calls and added
6 peers. Peers are the secret sauce to quickly build
7 trust, better de-escalate crises, advocate for the
8 right treatment, avoiding unnecessary and unwanted
9 hospital transports, and instead working with and
10 following up with local providers with stable
11 housing, community supports, better treatment plans,
12 yielding more engagement in treatment, less
13 emergencies by addressing what brought the person to
14 crisis in the first place. With all we know about
15 historical racism and police violence, New Yorkers in
16 crisis, my clients, your constituents, deserve to be
17 helped, not harmed. We must choose a better way. We
18 must choose peers, not police. Thank you for your
19 time.
20 CO-CHAIRPERSON LEE: Thank you so much.
21 Thanks all for being here and thank you to this panel
22 for your testimony. I really appreciate it.
23 Okay. So next we have Andrew Smith, Robin
24 Graham, Princess Benn Jams, and then we have
25

Galloway, but I don't know if that's an organization or an individual person, so I wasn't sure.

Sorry. Before you guys speak, if you could just give us your full names for the record and, if we're missing someone, please let us know. If there's anyone else in the room that hasn't spoken that signed up, let us know.

GALLOWAY: Cool. Thank you. Powerful testimonies today. I really hope the NYPD and the Mayor can hear some of this, but just thank you, Chair Lee, for sticking it out with us. I'm Galloway, they, them. I'm the Advocacy Manager at the Ali Forney Center. The reason I'm here is we are here to talk about the B-HEARD program and its critical need for the clients that we serve at the Ali Forney Center and, for those that are unfamiliar, we serve unhoused LGBTQIA-plus youth throughout the city and oftentimes beyond that, but one of the big things that our youth are facing is mental health crisis, and what we know and what's been said today is it pairs very much with the housing crisis and, because they're experiencing complex traumas, marginalizations, and emotional distress, we're not able to start to meet some of those needs that they

2 have. So I really want to talk about, because so much
3 brilliance has been said today, I want to talk about
4 the reality of what B-HEARD is happening for the Ali
5 Forney Center clients and the staff. So when the Ali
6 Forney Center, when the drop-in center, which our
7 drop-in center, what it does is it's the main
8 welcoming hub for folks to get connected to our
9 services and, again, housing services are plethora,
10 from education, mental health, making sure folks are
11 connected to job placements, but ultimately housing
12 so when they come to this drop-in center, it used to
13 be located in Harlem, where B-HEARD was dispatched
14 to. We saw some really helpful and successful support
15 with B-HEARD, but now our drop-in center moved to
16 Midtown so no longer B-HEARD comes, so therefore we
17 cannot utilize those services, and what's happening
18 right now is we've been in this location for a year,
19 and we started to notice this pattern, like EMS were
20 starting to take longer and longer and longer and, as
21 of last week, EMS told us they refuse to come unless
22 they come with the cops, and not only is that not
23 okay but that goes against our harm reduction model
24 because we’re one of the few runaway and homeless
25 youth providers that refuses to call the cops, we

found it is not helpful. It has been spoken here today when people are in mental health crises, and when they're triggered, being around somebody that has a weapon, that is just projecting onto you, does not help. It causes further harm, and therefore escalates the situation. We need more peers, we need more mental health providers that are specialized in this, such as social workers and folks like that to be there. So just wanted to highlight that, because it's something that staff and myself, we're really confused, like why are EMS telling us they can't come unless the cops come, and we want B-HEARD to be expanded back to all of our housing sites, but especially our drop-in center in Midtown so fully support the expansion, the funding, and thank you again for being here, and we want to continue our collaboration and support, so let me know any questions you have. Thank you.

ANDREW SMITH: Thank you. Before I start, I give out flyers. He's refusing to give out my flyers. Can you please give out my flyers, please? Each person, each person has a flyer. Can you please give out the flyers to each person, please?

GALLOWAY: I think there's only one person left.

CO-CHAIRPERSON LEE: Yeah, we have it.

ANDREW SMITH: No, they're sitting right there. Not all of them. You have seven of them. You have seven right there. Can you give out the rest of the flyers, please?

CO-CHAIRPERSON LEE: Okay. Yeah, Sarah's going to go grab and then hand them out, but yeah, they're on the table because it's for the record as well.

ANDREW SMITH: No, no, no.

CO-CHAIRPERSON LEE: Yeah, those. Okay. Okay, feel free to start.

ANDREW SMITH: Okay. Thank you. First of all, I want to thank you for your time, for meeting here, and the first thing I would like to say is I'm asking for investigation of the police for attacking me. Now, the reason why law enforcement throw people in the psych ward the sidewalk is to hide the evidence or to people that have evidence against law enforcement that they can't testify against them. For example, if you see a police raping a woman, murdering somebody, they say you're crazy, they toss

2 you in the psych ward, you're not allowed to testify
3 against them so it's a tool that law enforcement use
4 against the public. Also, there's a news article
5 called Is Law Enforcement Stalking You. Now, they
6 have resources that's supposed to help you. So far,
7 nobody has assisted me. I was assaulted in two
8 different states by law enforcement, sent to the
9 hospital with bodily injuries. That's why I'm asking
10 for an investigation. The CCRB refused to
11 investigate. It's on the website. We're going to
12 question the witnesses and get video. They refused to
13 do it. Internal Affairs refused to do it. So that's
14 why I'm asking for an investigation. Since last year,
15 I was asking for an investigation of police because
16 of the things that they're not only doing to me, but
17 they're doing to people throughout America. And for
18 some reason, they always like to kill my story. Like
19 this gentleman here, I’m asking him to hand out my
20 flyers. He gave it just to one person so like they
21 always trying to kill my story because they don't
22 want people to know what they're doing to me. These
23 people are constantly terrorizing me, like all
24 through my life. Like the guy with the hat on, went
25 to the psych ward, lost his job. That's a court case.

Law enforcement make people homeless and get people fired from their job. That's a court case right here in New York City. So if I get somebody to listen to me, because I have the evidence that law enforcement is definitely attacking me so I just need to get my story out there. That's why I'm asking for an investigation to be done by the police.

CO-CHAIRPERSON LEE: Okay. And just to clarify, it's not that he wasn't trying to give out the flyers, but I'm the only Council Member here and then they put the rest on for record, but now we all have it so it's good. I just want to thank you for that. I just wanted to clarify that one point and thank you for sharing your story as well.

For Galloway, I had a quick question for you. In terms of the decrease in the responses from B-HEARD that you've seen, is it because it's not in one of the 31 precincts, even though technically I know that they're supposed to be now operational, and they can go wherever is needed, but is that why or just wondering?

GALLOWAY: Yeah, that's why.

CO-CHAIRPERSON LEE: Okay.

2 GALLOWAY: And then it's also been chimed
3 a little bit today too and Coalition for the Homeless
4 said it as well, but it's also like there's a stigma
5 and also racism and homophobia within NYPD of why
6 they don't want to respond to queer youth so we're
7 seeing that. Because if you look at Midtown, tons of
8 unhoused people and the fact that it's not being
9 deployed there is like a huge, just eye-opening red
10 flag.

11 CO-CHAIRPERSON LEE: Right, which is what
12 others have said is that just based on the zip code
13 doesn't mean that we don't have mental health crises
14 in those areas too.

15 GALLOWAY: Yeah, exactly.

16 CO-CHAIRPERSON LEE: Okay.

17 GALLOWAY: Yeah, thank you for asking
18 that.

19 CO-CHAIRPERSON LEE: Okay, great. Thank
20 you so much.

21 And now we're actually going to move to
22 Zoom testimony so thank you for your patience, and
23 we're going to call four names at this time. Please
24 wait for a Staff Member to unmute you and wait until
25 the Sergeant cues you to begin.

The four names I'm going to call, Sabina Saleh, Susan Margaret Murphy, Brooke Taylor, and Beth Haroules.

SERGEANT-AT-ARMS: You may begin.

CO-CHAIRPERSON LEE: Oh, and we're going to start with Sabina, sorry.

SABINA SALEH: Trying to unmute here. Good afternoon. My name is Sabina Saleh. I'm the Vice President of Behavioral Health at Project Renewal. We are a non-profit providing homeless services in New York City for over 55 years. We appreciate the Council's commitment to mental health and this hearing on the B-HEARD program. I would also like to highlight our Support and Connection Center that was brought up several times today, or what we call the SCC, which opened in late 2020. The SCC partnering with DOHMH offers stabilization and treatment for adults in mental health or substance use crises. It's the only program of its kind in the city, often receiving referrals from B-HEARD and NYPD as an alternative to arrest or ER visits. Project Renewal can also now self-refer clients from our programs to the SCC, which has been helpful for connecting more people to the care they need. The SCC serves up to 18

2 guests for stays up to 5 to 10 days. It provides 24/7
3 intake and service, offers access to diverse support
4 from peer counselors, psychiatrists, and occupational
5 therapists, and provides necessities like meals,
6 showers, and laundry. What sets the SCC apart is its
7 low-threshold peer-led approach. In Fiscal Year '24,
8 we served over 800 New Yorkers with nearly 50 percent
9 choosing to engage in aftercare services for longer
10 term support. Our partnership with B-HEARD helps
11 increase community-based care connections and
12 decrease hospitalizations. However, as the only SCC
13 in the city, we need more such programs so B-HEARD
14 teams have additional non-hospital resources at their
15 disposal for people experiencing mental health
16 crises. In addition to expanding models like the SCC,
17 crisis residences, mobile crisis teams…
18 SERGEANT-AT-ARMS: Your time has expired.
19 CO-CHAIRPERSON LEE: Sorry, you can
20 finish, wrap up in one or two sentences. Sorry about
21 that.
22 SABINA SALEH: Thank you. So in addition
23 to expanding all of the services on the continuum of
24 crisis mental health in the city, we also support
25 expanding B-HEARD to all boroughs and precincts,

emphasizing proper training for personnel and 9-1-1 dispatchers to appropriately categorize incoming mental health calls. Intro. 1019 requiring additional reporting on mental health calls could improve call categorization and overall transparency into the utilization of B-HEARD, and we're ready to collaborate as an agency to continue strengthening our programs and improving care for all New Yorkers, especially those with the greatest needs. Thank you.

CO-CHAIRPERSON LEE: Thank you so much. And then Susan, next.

SERGEANT-AT-ARMS: You may begin.

SUSAN MARGARET MURPHY: Hello, and thank you for having me. I'm the President of the non-profit Drug Intervention Institute in West Virginia, and I'm honored to join you today and, while I recognize that I'm joining you from Huntington, West Virginia, please know that I was born in New York and raised in Detroit and I spent most of my summers as a child visiting New York with family so very honored to be able to speak to you today. What you've been doing with the B-HEARD program and your focus on safety in schools is a really great conversation, and it could potentially be a model for other cities

1
2 throughout the country. Last week, the CDC reported
3 that we had a decrease in overdose deaths in our
4 country by 10 percent. Many states are dropping well
5 below that average, including New York, which
6 declined by almost 14 percent, but I would argue that
7 this is not a time for us to rest on our laurels. As
8 I shared with you today, we were talking about B-
9 HEARD and you were talking about safety in schools,
10 and then I've heard a lot of the folks that testified
11 also say that mental health and substance use
12 disorder often go hand in hand, and we certainly see
13 this in New York as other cities around the country.
14 And we're also losing an entire generation of
15 children. We lose 22 students, an entire classroom of
16 students, each week to overdose death. And in New
17 York City, overdose continues to disproportionately
18 impact black and Latinos, the unhoused, the veteran
19 population, and young persons. One intervention that
20 is clearly helping is increasing naloxone education
21 and access. Naloxone must be made available in public
22 spaces, including shelters, transportation hubs,
23 schools, bars and restaurants, and music venues.
24 Communities across the country are deploying the one
25 box emergency naloxone kit next to AEDs and fire

extinguishers. These boxes provide on-demand video training in both English and Spanish so that anyone can respond to an opioid emergency. To date, our organization has distributed over 13,000…

SERGEANT-AT-ARMS: Your time has expired.

CO-CHAIRPERSON LEE: Okay, if you could wrap up in a couple sentences.

SUSAN MARGARET MURPHY: I sure can. To date, we have distributed over 13,000 boxes in all 50 states with reports of over 200 lives saved. We have municipalities like Nashville and Tampa that work with local law enforcement, community organizations, and crisis response teams to place these boxes. These cities are using OD maps to determine where best to place them. The goal essentially is to create a community of bystanders and eliminate stigma around overdose response. We would welcome the opportunity to discuss how to place these boxes in New York City as part of your coordinated response and connect you with communities that are using the boxes. I know it's probably not permissible, but I do have a box with me today and I'm happy to include a link to how to see how to use that in my testimony. Thank you.

CO-CHAIRPERSON LEE: Awesome. Thank you and please do include that.

Okay, and next is Beth.

SERGEANT-AT-ARMS: You may begin.

BETH HAROULES: Hi there, I'm Beth Haroules, Senior Staff Attorney at the New York Civil Liberties Union. We're members of Communities United for Police Reform, CCIT-NYC, and the Daniels Law Coalition. As a civil libertarian, I do want to start with brief comments concerning the Intro. 532. Just noting for the record that Local Law 2-2016 is a violation of the constitutional separation of church and state. This Intro. is the latest effort to extend that bad policy choice that has already been made by New York. Prior iterations of this measure have been incredibly unpopular, are identified as incredibly expensive, and never made it to public hearing before. It is incredibly difficult to understand how that came to be on the agenda for today's meeting. It has nothing to do with B-HEARD and mental health crisis response, and the Committees should not be considering the bill and, if the Committees were and the Council is planning to consider this, there

should be greater public notice provided to the stakeholders, including all city taxpayers.

With respect to B-HEARD, we have submitted comments that are extensive that touch on the B-HEARD program. We provide you with a menu of alternative models of mental health crisis response. We discussed Daniel's Law extensively, which is a state legislative initiative that we think the City should be adopting, and we discuss and suggest that the Council entertain proposed changes to the conduct of the Mayor's Office of Community Mental Health. We believe that the B-HEARD pilot project should be dismantled and that the Council should move forward to form a more appropriate peer-infused community-based crisis response model. The B-HEARD pilot continues to embed the NYPD's response to New York City's crisis response model. It provides no role for peers on teams or in leaderships. It solicits no community input, no needs assessment, does not offer trauma-informed care, does not engage in culturally competent, gender competent or linguistically competent service provision. It appears to engage in no outreach to or have any working relationship with trusted community providers…

SERGEANT-AT-ARMS: Your time has expired.

BETH HAROULES: Organizations. It appears to operate without any focus on key outcomes, provides no follow-up care or long-term assistance to individuals or their circle of support to avoid the next crisis. We do commend to you our comments. We support the Int. that is designated to ensure meaningful data is provided by the City about the operation of the B-HEARD pilot project, but we think this pilot project should be decommissioned and we think the Council should take the lead in forming a peer-infused community-led crisis response system that fits within a continuum of mental health services. We're here to speak with you. Thank you so much for having this hearing. Thank you for staying till the end. And it is really distressing to see that all of the City partners who run B-HEARD do not stay around to hear what the issues are. Thank you.

CO-CHAIRPERSON LEE: Thank you both, and next we have Brooke.

SERGEANT-AT-ARMS: You may begin.

BROOKE TAYLOR: My name is Brooke Taylor. I'm the Director of Social Work at the Urban Justice Center Mental Health Project, and I am standing with

2 Correct Crisis Intervention today and calling for the
3 New York City Police Department to be removed as
4 first responders to mental health crisis calls and
5 for peers, people with lived mental health
6 experience, to be a mandatory element of B-HEARD
7 teams. In providing the services that we do, we see
8 bureaucratic obstacles and communication gaps within
9 and among the various systems which impede our
10 clients' access to essential services. In New York
11 City, there's no way to request an immediate mental
12 health response for a person in crisis that will not
13 involve police officers. Receiving an immediate
14 response requires calling 9-1-1 for an ambulance and
15 that results in police involvement and potentially
16 leads to a traumatic or even deadly interaction for
17 our clients. At any time of the day or night, New
18 Yorkers should be able to call 9-8-8, the new federal
19 three-digit number for mental health crisis calls or
20 9-1-1 to get immediate help for themselves or someone
21 else experiencing a mental health crisis and know
22 that they will be met with a caring response from
23 trained healthcare providers, not law enforcement
24 agents. As a licensed social worker, I am required to
25 intervene when a client is at risk of harming

2 themselves. Because I know about the harm that can be
3 caused by police responding to a mental health
4 crisis, I am always reluctant to call 9-1-1. Many of
5 my clients have disclosed to me that they or their
6 family members have had traumatic interactions with
7 police in the past. I do everything I can to triage
8 the situation in another way, but when an immediate
9 response is needed, I have no other choice. If I were
10 able to call 9-1-1 or 9-8-8 and request that a B-
11 HEARD team respond and be assured that a B-HEARD team
12 would actually respond, that would make a tremendous
13 difference. I would know that a trained mental health
14 worker was going to assist my client and that the
15 client would get the appropriate level of mental
16 health support.
17 SERGEANT-AT-ARMS: Your time has expired.
18 BROOKE TAYLOR: Really, already?
19 CO-CHAIRPERSON LEE: Yeah, two minutes
20 goes by real quick, I know. If you could just wrap up
21 in one or two sentences.
22 BROOKE TAYLOR: Okay. I guess most
23 importantly, like a lot of my clients who do end up
24 going to the hospital, either with police or on their
25 own accord, are not connected to aftercare services,

2 and their mental health providers are not contacted
3 and they're often not even admitted or discharged
4 really quickly, and so the fact that B-HEARD involves
5 that aftercare support is really, really huge and
6 really important and should be available to people.
7 CO-CHAIRPERSON LEE: And just on a last
8 note, if you could make sure to include, maybe if you
9 could maybe adjust your written testimony and submit
10 it again if you haven't, because I just want to know
11 if you could include a couple examples of that in
12 terms of how the aftercare hasn't worked or hasn't
13 been connected because I was looking for some of
14 those examples myself so if you could send that,
15 that'd be awesome.
16 BROOKE TAYLOR: Definitely. Thank you.
17 CO-CHAIRPERSON LEE: Okay, thank you. I'm
18 going to call out some names because these are folks
19 that had signed up earlier and I don't know if they
20 were here and missed their names and so if you hear
21 your name, if you could come up to the front. Yehoram
22 Silber (phonetic), Chinue Foreman, Claudette Hill,
23 Roland Pierre, Monica Harris, Aaron Minor, Moe Rosvie
24 (phonetic), which I know who's not here, Robin
25 Graham, and Princess Benn James.

2 Okay, seeing no one else, I'd like to
3 note that written testimony again, which will be
4 reviewed in full by Committee Staff, may be submitted
5 to the record for up to 72 hours after the close of
6 this hearing by emailing it to
7 testimony@council.nyc.gov.
8 Thank you, thank you, thank you to
9 everyone who has participated in this hearing and
10 shared your stories. Very greatly appreciated. With
11 that, we're done. [GAVEL]
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<u>C E R T I F I C A T E</u>

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 September 29, 2024