CITY COUNCIL
CITY OF NEW YORK

---------- X

TRANSCRIPT OF THE MINUTES

Of the

COMMITTEE ON GENERAL WELFARE JOINTLY WITH THE COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITY, SUBSTANCE ABUSE AND DISABILITY SERVICES

---------- X

November 21, 2016
Start: 10:16 a.m.
Recess: 2:01 p.m.

HELD AT: 250 Broadway – Committee Rm.
14th Fl

B E F O R E: STEPHEN T. LEVIN
Chairperson

ANDREW COHEN
Chairperson

COUNCIL MEMBERS: Annabel Palma
Fernando Cabrera
Ruben Wills
Vanessa L. Gibson
Corey D. Johnson
Ritchie J. Torres
Barry S. Grodenchik
Rafael Salamanca, Jr.
Elizabeth S. Cowley
Paul A. Vallone
Joseph C. Borelli

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

Daniel Tietz, Chief Special Services Officer
New York City Human Resources Administration,
Department of Social Services and Department of
Homeless Services, NYCDSS, NYCDHS

Dr. Fabienne Laraque, Medical Director
NYC Department of Homeless Services, NYCDHS

Dr. Gary Belkin, Executive Deputy Commissioner
Department of Health and Mental Hygiene, DOHMH

Dr. Bouchard Burns
Behavioral Health Director
NYU Lutheran Community Medicine Programs

Stephanie Gendell, Associate Executive Director
Policy and Advocacy
Citizens Community for Children

Catherine Trapani, Executive Director
Homeless Services United
Also Appearing for:
Christy Parque, President and CEO
Coalition for Behavioral Health NYC

Nicole Bramstedt
Director of Policy
Urban Pathways

Giselle Rivera, Policy Director
Coalition for the Homeless

Joshua Goldfein
Legal Aid Society

Lynette Verges, Director
Social Work
Care for the Homeless

Bradley Rapanut, Program Director
Bronx Works

Wendy O'Shields, Safety Net Activist

Regina Clark, Deputy Director
My Time, Inc.

[sound check, pause]

CHAIRPERSON LEVIN: Good morning everybody. My name is Council Member Stephen Levin. I am Chair of the New York City's--New York City Council's Committee on General Welfare. Today we are here to hold part 2 of our hearing series on health services for homeless individuals and families in the DHS system. Jointly with the Committee on Mental Health, today's hearing will address mental health services, in the DHS Shelter System. We will also be considering Intro No. 932, a Local Law to amend the Administrative Code of the City of New York in relation to requiring information on mental health services in shelters. This bill accompanies the legislation we heard last week to provide public information and transparency around the services available in shelter system. I want to thank my colleague Council Member Andrew Cohen, Chair of the Mental Health Committee for agreeing to co-chair this important hearing with me today. I'd also like to acknowledge the council members who have joined us this morning, Council Member Annabel Palma of the Bronx, Ruben Wills of Queens, Paul Vallone of Queens and we are expecting more committee members of the

Mental Health Committee and the General Welfare Committee to be joining us throughout the morning. I'd also like to thank Committee staff, who I will be thanking at the end of my remarks. As we discussed last week with regard to health services, homeless individuals tend to experience higher rates of mental health issues, and often have difficulties accessing services on a consistent basis. Mental health issues can also create barriers in getting people to accept services. Based on data from the most recent point in time counts, there are over 2,700 unsheltered homeless individuals in the city, and approximately 40% of those suffer from a serious mental issue. This makes the difficult job of helping unsheltered homeless individuals, access temporary or permanent housing even more difficult. At today's hearing, one topic we will address and hopefully receive updates on is the Mayor's NYC Safe Program. Launched in August of 2015, this program was intended to support New Yorkers with untreated mental illnesses. Under this initiative, the city intended to add both— intended to add both increased security and clinical services at single adult shelters with the focus on mental health shelters. Further, as—as part of the

90-Day Review of the shelter system conducted last year, two other reforms we—we're focused—we're focused on individuals with mental health issues. First, city rental assistance would be "strategically targeted to identify—to identified at-risk clients with mental health needs, cycling between Rikers Island and DHS shelter." In the second recommendation, the City proposed a joint—joint city and state taskforce to implement community based programs to eliminate the need for mental health services. We expect to receive updates on all of these initiatives today. In addition to the services provided to the unsheltered homeless population and single adults, we need to focus on the mental health needs of families and children in shelters. An increasing number of children are living with the trauma of becoming homeless, and growing up in shelter. There are now close to 24,000 children in the New York City shelter system. As we discussed at last week's hearing, a growing number of families are being placed in hotels and continue to reside in cluster sites where there are no on-site services. Also, not every Tier II shelter has available on-site services. Today, I expect to discuss how we can make

it easier for children and families to access these services, and also what further measures the City is going to be taking to ensure that every child that lives in shelter is not suffering from needless mental health issues. I'd also—I would like to thank Council staff for their work today preparing for the hearing Counsel Andrea Vasquez; Policy Analyst Tonya Cyrus; and Samara News-Haut (sic), Finance Analyst. Finance Unit Head Donhini Sompura as well. I'd also like to thank my Legislative Director Julie Bero; Communications Director Ed Paulino, and Chief of Staff Jonathan Bucher. I'd also like to thank the members of the Administration who have come here to testify Dan Tietz of HRA; Fabienne Laraque of the Department of Social Services—or Dan Tietz and Fabienne Laraque of the Department of Social Services, as well as Dr. Gary Belkin from DOHMH, Executive Deputy Commissioner. I'd like to now turn it over to my colleague Council Member Andrew Cohen Chair of the Committee on Mental Health. Thanks.

CHAIRPERSON COHEN: [coughs] Thank you Chair Levin. Good morning. My name is Andrew Cohen, and I am the Chair of the Council's Committee on Mental Health, Developmental Disabilities,

Alcoholism, Drug Abuse and Disability Services. I am pleased to be holding joint hearing with Council Member Levin, Chair of the General Welfare Committee. Today, we are conducing oversight on mental health care services available to individuals experiencing homelessness in New York City shelters. One in five New Yorkers experiences a mental health disorder in any given year. Among the homeless, that number is even more staggering. Approximately 35% of people in New York City shelter, homeless shelters suffer from serious illness. This figure is closer to 40% among people who ae street homeless. Individuals who are experiencing homelessness due to addiction and other mental health disorders face additional barriers to housing and services beyond more traditional income issues. These barriers may include an inability to secure the right treatment providers or the correct prescription regimen, not to mention stigma about their illness. There are also challenges to service providers who serve homeless individuals including dealing with a lack of continuity of care, limited resources and transportation issues. We are eager to gain a better understanding of how the city is overcoming these barriers facing the homelessness—

homelessness and service providers. Specifically, I am interested in the mental health services that are being accessed by those experiencing homelessness. How—how effective these services are and how we will better serve our homeless population who need mental services now and in the future. Council Member Levin acknowledged all the members of the mental health committee. Lastly, I want to thank the committee staff for their work in preparing for this hearing Nicole Aladeen (sp?), our Legislative Council; Michael Benjamin, our Policy Analyst; Janette Merrill, our Financial Analyst; and Kate Diebold our Legislative Director. I am now going to turn it back over to Chair Levin, and I guess we're ready for the Admin now.

CHAIRPERSON LEVIN: Thank you very much, Chair Cohen. I also want to acknowledge Council Member Barry Grodenchik, member of the General Welfare Committee.

COUNCIL MEMBER GRODENCHIK: [off mic] Actually, both committees.

CHAIRPERSON LEVIN: Both committees. Okay. [background comments] So, we'll turn it over to members of the Administration to testify to day. If

I could ask you all to raise your right hand. Do you affirm to tell the truth, the whole truth, and nothing but the truth in your testimony before this--these committees, and to respond honestly to Council Members' questions?

PANEL MEMBERS: [off mic] I do.

CHAIRPERSON LEVIN: Thank you. You may proceed.

DANIEL TIETZ: Thank you and good morning Chairman Levin and Chairman Cohen and distinguished members of the General Welfare and Mental Health Committees. I just wanted to before I actually just read my prepared testimony, I just want to note that folks who are sheltered in commercial hotels have on-site services. So they have case management. They have social work services. They have housing placement assistance. In hotel that we operate entirely at the shelter so no longer commercial, if you will. The same is true. I won't argue that—that commercial hotels—that still operates commercial hotels are ideal settings at shelters, and I'll have more to say about that in my testimony, but I just wanted to be clear that every place that the shelter has services.

Thank you for inviting us to appear before you today to discuss behavioral health services in the DHS shelter system. My name is Daniel Tietz, and I am the Chief Special Services Officers for the New York City Human Resources Administration in the Department of Social Services, which in—includes the Department of Homeless Services. Since the start of the 90-Day Review of DHS that was conducted earlier this year, I have assisted in oversight of program services at DHS. I'm joined today by my colleague Fabienne Laraque, the DHS Medical Director who started in early September after a distinguished career at DOHMH, and by Gary Belkin, the Executive Deputy Commissioner at DOHMH.

From the start, this administration has made unprecedented investments to address the very serious challenges faced by low-income New Yorkers, particularly the most vulnerable New Yorkers many of whom are served by DSS. Notable among these challenges are the many problems that have built up over more than two decades, and which tend to drive the DHS shelter fences higher. Insufficient behavioral health programs, criminal justice system involved individuals who are returning to New York

City from prison, the loss of relatively inexpensive single-room occupancy housing units, and limited supply of available supportive and low rent housing across the city. Taken together with long-term under-investments in truly affordable housing and flat incomes for hard working families, it becomes clear why one of the administration's chief priorities is has been reducing income inequality and leveling the playing field for all New Yorkers. From it's inception this administration has recognized and directly addressed these challenges through multiple historic investments to break the trajectory of homelessness, which has increased this administration has recognized and directly addressed these challenges through multiple historic investments to break the trajectory of homelessness, which has increased 115% since 1994 and exponentially form 2011 and to 2014 when there were no rental assistance programs in place to address homelessness after the Advantage Program was ended by the city and the state. Beginning in late 2014, the Administration announced the creation of the Living in Communities Rental—Rental Subsidies—Subsidies and since have expanded the availability of rental assistance to

support New Yorkers who qualify for assistance in order to remain stably housed. In June 2015, the Administration created the Three-Quarter Housing Taskforce bringing together representatives from across city agencies to address a long ignored problem thereby signing a wide and unregulated segment of the low-income housing market, whose operates prey on New Yorkers in need of services and support as they transition to independence and self-sufficiency. Almost exactly one year ago today Mayor de Blasio made a historic announcement concerning supportive housing, investing in 15,000 city funded units over the next 15 years with the first 500 to be awarded shortly. We know from evidence based research that supportive housing programs help reduce the use of shelters, hospitals and psychiatric centers, reduce chronic homelessness and improve stability. In December of 2015, prior to the completion of the 90-Day Review, the Mayor announced HOME-STAT, the Homeless Outreach and Mobile Engagement Street Action Tea, a first of its kind in the nation’s response to addressing street homelessness, and by April the program was fully operational. Safe Haven beds are an essential tool in

assisting outreach workers and bringing our street homeless off the streets, and into services. These individuals are the most vulnerable and hard to reach New Yorkers. I'm sorry, hard to reach homeless New Yorkers, and require ongoing and lower threshold engagements. To date, the city has opened 225 Safe Haven beds increasing the total to 752 beds with more to come. There are also 357 stabilization beds to help bring New Yorkers in from the street.

Cluster Takedown. To date, the city has discontinued the use of 250 cluster units and identified another 295 to be closed soon. This 16-year approach of removing affordable apartments from the housing stock and using them as shelter, subjected families to fractured social services, challenges on their path toward independent living, and led to disrupted communities.

Thrive NYC launched earlier this year is an extraordinary $850 million investment over the next four years aimed at transforming the way we address the mental health needs of New Yorkers. This initiative not only aimed at homeless New Yorkers, but all city residents who struggle with mental illness or affected by a loved one's experience. No

New Yorker should suffer homelessness, and no one with a mental health problem should become homes because of such an illness. Unfortunately, many people with behavioral health needs become homeless because it affects their ability to maintain employment, housing or healthy relationships. To get at the root of this problem we have embarked on a mission to transform the way we address mental health needs in New York City. ThriveNYC is an action plan to change the way our city thinks about mental health, and substance use disorders and the way the city delivers services. Through ThriveNYC we have increased the behavioral health workforce, developed innovative, across agency program models, and expanded crisis services for all New Yorkers. It is important to acknowledge that no one became homeless overnight because of an illness. For homeless individuals with serious mental illness, there were numerous points in their lives when they were not able to get the help they needed when the system broke down. No illness should result in homelessness and, therefore, everyone needs assistance where care is accessible. Each of these actions taken alone is important, but together they represent a—a commitment

by this administration to tackle the very difficult challenges faced by low-income working class New Yorkers, and that have received far too little attention for far too many years. Likewise, it will take time for our solutions to have full and lasting impacts and will we need the help and support of all including this Council and our state and federal partners.

In my testimony today, I will provide a summary overview of the DHS system, which provides temporary and transitional housing and serves as a place of last resort for those in need of shelter. I will focus much of my testimony on updating the committees on the progress of relevant and substantial reforms stemming from the completion of the 90-Day Review of the homeless service system in New York City. I will close with a more specific overview of the programs and services for families with children as well as for single adults and adult families to address client's behavioral health needs while in shelter and the associated outcomes.

Last week, in part 1 of this hearing, I provided some context and noted several ways in which HRA and DHS work closely to serve our shared

constituents taking a—taking a prevention first approach. To summarize, HomeBase, which has been administered by DHS has been moved to HRA. Over the past two years, the new Rental Assistance Programs and other permanent housing efforts have enabled 47,810 children and adults in 17,094 to avert entry into or to move from DHS and HRA shelters. January 2014 through June 2016, about 131,000 households, approximately, 390,000 people received emergency rental assistance to help them stay in their homes, averaging about $3,600 per case, which is much less than the $41,000 it costs each year to shelter a family. This administration has increased funding for legal services to prevent evictions, harassments and homelessness tenfold from $6.4 million in FY13 to $63.8 million in FY17 when the program is fully implemented. Three has been a 24% decrease in evictions by city marshals over the past two years, and an increase in legal representation of tenants in Housing Court from 1% as reported by the State Office of Court Administration for 2013 to 27% this year. As was noted last week and is worth repeating, those most at risk of homelessness are affected by high rates of poverty, family conflict and domestic

violence as well as poor health including high rates of chronic disease and behavioral health diagnoses coupled with low access to care. At DHS intake points, clients arrive with a host of complex and interrelated challenges, but have one thing in common, a lack of safe and affordable permanent housing. It is both our legal and moral obligation to shelter those New Yorkers who are found to be eligible for and in need of shelter. As of November 19, 2016, DHS is sheltering 60,318 individuals including 23,657 children and 36,661 adults. These individuals and families are housed across DHS' system of facilities for single adults, adult families with no minor children, and families with minor children utilizing shelters, cluster units and commercial hotels. Among the facilities that constitute the DHS portfolio, 47 single adult shelters and 22 families with children shelters have access to on-site healthcare. We also operate a number of specialized shelters including 27 mental health shelters, nine substance use disorder shelters, plus 14 Safe Havens and five Drop-In centers. I refer the committees to my testimony of November 17, 2016 in regards to the shelter intake

process and the medical and behavioral health screenings that take place at the Front Door Shelter.

I will now describe details of the ongoing reforms most relevant to this hearing that were identified as part of the 90-Day Review of homeless services, and which have been implemented since the announcement of that review.

Reforms. Target services and rental assistance for clients with mental health needs cycling between jail and homelessness. City Rental Assistance will be strategically targeted to identified at-risk clients with mental health needs cycling between Rikers and DHS shelters. DHS is working on this initiative with MOCJ, and we look forward to continuing to update the Council on—on our progress in addressing the needs of these clients. Fully launched HOME-STAT to address street homelessness. HOME-STAT is a first of its kind approach to allow us to better understand and address the city's street homeless population. This initiative partners existing homeless response and prevention programs with a series of new innovations designed to better identify, engage and transition homeless New Yorkers from the street to low threshold

engagement and support services as well as permanent housing. This reform initiative began prior to the completion of a 90-Day Review and—and was made fully operational in April of this year. This innovative program is the most comprehensive street homelessness outreach ever deployed in a major American city. HOME-STAT innovates by partnering homeless response prevention programs, and by using modern technology such as a mobile application and 311 services to more accurately identify, engage and transition homeless New Yorkers from the streets to services. Additionally, by conducting more frequent quarterly counts, the last having been completed in the overnight hours of November 6th, we are able to more closely track our efforts and evaluate our approaches to better tailor solutions to the visible program of street homelessness. With nearly 500 workers to help transition homeless individuals from the streets and into shelters, HOME-STAT is enabling the city to better address the needs of New Yorkers who are living on the street. Canvassing conducted by the Mayor's Office of Operations has increased our ability to identify street homeless individuals from Canal Street to 145th Street, and in other hot spots

and deploy outreach resources where they are needed most. With HOME-STAT, the contracted homeless outreach staff grew from 195 to approximately 385. Additionally, the NYPD redeployed 40 officers to a 70-officer homeless outreach unit to respond to calls concerning street homeless persons, encampments, large hot spots and those individuals experiencing emotional disturbances or exhibiting erratic behavior. Additionally, we enhanced funding for additional Safe Have beds, and three more Drop-In centers. Drop-In centers provide a low threshold alternative to traditional shelter for street homeless individuals, and offer temporary respite where individuals can shower, eat a meal, see a doctor and rest. There is also on-site case management of housing placement services as well as a limited number of off-site overnight respite beds.

The city announced a new $8.5 million annual commitment to double the number of Drop-In centers that currently operate. DHS will open three new Drop-In Centers, and from the current HUD funded Drop-In Center in the Bronx, which is operated by Bronx Works, as HUD looks to reinvest those dollars in permanent housing. These four locations will be

added to the four existing city funded centers, two in Manhattan, one in Staten Island and one in Brooklyn. The new centers will open in Manhattan, Brooklyn and Queens serving approximately 75 clients at any given time. These tools are important to creating a low threshold option to serve as a initial link to DHS programs and services as part of our intensive effort to persuade street homeless individuals to engage in services, and ultimately accept permanent housing.

All of these initiatives—initiatives to address street homelessness recognize that the pathway to the streets is not linear for these individuals, and the path from the street, likely wont' be either. Therefore, our one-size-fits-all approach is unlikely to work. All HOME-STAT agencies play a role in this effort, including DHS, HRA, NYPD, other health, housing and human services providers. DHS would also like to remind caring New Yorkers to help us help homeless New Yorkers by calling 311 if they see a homeless person on the street or in the subway so that an outreach team can be deployed. This can also be done by accessing the 311 website.

Enhanced Tools for Outreach Teams to Bring People

in from the Streets. This aid will increase Safe Haven beds, decrease the number of Drop-In centers and develop 15,000 units of supportive housing to provide essential tools to address street homelessness. As described in my testimony, progress on these reforms is well underway, we continue to ask the City Council to partner with DHS in order to site no only Safe Have beds for all specific Drop-In centers, and supportive housing, but also necessary purpose-built shelters for families with minor children, adult families and single adults. Homelessness is a citywide problem, and we each have a role to play in securing effective solutions. As such, good purpose-built shelter ensures greater impacts and better helps families to more quickly transition to permanent housing and independence.

Targeting Services for Emerging New Trends in Single Adult Population for Persons 50 or Older and for Those 18 to 24: More effective targeting will promote our prevention and rehousing efforts. For example in partnership with Council Member Ritchie Torres, we announced last Friday the first of its kind shelter in the DHS system targeting young adults, LGBTQI homeless New Yorkers. DHS'

ability to respond to emerging trends in the single adult population allows us to better serve clients and more quickly move them to independence through targeted support. Additionally, DYCD is expanding its runaway and homeless youth beds and working closely with DHS and DSS to improve coordination in services for youth who come to DHS shelters. I should also note that for older adults in partnership with HPD and DFTA, HRA recently released a Senior Affordable Housing Concept paper. The concept paper focused on receiving comments about the most appropriate services to support seniors living in independent housing. An RFP will soon follow.

Implement a More Effective After Care Program: Using the critical time intervention as a model, the city will enhance after care services to rehouse clients. DSS released a concept paper in late October with the goal of expanding and realigning services at Home Base, such that HRA staff can provide additional anti-processing and triage for HRA benefits including public assistance and rental assistance and Home based not-for-profit staff can expand their case management services to include landlord and family medication, educational events

and employment, and financial literacy services. Additionally, we intend to provide enhanced community support services for residents receiving rental assistance to help ensure that they do not return to shelter and remain housed in the community. Comments on the concept paper are due December 14, 2016, and an RFP will be issued shortly thereafter.

Provide Assistance to Obtain Federal Disability Benefits: The city will dedicate services focus on enrolling shelter residents on SSI and SSD to increase income and promote rehousing. We are expanding legal services to help clients obtain disability benefits, and we continue to focus on ensuring that New Yorkers who are eligible for benefits and services are linked to the same. DSS is actively exploring ways in which we can reduce barriers to access to benefits, and promptly link eligible clients to benefits. We're making critical improvements to AccessNYC, the city's one-stop online benefits tool that screens individuals for over 30 benefits as well as an online portal so that clients can obtain information about their benefits in real time. I will now focus on several core programs at

DHS that serve clients with behavioral health diagnoses.

Adjusting and Screening for Families with Children: [coughs] As I testified on November 17, 2016, many clients have existing medical and mental healthcare providers upon arrival at the Prevention Assistance and Temporary Housing, or PATH Center and, thus, not all families are referred to the on-site medical provider for comprehensive assessments. At PATH [coughs] each woman of child bearing age in the family is asked about pregnancy, the presence of an infant under four months of age, any hospitalization in past month, and the acute medical needs or the presence of a communicable disease. If any of these are present, the family is referred to the Floating Hospital, which is the on-site clinical provider. In addition, families self-reporting or observed to be facing mental health or substance use challenges are referred to DHS resources rooms and social workers for further assessment. As part of our reform process, the DHS Medical Director's Office in collaboration with HRA and DOHMH is reviewing which questions families are asked in order to best address immediate medical and behavioral health needs in the

intake process, setting standards for Behavioral Health Services at intake points, crafting oversight tools, and implementing the oversight and evaluation processes. [coughs]

Completion of Mental Health Assessment by Resource Room in the floating hospital. Resource Room social workers complete mental health and substance use assessments in the DHS care system including a history of symptoms and treatments and a risk assessment to determine orientation to time, place and persons, a potential presence of auditory and/or visual who was mentioned, and any attempt [coughs] or plan to harm self or others. [coughs] Assessment findings determine whether or not the call that you placed to 911 for EMS assistance and possible hospital hospitalization. The Emergency Protocol including 911 or presenting at the closest emergency room in the event of a psychiatric emergency is reviewed with family. Available community based services are also discussed with presenting families including 1-800-LIFENOW. Families identify the behavioral health needs not currently reaching Human Services are scheduled to meet with the floating hospital psychiatrists who are

stationed at PATH on Wednesday from 10:00 to 6:00. A psychiatrist completes the comprehensive mental health evaluation, which is maintained in the floating hospital's electronic medical records. Families identified with mental health or substance use concerns that are currently receiving treatment are also given the opportunity to present supporting documentation from a treating clinician. The findings of these evaluations are reviewed by a social work supervisor or a manager in conjunction with the prior preliminary shelter eligibility determination with recommendations for final eligibility made after full consideration of the client's behavioral health needs. If service needs are identified and services are not in place, resource from the social worker will discuss available options with the family, and will provide support during the conditional stay. Ensuring shelter staff are aware of the presenting issues, and that necessary services are maintained or connect. Within the families with children's system, a Clinical Services Unit launched in the winter of 2015, to address the particular needs of families and consists of a team of social workers who work across

the family with children in shelter system. Please reference my November 17 testimony for additional details. Social work—a social worker in shelter demonstrates some projects. In order to improve access to mental health services in families with children shelters to improve family functioning and to assist families with children in shelter to navigate multiple systems and cope with the stressors and anxiety that are—that are induced by homelessness. DHS is developing a plan to place 368 licensed maters of social work staff in shelters for families with children. These LMSWs will—will serve as client care coordinators. DHS and DSS are working with state OTDA on approval of the demonstration project plan and budget such that new client care coordinator physicians will be included as part of the standard families with children budget. This will facilitate the rollout of the plan, and ensure that shelter providers are able to expeditiously hire these LMSWs. Through the use of these LMSW Client Care Coordinators, DHS will vastly enhance the delivery and coordination of mental health and related services to family—to families for children in shelter, promote model best practices for social

services staff, and care management staff, and serve as linkages to mental health and community based services, increase the ability of the shelter social services staff to address mental health needs in our culturally and linguistically sensitive manner that incorporates strength based family driver and youth child guided care, and strengthen overall permanency outcomes to families with children in shelter.

Adults and Psychiatric Evaluation at Assessment Shelters: After intake, all adults are—all adults admitted to the shelter system are sent to an assessment shelter where providers conduct a comprehensive assessment including history and physical free psychiatric assessment and substances assessment. The brief psychiatric assessment includes any presenting complaint, history or present illness, past psychiatric history, substance use history, medication, family and social history, and full mental status examination. The assessment is completed with—within five and ten days of the client's arrival. This assessment is used to direct new entrants into the DHS shelter system toward either a general or mental health or a substance use shelter. These shelters provide specialized services

on site as well as linkage to an array of outpatient mental health services as described below. [coughs] Excuse me.

Assisted Outpatient Treatment: In 1999, New York State enacted legislation that allows for mandated outpatient treatments by court order for persons with mental illness who are unable or unwilling to follow clinical guidance in treatment. This service called Assisted Outpatient Treatment or ART, mandates mental health care for a period of up to six months, which can be extended once. Whether they're acting on an ART order or voluntarily, the following the outpatient services are available to DHS clients with mental health issues.

Care Coordination. A specially trained individual or team that helps clients better understand and manage their conditions works with clients to create a plan of care that meets their physical and mental health and social service needs, and assist the clients in finding the services and programs that are right for their needs.

Assisted—I'm sorry Assertive Community Treatment: ACT is an evidence based practice model that provides treatments, rehabilitation and support

to individuals diagnosed with a severe mental illness, and his needs have not been well met by more traditional mental health services. The ACT Team provides services that are tailored to each client's specific needs. ACT teams are multidisciplinary and includes psychiatry, nursing, psychology, social work, substance use counseling, and vocational rehab. Team members collaborate to deliver integrated services to the client. Specialized ACT teams are being trained to reaching to people who are chronically homeless.

Intensive Mobile Treatment: IMT is a specialized that provides intensive and non-billable treatment in settings that are convenient to clients who may be unstable. The teams are designed to keep clients in treatment even if they are in an unstable situation such as cycling from jail to street, in shelter or facing housing instability.

Co-Response Teams: The Co-Response Teams are specially trained NYPD officers with embedded DOHMH clinicians that can more effectively respond to and triage individuals with a serious mental illness and about whom we have great concern with getting potential violent behavior. DHS and DOHMH

collaborate to identify ART clients in DHS facilities via a monthly data mass. Each shelter operator is alerted to individuals with ART orders residing in shelter and efforts are made to transfer ART clients to mental health shelters given that stay to better ensure the continued connections to mental health treatment providers and to more quickly placed in appropriate permanent housing. In addition, contracted clinical providers may refer to or request ART services for their clients who meet the criteria. In City Year 15 there were 239 individuals with ART orders from DHS shelters.

Multiple Crisis Teams are an interdisciplinary team of mental health professions including nurses, social workers, psychiatrists, psychologists, mental health technicians, addiction specialists and peer counselors. These teams operate under the auspices of voluntary agencies in municipal hospitals responding to persons and mandates, which it did usually visiting them at home, although they're mandate allows them to make contact at other locations. Mobile crisis teams serve any person in New York City who is experiencing or is at risk of a psychological crisis, and who—who requires mental

health intervention and follow up support to overcome resistance to treatment. Mobile Crisis Teams are often called by family members, neighbors, friends, landlords, clergy or other persons concerned about an individual. Mobile Crisis Team staff provide a range of services including assessment, crisis intervention, supportive counseling, information, referrals, linkage with appropriate community based mental health services for ongoing treatments and follow up. Often the assistance from a Mobile Crisis Team is requested for a person identified as homeless. In such instances, the teams contact DHS to verify the homeless person's location within DHS to ensure full collaboration. The DHS Medical Director's Office promptly alerts the shelter to a mobile crisis team's eminent arrival to evaluate the client. In City Year 15 there were 246 Mobile Crisis Team referrals for shelter residents. [coughs]

Naloxone in Shelters: Drug overdose is a serious public health concern and opioid related overdoses have increased as a health threat. A lifesaving law took effect on April 1, 2006, making it legal in New York State for non-medical persons to administer Naloxone to another individual to prevent

an opioid or heroin overdose from becoming fatal. Naloxone or Narcan is a medicine that reverses an overdose by blocking heroin or other opioids in the nervous system from 30 to 90 minutes. In shelters, Naloxone is administered internally. The DHS Medical Director's Office began training shelter staff as certified opioid overdose responders in 2009. To date, all DHS peace officers are trained in Naloxone administration, and are certified opioid overdose responders. DHS peace officers administer Naloxone in DHS directly operated shelters and in contracted shelters where they are stationed. DHS had also been working with all contracted shelters so that they become opioid overdose prevention programs, and many contracted shelters now have their own OPPs, and train their staff. Since 2009, 1,193 peace officers and 2,787 shelter staff have been trained to become certified responders. Our immediate goal is to train shelter staff and some residents at all directly operated and contracted shelters with opioid overdose responders in 90-minute sessions offered over several days by the end of this calendar year. Thereby, ensuring enough staff are trained to offer 24/7 coverage in every shelter. This will be done by

training a select number of shelter staff as trainers who will in turn train other staff at their shelters. In addition, we are providing Naloxone administration kits to every shelter to be kept in an easily accessible central location at the shelter to which trained—to which trained staff shall have access. To date, we have conducted a survey to notify those shelters in need of Naloxone training. All adult family and friends of children shelters are required and will offer—will obtain training and certification by the end of 2016. Most single adult shelters already have fully trained and certified staff as do all of those street outreach programs. The remainder will also be required to participate in training and will receive Naloxone kits by the end of the calendar year. In addition, NYU medical students have been training clients at the 30th Street Shelter.

By ensuring widespread availability of Naloxone training and certification among shelter staff including having staff able to train others at their shelter, as well as some residents. We expect to significantly reduce the instance of overdoses and OD deaths. In calendar year 2016 to date, there were

79 Naloxone administrations with 56 lives saved and 13 deaths after an attempted reversal.

The Chronic Public Inebriates Pilot: The Chronic Public Inebriate Pilot program is a joint initiative of Bellevue Hospital Center and DHS and the Goodard Riverside Community Center. Bellevue identified the most frequent emergency—emergency department users who were thought to be street homeless who had been diagnosed with at least one alcohol related disorder during their emergency department visit. With the patient's consent, the hospital and DHS outreach teams provide case management and help place individual in a stabilization bed or Safe Haven. The ultimate goal is permanent housing placement that's improving each client's health and decreasing the risk of death. The limited data from the pilot show a 38% and 35% deduction in hospital emergency visits and in-patient days respectively as well as a reduction in associated costs for individuals in the program. The majority of program participants, 79% and 19 or 24 are in transitional or permanent housing. DHS recently expanded this program to two additional New

York City hospitals, St. Barnabas and Lincoln Hospital in the Bronx.

The Training and Security Action Plans. The NYPD assigned a management team to be placed at DHS to develop some action plans to upgrade security at all shelters. NYPD also retrained all DHS security staff. Currently, all non-cluster shelters have some level of security provided by either DHS peace officers or by private security guards, and as part of the 90-Day Review, security increased at mental health centers and at commercial hotels. [coughs] This administration has substantially increased spending for security at homeless shelters. Direct spending by DHS on DHS peace officers and contracted FDAC security guards has increased 63% from $48 million in FY 2013 to $78 million in FY 2016. In addition, DHS reimburses shelter providers for those security costs, which were $62 million in FY 16 for a total of $140 million in security costs. [coughs]

I would now like to respond to the bill before this committee, Intro 932, which would require the Department of Homeless Services to submit to the Council and post on its website annually a report

containing information on mental health services provided to individuals in shelter. We support the intent of this legislation and agree with this body and the importance of reporting to promote transparency and accountability. We welcome working with the Council on potential modifications in order to develop reporting metrics that would be clear and useful, and which will accurately capture the work of DHS that we—as it relates to mental healthcare services in shelter. Thank you for the opportunity to testify today, and to respond to the bills before each committee. We welcome your questions.

CHAIRPERSON COHEN: Thank you for your testimony. I'm going to hop around. I—I have a bunch of different questions. You know, you prefaced your testimony talking about services at hotels. Could you just clarify if a hotel is—is not entirely a shelter, but it is operating as a hotel, and as a shelter, the availability of services there?

DANIEL TIETZ: Yeah, yeah, there—there are services on site at every sit that each shelter has. The—so the—the narrow exception is clusters, but we're getting out of clusters, but even in commercial hotels it's still operated as a hotel. We

have case management and social work and housing placements for people to actually go there.

CHAIRPERSON COHEN: Okay. I'm going to come back next because I—I had some questions, and I—and I know the—the—the subject of the hearing is really mental health services in shelters, but I am curious about street homelessness. Do we—do we know at this member how many people are on the street?

DANIEL TIETZ: I don't think I have the—this has the number from November 6th. Do we? I don't think we do. So I think the number that was mentioned earlier is close. It's 27—2,800 probably, but I don't—I don't have the number with me. So we'll—we'll—we'll get you the November 6th number.

CHAIRPERSON COHEN: Can—can I ask you in terms of your accuracy regarding that the number, like, you know, I represent the—as far north and as far west as you can get in the city. And periodically, I—I do discover homeless people living in the most remote hidden away in parks and—and I have some very remote parks. Do you have confidence in the number in terms of accuracy about people living in, you know, far out in the outer boroughs

who might be sort of living off the grid, so to speak?

DANIEL TIETZ: Yeah.

CHAIRPERSON COHEN: And—and in terms of getting outreach to those people, like I—like I said, I—I was not that long ago in Riverdale Park, which again it's a very remote park, and—but there as evidence there of someone living there. I wonder how we—how we find those people in terms of resources just getting there.

DANIEL TIETZ: So, you know, the way in which this works generally is that folks like you like, you know, your average citizen tells us. So calling 311 and telling us means that we then send our Street Outreach folks to go to the—the place, and so whether it's an encampment or it's a hot spot or it's a, you know, someone on the street that they fear in the subway. So I think that's in part why I have fair confidence in—in our counting because the truth is that the outreach staff know, if you will, all the usual places, the places where people have told us and where they've been repeatedly. So I think we're in most of the spots.

CHAIRPERSON COHEN: Okay. In—in terms of mental health issues for street homeless, do you have any idea, a percentage of people who you think have mental health issues and—and are they the most acute? You know, sort the—a profile of street homeless?

DANIEL TIETZ: I think really as a result of being street homeless [coughs] you would expect that folks are going to have challenges. So if they didn't have them before hand, they have them now really as a result. So I would suggest actually that everybody who is street homeless has some need for services. With regard to—to, you know, serious mental illness, I don't have a number today. We can certainly work on getting you one. I don't have one with me.

CHAIRPERSON COHEN: I—I am loathe to analogize between, you know, people on Rikers and people with moving—who—who are homeless, but I—you know, I discovered sort of through a number of hearings on—on the topic, but at Rikers there was a—while there might be four or five thousand people on Rikers with significant mental health issues, there is a relatively small percentage of those people who sort of had very acute mental health issues, and were

sort of the frequent flies that who end—ending up repeatedly in Rikers and whose primary offense was significant mental illness. Do—do you find that to be in the shelter system? Do—do you think that there's a, you know, a sort of—a more acute population that might be most—you know, where resources were devoted to might be more effectively treated and—and sort of targeted?

DANIEL TIETZ: So we have—I mean part of what I described here is that which either way to meet the—the 90-Day Review in which we've expanded mental health services, and we've had a good look at—at mental health shelters and who's in them and what they need. We're having a thorough going look at what we do at intake in assessment shelters for everyone, and how much—how much more we can add to early assessments, and then early engagement in care and services. Certainly, our partners at DOHMH have been very helpful in this, and thinking about the ways that we can use the resources at—at least our two agencies to better target services to folks upon entering the shelter or while they're in shelter.

CHAIRPERSON COHEN: But I'm just—what I'm trying to get a—sort of a handle on the—on—on the

spectrum of severity. Like, you know, toward the end of your testimony you talked about it's the outpatient—out-patient treatment, sort of the community treatment. Do you know how many people in the shelter system are—fall under the rubric of getting those services?

DANIEL TIETZ: I don't have a—I don't have a good number with us with regard to how many are in the—the mental health shelter, the 27 mental health shelters.

CHAIRPERSON COHEN: Is it hundreds? Is it thousands?

DANIEL TIETZ: It's thousands.

CHAIRPERSON COHEN: Okay. In terms of assisted outpatient treatment—outpatient treatment, are you ever the applicant to—to—to get a court order for these services? [pause]

DR. FABIENNE LARAQUE: For sure, but I imagine our providers may be the applicant, because those shelters have a—our community providers with them.

CHAIRPERSON COHEN: It would be good to know I think if—if—if—if people are being proactive if the service providers are being proactive in

terms—because it—I mean ultimately you want people to, you know, get treatment of their own volition, but people might not be able to do that.

DANIEL TIETZ: Oh, it's actually--

DR. FABIENNE LARAQUE: [interposing] They—they are being processed.

DANIEL TIETZ: Yeah, because it's—it's—it's both in our interest and in the client's interest to be proactive. Like no one is served by having someone in shelter who needs help in the beginning.

CHAIRPERSON COHEN: Right, but I-I would be interested in knowing if you could at some point provide us information on the times where—where the service provider was the applicant, because I think that would be—be good to know. In—in terms of substance abuse, you have dedicated substance abuse shelters, but obviously you're trying to make Naloxone available across the—the—all the shelters. How many people do you think the system have substance abuse issues, and how many of those people do you think are actually substance users?

DANIEL TIETZ: Well, I think the plurality have a substance use challenge and could

use and benefit from our care and services. Those kinds of services are available frankly in ever shelter. There are, as I noted earlier, there are social workers that serve throughout the system and—and can refer to appropriate programs. Maybe they don't have those programs on site. So it's true that we have a handful of shelters that are targeted for this purpose, but that's not the only places in which we have folks who may have substance use challenges of a greater or lesser degree.

CHAIRPERSON COHEN: How would someone end up in a substance abuse shelter versus being in another type of a shelter if you suspect substances?

DANIEL TIETZ: I—I think as an initial matter at the assessment shelter is where there seems to be—a significant issue for them. They would refer them to the substance abuse shelter.

CHAIRPERSON COHEN: Do you know how often, how many times Naloxone has been administered in—in shelters?

DANIEL TIETZ: I'm gave you the number here in year to date. I don't think I could pull it off hand. It's in the—it's in maybe 70 something, 80 something in that number.

CHAIRPERSON COHEN: Do you think it's being administered in instances that you don't know where the kit is available?

DANIEL TIETZ: I'm probably. This is—there's reporting system within—within our DHS, which is a priority to report. So, it's in part because you are then—you're expected to call EMS because the person reported in the additional care. So we actually track those three care programs.

CHAIRPERSON COHEN: Well, I was very interested in your testimony talking about making—trying to get people who were eligible for SSI onto SSI. So you know how—how often—how many people—how many applications you make? How often you're successful?

DANIEL TIETZ: I don't have it with me, but we can get it for you.

CHAIRPERSON COHEN: I think I'm good for the moment. I'll turn it back over to Chair Levin.

CHAIRPERSON LEVIN: Thank you very much, Council Member Cohen, Chair Cohen. So I just wanted to follow up on a few of Chair Cohen's questions. So with regard to individuals living on the street, have—have you been able to identify through—through

efforts under this administration through NYC Safe, or through—or through HOME-STAT the—a comprehensive number of individuals living on the street who are in need of mental health services? Have—have you been able to kind of get a comprehensive view of the challenges or the need?

DANIEL TIETZ: So likewise you're kind of agreeing with your colleague to ask—ask me that question, and I said that—that I don't know exactly. I mean this—this depends a little bit on how you define serious mental illness, but certainly as a result of seeing street homeless people have—probably have mental health challenges just—just because of—because of. But I'd be happy to go back and take a look at what data we have on—on, if you will, serious mental health problems with those who are street homeless.

CHAIRPERSON LEVIN: Can you explain the methodology for delivery of mental health services to individuals living on the street?

DANIEL TIETZ: Yes, so there are, of course, the street homeless street homeless teams who engage folks regularly. In some instances, you know, the folks on the street refuse to engage in return,

and they circle back again and again in an attempt to engage folks.

CHAIRPERSON LEVIN: But that—but everybody is—I mean at that point, every—once—once there's initial contact that individual is—is identified within the system, is that correct?

DANIEL TIETZ: Yes, they give us their name and their information, and we would have a way to record that if it's an otherwise—you know the teams—the teams that are out there are—are consistent. It's the same folks. They know who's who by sight as well. So even if the folks don't giver us their name or their information, they'll circle back to them again and again. Our goal is to ultimately persuade someone to get some service or another from us. So that could be bringing them to a Safe Haven. It could be bringing them to a Drop-In, and at that point, there are then social work staff mental health, substance abuse professionals who try to have—get more conversation with individuals about what their needs are, what kind of services they could use. But it's a—it's going back again and again, and those services—mental health services are available at Safe Havens and Drop-Ins.

CHAIRPERSON LEVIN: So through HOME-STAT, how many individuals have been identified through—through the—the HOME-STAT model or through—through that process? Just in general. I mean how many individuals have been identified?

DANIEL TIETZ: [off mic] I—I don't have any numbers. Would—would have that? I don't have a number in front of us. I'm sorry. We—we can get it.

CHAIRPERSON LEVIN: Okay, and I guess it would be helpful to know, you know, the—the various levels of engagement. People where they've made an—an initial contact or you've made a follow-up contact. People that have gone into the Drop-In Center. All of that is then tracked. If an individual has—if an individual has gone into a Drop-In Center that will be part of their case history> Case history is able to be brought up--

DANIEL TIETZ: [interposing] Yes, to the degree that--

CHAIRPERSON LEVIN: --at any time by a HOME-STAT person?

DANIEL TIETZ: Right, to the degree that they've given us identifying information, then yes.

CHAIRPERSON LEVIN: Okay, but we don't have off hand just kind of a—a comprehensive view of how many individuals we're talking about?

DANIEL TIETZ: I don't have it here today, but I'm sure we do.

CHAIRPERSON LEVIN: I mean at what point in that—in that process is for an individual on the street is a—is an evaluation and psychiatric eval and psychological evaluation done, and who does the evaluation for individuals on the street?

DANIEL TIETZ: So it would be a social worker generally would do a psychosocial evaluation in the Safe Haven or Drop-In.

CHAIRPERSON LEVIN: But if they're not—if they don't get to that point?

DANIEL TIETZ: It's the-it wouldn't be done on the street. I mean, it's outreach workers on the street, you know, some of whom are social workers as well, but we wouldn't do it there.

CHAIRPERSON LEVIN: But there are plenty of people that are on the street that don't go into the Safe Haven or Drop-In Centers, right?

DANIEL TIETZ: Yeah. I would say that most at some point agree to some service. And so our whole goal is to persuade on that.

CHAIRPERSON LEVIN: Okay.

DANIEL TIETZ: I mean we can't compel them. The truth is, of course, as you know, unless three is serious concern at that very moment of risk to themselves or others, they can't be involuntarily transported to a hospital. So what we're left with is engagement, and this engagement as a replacement.

CHAIRPERSON LEVIN: Right. I-I think it's what we'd like to know here at the committee as you say a-a comprehensive view of—of quantitatively what the impact is. Is that something that we can—you can -you can get back to me on?

DANIEL TIETZ: Sure.

CHAIRPERSON LEVIN: With regard to the recommendations from the 90-Day Review, has—has DHS or HRA made any progress on establishing or developing a rental assistance program that would be strategically targeted to identify our responsive mental health needs cycling between Rikers and DHS as identified as a reform in that area? Do you have—what's—what's the progress on that? I know that you

said that we're looking, you know, you're looking forward to continuing to update the Council on the progress. What—what is the progress with that? So that's been seven months in Fiscal 16. (sic)

DANIEL TIETZ: [interposing] Right, we're working on the [coughs] planning and implementation with MOCJ. That's about all I can report today.

CHAIRPERSON LEVIN: When do you expect to have—so obviously there's—there's no rental subsidy program developed--

DANIEL TIETZ: [interposing] Not right now.

CHAIRPERSON LEVIN: --just yet?

DANIEL TIETZ: That's right. It hasn't started up just yet, but it's seen.

CHAIRPERSON LEVIN: And how would that funded? Would that be funded through a city tax levy or is that a combination of funding sources?

DANIEL TIETZ: I couldn't be certain at this point. I would—my assumption at this moment is that would be a city tax levy.

CHAIRPERSON LEVIN: Through HOME-STAT are individuals—is every individual assessed for qualification for—for any type of benefits? I mean

is everybody going—I mean has that been able—is that able to be administered to individuals that are not going to Drop-In Centers or going to Safe Haven?

DANIEL TIETZ: Right. Yes. So the effort, of course is always to be—to just folks to engage with us, and then to the degree that they give us some identifying information, we have a look at what resources are available to them. Right now, what resources we're getting. So, benefits and entitlements is part of that.

CHAIRPERSON LEVIN: And how many have—have gone through that type of assessment through HOME-STAT?

DANIEL TIETZ: I don't have those numbers with me, but we can get them.

CHAIRPERSON LEVIN: How many—how many people are—how many in terms of headcount, how many individuals have been brought onto the DHS system or hired as part of the HOME-STAT program?

DANIEL TIETZ: I think I said there are 395 in total right now, and that excludes the contracted folks. I think there's something around 500.

CHAIRPERSON LEVIN: Exactly how it is broken down, what's—what's the job titles for street development? Did you mention anything for them?

DANIEL TIETZ: No, and I don't have it with me. I mean generally speaking it's outreach workers, social workers with predominant case managers.

CHAIRPERSON LEVIN: And those are located—those are--

DANIEL TIETZ: Meetings for a--

CHAIRPERSON LEVIN: [interposing] Out of, but a street in—in terms of street outreach? Are they located within the Drop-In Centers? How—how is that—how is it being deployed?

DANIEL TIETZ: So that's a—that's the outreach workers.

CHAIRPERSON LEVIN: They're all outreach workers?

DANIEL TIETZ: Yes, those are the folks who are in HOME-STAT.

CHAIRPERSON LEVIN: And those are all DHS staff lines or how does that work?

DANIEL TIETZ: No, I think that some of them are—are contracted as well.

CHAIRPERSON LEVIN: And you mean that—but that's not—that doesn't include NYPD personnel or DOH personnel.

DANIEL TIETZ: Because that's a wage (sic) for NYPD.

CHAIRPERSON LEVIN: What—what is the—okay. So, individual is a—there's a—there's a—is it a psychosocial evaluation then. What—how is the—what does that consist of? Like you detail kind of what—what type of evaluation is being done? What methodology is being—what is the—the model that is being implemented, and is there—are there different methods? You know, are there different modalities for that, or is that—is there single evaluation that's being done for—for an individual?

DANIEL TIETZ: You meet for the street homeless?

CHAIRPERSON LEVIN: Correct.

DANIEL TIETZ: It looks just like it does for—for others who are coming to intake or—or at assessment shelters. It's the same kind of mental health and substance use psychosocial evaluation that's otherwise used. I mean, of course, [coughs] and again this is the degree to which folks, you

know, participate in that. So, our goal is to get them in.

CHAIRPERSON LEVIN: Uh-huh.

DANIEL TIETZ: So, that's something that often times means, you know, the offer of a meal or a shower or the opportunity to rest. It's in that—in those periods when we start engaging, you know, we, if you will, press further to engage folks. And so, this may not happen all at once at the same sitting.

CHAIRPERSON LEVIN: What are the metrics that DSS is using for evaluating the effectiveness of—of HOME-STAT?

DANIEL TIETZ: Well, certainly one of them is simply getting folks off the streets and into care.

CHAIRPERSON LEVIN: How are you evaluating that metric?

DANIEL TIETZ: Well, it's simply the sheer number. It just has a process measure to measure the sheer number would matter--

CHAIRPERSON LEVIN: [interposing] Okay.

DANIEL TIETZ: --but that, you know, it wasn't done before. So that—that as one measure, and

then the types of services that folks are engaged in, and then ultimately placements.

CHAIRPERSON LEVIN: Okay, and are you—how are you gathering that information? How are you—how are you—and—and are you able to share some of those metrics then with us now?

DANIEL TIETZ: Not today, but soon.

CHAIRPERSON LEVIN: Okay, but then how—what's—how are you—how are you expecting it? Who's reviewing it? Who's—who's analyzing the data? What—who's doing all that?

DANIEL TIETZ: We are. I'm not sure what you're asking me.

CHAIRPERSON LEVIN: Well, we don't have any—how are we measuring the effectiveness of this program?

DANIEL TIETZ: Yes, so--

CHAIRPERSON LEVIN: [interposing] And when are we going to know the effectiveness of the program based on what data set?

DANIEL TIETZ: Yeah, so it's early in the life of the program, right? So, we're talking about just several months here. It's not very long.

CHAIRPERSON LEVIN: Uh-huh.

DANIEL TIETZ: We are assuming looking at sort of total number of engagements, and then the total of all the types of services I just mentioned, and the kinds of ways in which folks could be engaged, and having a look at how many there are, each of those. And then, of course, ultimately we're looking at permanent placements and getting folks into both transitional and permanent housing. So, we'll have some data on that soon. I—I don't have it here with me.

CHAIRPERSON LEVIN: Okay, when do we expect to be able to have some--?

DANIEL TIETZ: I know that—that we're—we're reporting some in the next few weeks, but I don't—I don't—I'm not sure that we'll have all the data you're looking for that we'll have all the data you're looking for, but it will be some initial data soon.

CHAIRPERSON LEVIN: And is there—? [pause] In your testimony you spoke about that there's counts being done on the quarterly counts now that are—the last one being complete on the overnight hours of November 6, 2016. So the whole count is obviously done with thousands of volunteers. How is—

are these counts being done without the—the volunteer manpower that—that's part of the full count?

DANIEL TIETZ: There are volunteers in this as well. S o there is—the street outreach folks, plus a good number of staff at DHS from other areas that DHS with—within the count.

CHAIRPERSON LEVIN: And what--and that's been—been happening quarterly since—

DANIEL TIETZ: There's been two.

CHAIRPERSON LEVIN: [background comments] And has data been released for either of those two?

DANIEL TIETZ: I think for the first one it was released, and then you get—I don't have demographic big data yet.

CHAIRPERSON LEVIN: And what was the data on the first one?

DANIEL TIETZ: [background comments] It's on the website. I don't have a number with me.

CHAIRPERSON LEVIN: So I'll turn it over to my colleagues for questions. I'm come back for questions. Council Member Grodenchik.

COUNCIL MEMBER GRODENCHIK: Thank you, Chair. Good morning.

DANIEL TIETZ: Good morning.

COUNCIL MEMBER GRODENCHIK: Last Thursday I believe you were here. Dr. Belkin wasn't here. Our colleague the Chair of the Health Committee who represents a good chunk of the Lower West Side of Manhattan, Mr. Johnson, was talking about a tremendous increase in the number of street homeless people who are exhibiting symptoms of mental illness. When you get a call, what happens? When we get a call, DHS or the Department of Mental Health gets a call, the police gets a call, how are these people analyzed and what—I'll take it from any one of you.

DANIEL TIETZ: So, you're—you're referring to a call the 311 for street people?

COUNCIL MEMBER GRODENCHIK: 311 or 911. It could be 911 depending on the—the case.

DANIEL TIETZ: Well, first, for 911, it's pretty straightforward. I'm—I don't work at EMS, but they come and they stake them.

COUNCIL MEMBER GRODENCHIK: Okay.

DANIEL TIETZ: And if they're mentally ill, and/or appear to be mentally ill or exhibiting behavior that would suggest that to the police and EMS, they take them to the emergency room for an

evaluation, and they're treated from there. If it's—if it's someone simply calling to say here there's this—I see a person who appears to be homeless on the street, we send our street outreach team within an hour to go see them and to engage them. That conversation is—is largely about here can you—would you come with us to a Drop-In Center or a Safe Haven to get services. So eventually it's an effort to persuade them to get in the van and come with us.

COUNCIL MEMBER GRODENCHIK: If—if somebody is deemed to—I guess it would under—under what conditions are—are the police or the Department of Health allowed to detain these people if they're a menace to themselves and to others? Can you answer that, Dr. Belkin?

DR. BELKIN: So far, the people mention Homeless Salvage Teams, the police, whatever the responder is that standard of likelihood harm, applied to all and all of those people are empowered to act on that, and have somebody transported for one of the violations.

COUNCIL MEMBER GRODENCHIK: And what happens after the evaluation if—if they're deemed to be a menace to themselves especially?

DR. BELKIN: So if they meet those criteria for acute hospitalization, then they're seen by me at that—at the hospital to admit them into there, or another appropriate place.

COUNCIL MEMBER GRODENCHIK: Okay, thank you. In your testimony this morn, Mr. Tietz, and thank you for being here again. I think we've been seeing a lot of you.

DANIEL TIETZ: We can change that.

COUNCIL MEMBER GRODENCHIK: Well, I'd like—I'd like to change that, but in the meantime, your testimony on page 1 said this administration has made unprecedented investments. The Wall Street Journal had column. I didn't have a chance to read it because I don't—I don't subscribe to that paper, but I'll get it later from my counsel. But unprecedented investments and the Wall Street Journal said spending is up 60% but as of DHS website this morning, we have 60,709 people who are deemed homeless in the City of New York, and I've asked this question before. I've spoken to Commissioner Banks. Do you have an estimate on when we're going to be able to turn this meeting around because it just seems to be going up, and it doesn't seem to be going

up incrementally. That's almost 3% increase in just the last few months, and I know you're working hard, but we just don't see the results that New York has expected, especially after a 60% increase in the amount of spending.

DANIEL TIETZ: Not unlike other New Yorkers, it's difficult for consultations. I don't have a lot of them. So I appreciate that-that the urgency. I think we all appreciate the urgency. That 90-Day Review was completed just six months ago. We've spent more than two decades getting to this place. It's going to take some time, and I think all along, both the Mayor and the commissioner have made clear that the number would likely go higher before it ultimate went lower. It's worth noting that among our efforts, and which I stated here in today's testimony and some from last week. But for those efforts, the number would be far, far higher. So there's many things, as I've raised here in the testimony both today and last Thursday, that have pushed that number higher, and we've responded with a host of programs and investments. But I—I—I think, you know, give us a chance to make all of this work, and—and I'm fairly confident that it will.

COUNCIL MEMBER GRODENCHIK: When you say work, you mean we start to see results next month, early next year, the middle of next year? This administration has been in office three years. I've only been here one year, but this administration has been in office three years now, and the needle just keeping in the wrong direction.

DANIEL TIETZ: [interposing] Yeah, I want to know context, though. I think the context is terribly important about what happened over the last 20 something years, and in particular from 2011 to 2014 when before this administration there wasn't any rental assistance. So when the city and state ended Advantage, and there was no assistance to get folks out of shelter, that number in shelter grew exponentially. But for our efforts, that—that trajectory would have continued, and because of our efforts, it has not.

COUNCIL MEMBER GRODENCHIK: We'll be holding a press conference to try to get the Governor to move in the right direction on that tomorrow, Chair Levin and I and a number of our colleagues. I think that's for now. I may come back. Thank you. Thank you, Mr. Chairman. Than you for your answers.

CHAIRPERSON LEVIN: Council Member Crowley.

COUNCIL MEMBER CROWLEY: So, I want to thank my colleague first of all the two chairs of this—these two committees for having this hearing today, my colleague Council Member Grodenchik for asking important questions, and I'll follow some of his questions. Being that this administration has had three years, at what point do you seek guidance from outside your 90-Day Review and say look, that was—that was almost a year ago when we said let's stop everything we're doing and let's analyze and see how we could do better because things were out of control then, and they're still out of control. So at what point do you say that my plan is just not working?

DANIEL TIETZ: Yeah, as I just stated Council Member, I know it's difficult persuading each of us to be patient, but I want to—I want to emphasize again the context that the 90-Day Review is completed in April. We're now in November. We've instituted a host of things, which I just went through at some great length both here today and last Thursday. Many of those things are having an impact.

We would be in a far worse situation but for the those efforts.

COUNCIL MEMBER CROWLEY: [interposing] You say that again, but we look at the data, and the numbers don't lie, and when the numbers keep on increasing [coughing] things are clearly not getting that. So, it's difficult for me to be patient three years into the de Blasio Administration with a record high level of homelessness. What is the city doing to create permanent housing that will guarantee housing for people who are currently homeless?

DANIEL TIETZ: So in addition to the efforts at DSS, you know, both DSS and HRA in terms of both shelter and transitional housing, of course, we have the 15,000 units of supportive housing. We have the senior affordable housing. We have—we have some number of efforts, and then there's the--

COUNCIL MEMBER CROWLEY: [interposing] Has there been one unit--

DANIEL TIETZ: --and then there's finance.

COUNCIL MEMBER CROWLEY: --has there been one unit over the past three years that has been

built specifically to house people, say homeless people?

DANIEL TIETZ: Yes, those numbers again, I don't--

COUNCIL MEMBER CROWLEY: [interposing] Right, there's—there's no—there's not one dollar in the city budget that specifically goes to house people who were previously homeless in affordable permanent housing. That—being that housing subsidized in part by the city.

DANIEL TIETZ: Well, there is. I, as I stated in my testimony here today, and as well as last week, we have a host of rental assistance that's not permanent housing.

COUNCIL MEMBER CROWLEY: [interposing] No, I'm not—it's very difficult to find housing whether you're homeless, previously homeless or just any individual in terms of affordable housing. There's—there's no vacancy rate for affordable housing. It's one thing to offer rental assistance, but when you cannot find landlords that have the space available to rent, what is the city doing to build permanent housing—housing, the—the brick and mortar new housing, construction for people who are

currently homeless? [background comments] The answer is nothing. There's no money in there.

DANIEL TIETZ: [interposing] In January 2014 to June 2015, about 131,000 households including approximately 390,000 received emergency rental assistance to help them stay in their homes averaging about $3,600 per case, which is much less than the $41,000 it costs to shelter them. Over the past two years, the new rental assistance program—so that includes LINC and SEPS and other rental assistance programs, and other permanent housing efforts have enabled 47,810 children--

COUNCIL MEMBER CROWLEY: [interposing] We're—we're—we're getting away from the topic--

DANIEL TIETZ: --and adults. No, I think this is actually the topic, Council Member.

COUNCIL MEMBER CROWLEY: I heard your—I heard your testimony--

DANIEL TIETZ: Right, that's done, yes. That's permanent housing, Council Member.

COUNCIL MEMBER CROWLEY: No, no, no, those are vouchers.

DANIEL TIETZ: You--you understand the fast permanent housing?

COUNCIL MEMBER CROWLEY: No, no, that's not.

DANIEL TIETZ: It is.

COUNCIL MEMBER CROWLEY: That's vouchers. It's different.

DANIEL TIETZ: To keep them in permanent housing, Council Member.

COUNCIL MEMBER CROWLEY: Right, right, no.

DANIEL TIETZ: It's not shelter. It's not transitional. It's permanent housing.

COUNCIL MEMBER CROWLEY: It's not. It's not the same. There's nothing this administration is doing to build permanent housing for people who are currently homeless, permanent housing built, brick and mortar, construction, HPD.

DANIEL TIETZ: I'm happy to get from—get from HPD whatever—whatever that you'd like.

COUNCIL MEMBER CROWLEY: There—owners who are building affordable housing units have the right to do background checks, and it's very difficult for people who have been homeless to be able to get the credit needed that credit score that these affordable housing units are—are—the owners are—are having a

number of different obstacles that people have to go through in order to get this housing. There's nothing—there's—there's nothing there right now outside of groups like maybe Catholic Charities, and other non-profits that are trying so desperately, but they have a very, very long waiting list, but there's nothing that HPD is specifically doing with DHS that is building affordable permanent housing.

DANIEL TIETZ: That's simply incorrect.

COUNCIL MEMBER CROWLEY: We—we can go back and forth and—and discuss this some more.

DANIEL TIETZ: We can. Facts matter. It's simply incorrect.

COUNCIL MEMBER CROWLEY: The facts—the facts matter is that you have nearly 61,000 people who are currently homeless right now, and you don't have a real plan put in place that will reduce the number of homelessness.

DANIEL TIETZ: I'm going to—I'm going to just refer again to the—to the list of reforms. Nearly four dozens items, and that's just setting aside for a moment that HPD is one of the provider.

COUNCIL MEMBER CROWLEY: [interposing] Reforms mean things are getting better, but everyday

it's getting worse. So—so that's disingenuous at best. Now, let's go into the number of people who are within your shelter system that are diagnosed with a mental health disability. Do you know what the percentage is?

DANIEL TIETZ: It depends on how we define the serious mental illness. I—I can certainly get some data on—on both of these things. (sic)

COUNCIL MEMBER CROWLEY: [interposing] Mental health diagnosis. It doesn't—I didn't ask if they had a serious mental health disability, which I would consider that to be something like bi-polar or schizophrenia, but—but anybody who could fall under the mental observation category of depression, anxiety, trauma experience. What is the percentage of the people that that live within your shelter system that have some form of mental health diagnosis?

DANIEL TIETZ: Yeah, I think that we accept that everybody who's in shelter just because of homelessness has some mental health needs.

COUNCIL MEMBER CROWLEY: So, now, what type of trauma care do you currently give the population? Like--?

DANIEL TIETZ: [interposing] I'm—I can go back over the testimony if you wish.

COUNCIL MEMBER CROWLEY: Sure. What kind of trauma care? So every—since 100% of the population within—within your shelters have had some type of trauma, that means that 100% of them are receiving some type of mental health services. Is that correct?

DANIEL TIETZ: To the degree that folks wish to engage in care and services, we've made it available. That's correct.

COUNCIL MEMBER CROWLEY: And can you tell me about children who are victims of the domestic violence, can you tell me what type of trauma care are you giving the kids? Because they're kids, and whether their parents agree to or not, I would like to know those that are 18 and younger in your care, what types of programs are you providing to them so that they—they could get help for the trauma that they've experienced in their lives?

DANIEL TIETZ: There are social workers in families with children's shelters that serve all in shelter and, of course, to the degree that the

family is interested in having that made available to their family members, they can have it.

COUNCIL MEMBER CROWLEY: So there's no specific program whether after school or on the weekends that are mandatory as part of being in the shelter system that you would have families go there?

DANIEL TIETZ: No, no, we cant' compel them.

COUNCIL MEMBER CROWLEY: So what level of evaluation do children within the shelter system go through in terms of mental health evaluation in terms of understanding the level of trauma that they've experienced, and what types of services that they should be offered?

DANIEL TIETZ: There's engagement at PATH at intake when—which I described both last week and again today to some degree on—on what happens with the providers there. So, that there's the option to engage there, and then in shelter, again there are social workers--

COUNCIL MEMBER CROWLEY: [interposing] Do you have a percentage?

DANIEL TIETZ: I don't have a percentage of that, no.

COUNCIL MEMBER CROWLEY: So you bring data with you today in regards to the specific count within here?

DANIEL TIETZ: No, I think I provided quite a bit in this testimony.

COUNCIL MEMBER CROWLEY: It's very—the topic has to do with mental health services for the people within your population, and you don't have a—a statistic or a data—data giving us a better understanding of just how many people especially the children are most vulnerable and our most neediest population. You—you can tell us--

DANIEL TIETZ: [interposing] With all themes,(sic) I'm not—I'm not quite sure what you're getting out council member, but all our themes or all assessments at intake and/or again by social work and case management staff, all of them.

COUNCIL MEMBER CROWLEY: [interposing] And at that point, how many—what percentage is referred to more—for more services?

DANIEL TIETZ: That—that number I don't have with me.

COUNCIL MEMBER CROWLEY: But you can't estimate as to how many?

DANIEL TIETZ: No, I wouldn't want to estimate.

COUNCIL MEMBER CROWLEY: [interposing] Okay, but--

DANIEL TIETZ: We'll get the number for you.

COUNCIL MEMBER CROWLEY: Okay, but of your population, 22,000, approximately 22,000 of the 61,000 people currently homeless are kids? Do you have an idea of how many of the 22,000 are receiving care from professionals?

DANIEL TIETZ: Well, they're all receiving care from professionals.

COUNCIL MEMBER CROWLEY: From professionals who ware trained in—in psychiatric care?

DANIEL TIETZ: Yeah, they're receiving care and services from social workers who are trained.

COUNCIL MEMBER CROWLEY: [interposing] So all 22,000 receiving care?

DANIEL TIETZ: To the degree that their family wants them to—to be engaged in care, they can be engaged in care. It's available to all. All are

given an evaluation. All are given assessments. All are seen everyday. To the degree that they wish to be engaged, they can be engaged.

COUNCIL MEMBER CROWLEY: Now, what happens when they shuffled from one center to another?

DANIEL TIETZ: I guess--

COUNCIL MEMBER CROWLEY: [interposing] I imagine they--

DANIEL TIETZ: [interposing] There's a provider for them.

COUNCIL MEMBER CROWLEY: --isn't there a continuity of care and, you know--

DANIEL TIETZ: [interposing] Uh-huh.

COUNCIL MEMBER CROWLEY: --because there were almost 100,000 kids who have—who are in our public schools who have experienced homelessness at—at some point last year or the year before that, and so—but—but what they said was what was most unsettling about these kids who had to undergo and experience homelessness, is that they were often moved from one shelter and one borough to another shelter in another borough, and that they had to either take a long bus ride to school to continue

education at their current or previous school, or they would have to then just be disrupted and go to the new school. So what I'm trying to figure out is whether that's the same—and the same is true for the care of mental health services. Do they have to travel far to get those services, or are they provided to them with a continuity in terms of professionalism and psychiatric—psychiatric professionals?

DANIEL TIETZ: So to the degree that folks want and need services, they can get them at the—at either the provider that's serving them in shelter or the referral, and our goal here is to ensure that folks have that continuity particularly from—from providers in the community because ultimately they're going to return to the community. So we—we assist them to engage in those care and services in the community, but certainly in shelter there are social workers and case management staff who assist them.

COUNCIL MEMBER CROWLEY: But if a family is moved from one borough to the—to--to the different borough, or from one shelter let's say or you're closing a lot of these cluster, right, you were

saying there's 3,000 of them in the city and many of these families are going to hotels. Is that—is that why there's been so many?

DANIEL TIETZ: No, no.

COUNCIL MEMBER CROWLEY: Okay, what's happening?

DANIEL TIETZ: The—the-in most—in—in—in the majority, we—our goal is to have them remain in place if they obtain a lease for the unit that they're in. The advantage of—of-of that is obvious, right, which is they're already in the unit. If—if—if we can strike that deal and the cluster unit (sic) and—and keep folks in place. So they will remain in the community in which they already are, and then provide rental assistance and other supports to those who won't remain in—in that cluster unit to—to—to permanent housing.

COUNCIL MEMBER CROWLEY: No, the—the numbers that DHS has provided in press releases that the Mayor's done both in February and then again in—in the late fall, show that you are. Indeed close units, cluster sites because although the rate of homelessness is higher than it's ever been, your housing a significant amount of more people than are

going homeless in hotels. So some—so they're coming from somewhere. People who are going to these hotels are you closing? You're either closing—you're either closing the clusters--

DANIEL TIETZ: [interposing] I am not sure what you're asking me. Are you asking me if we're sending folks from clusters to hotels? The answer is no.

COUNCIL MEMBER CROWLEY: In February when a family was horrifically murdered in Staten Island in a shelter hotel, at that point in time the Mayor and this Administration said that were 2,500 people living in hotels—shelters, 2,500 in February. Then on September 30th, the Mayor release a press release that says there's over 6,000 people living in shelter hotels. Now, if you take 6,000 and you subtract 2,500 you get 3,500. Now, from February to the end of September 3,500 more people did not go homeless. So what I'm asking is where are they coming from? Are you closing existing shelter sites? Are you closing the clusters to put people in hotels? They're going there from somewhere. They're not all just going homeless.

DANIEL TIETZ: [interposing] But they want their housing, Council Member.

COUNCIL MEMBER CROWLEY: No, it in addition to that.

DANIEL TIETZ: No.

COUNCIL MEMBER CROWLEY: So then their numbers are wrong.

DANIEL TIETZ: They're not coming from clusters. They're not coming from other hotels to go to those hotels.

COUNCIL MEMBER CROWLEY: And they're not coming from existing shelters that have closed?

DANIEL TIETZ: [interposing] Right now, Council Member, you can go to PATH, and you will see dozens of families who are coming from wherever they were living. It could have been doubled up, they could have been with families. They may have lost—they may have been evicted from their apartment.

COUNCIL MEMBER CROWLEY: [interposing] So, just explain the disparity there.

DANIEL TIETZ: They're not coming—they're not coming, Council Member, from other clusters. They're really not.

COUNCIL MEMBER CROWLEY: [interposing] So, how many people—how many people were homeless in the city? The census in February, you census in February was not 3,500 fewer than you have today? Have you gone up that rate, so much so much so?

DANIEL TIETZ: Council Member, everyday somebody loses their apartment for reason or another and they go to PATH. Like I'm not quite sure what you're getting at.

COUNCIL MEMBER CROWLEY: Well, the point is your--

DANIEL TIETZ: [interposing] It's not a shell game.

COUNCIL MEMBER CROWLEY: --the percentage of people staying if you had 100%--

DANIEL TIETZ: [interposing] You—you get the people that are getting new apartments everyday, Council Member.

COUNCIL MEMBER CROWLEY: You're not answer the question.

DANIEL TIETZ: I think I've answered it.

COUNCIL MEMBER CROWLEY: This is the last question I asked, and I've been asking this administration for the answer--

DANIEL TIETZ: [interposing] I'd be grateful if I do.

COUNCIL MEMBER CROWLEY: --for months. Yes. Now, this is the question. Let's say whether it's 60,000 or 61,000, you have 100%, right? 100%. What is the percentage? What was it in February that lived either in clusters, hotels, or traditional shelter sites? The three is your only option out of 100%. I'm asking--

DANIEL TIETZ: No, no, it isn't actually.

COUNCIL MEMBER CROWLEY: Well, what other people?

DANIEL TIETZ: Everyday people come from—from—from—they could be doubled up, could be an apartment they lost. They're not coming from clusters. I don't know how many ways to say it.

COUNCIL MEMBER CROWLEY: [interposing] But they—they go A, B or C. They don't--

DANIEL TIETZ: No, what there's a D--

COUNCIL MEMBER CROWLEY: [interposing] What is—what is the D?

DANIEL TIETZ: --if they're coming from--

COUNCIL MEMBER CROWLEY: What is the D? What is the other option? What is the other option?

I f you're housing somebody as a provider, a shelter provider, you're either putting them in a hotel, a cluster site, or a traditional shelter—or traditional shelter. What is the third—what is the fourth? What does it say?

DANIEL TIETZ: Do you understand—do you understand that the folks lose their apartments daily and then come to us for shelter?

COUNCIL MEMBER CROWLEY: I understand that you have nearly 61,000 people that you are serving that are currently homeless, that—that are sleeping within your shelter system.

DANIEL TIETZ: [interposing] I think I can't answer your question better than I have.

COUNCIL MEMBER CROWLEY: You're not being direct. Is—is there a fourth?

DANIEL TIETZ: [interposing] I couldn't be more direct.

COUNCIL MEMBER CROWLEY: Is--is there a fourth option?

DANIEL TIETZ: The people who have lost their housing.

COUNCIL MEMBER CROWLEY: Yes, of course. Where are they—where are they sleeping tonight?

They're not sleeping on the street and they're in your shelter system. There's only three different options?

DANIEL TIETZ: Yeah, then they end up in those--

COUNCIL MEMBER CROWLEY: [interposing] Okay.

DANIEL TIETZ: --in those options. That's correct.

COUNCIL MEMBER CROWLEY: Right. So why is there a greater percentage--

DANIEL TIETZ: [interposing] If I could just go, by the way--

COUNCIL MEMBER CROWLEY: --of homeless people living in hotels today as opposed to February? What's--

DANIEL TIETZ: [interposing] Because it's difficult to site perfect shelters out there.

COUNCIL MEMBER CROWLEY: --you have to be—you have to—you're reducing your population in another category, and if you're not reducing it in--

DANIEL TIETZ: [interposing] No.

COUNCIL MEMBER CROWLEY: --the clusters then where are you reducing it?

DANIEL TIETZ: No, so—so--

COUNCIL MEMBER CROWLEY: Yes, yes. Just answer my question. That's it.

DANIEL TIETZ: I'm—I'm happy to answer the question if you'd give me a moment maybe without interruptions. So, we essentially right now have—have a few different types of shelter one of which we're actively closing down. So that would be the clusters.

COUNCIL MEMBER CROWLEY: [interposing] Right, so you're closing them.

DANIEL TIETZ: And we're closing-- If I may.

COUNCIL MEMBER CROWLEY: Yes.

DANIEL TIETZ: So we're closing down those clusters. We're not moving folks from clusters to other—other—but we're not moving then into hotels because that just doesn't make sense, and we wouldn't be bothered with that. Our goal is to keep as many people in—in place as possible. Those are apartments. We prefer that they stay. For folks who are entering the system for the first time, today the options are purpose built shelter or hotels. That's pretty much what we have.

COUNCIL MEMBER CROWLEY: Right.

DANIEL TIETZ: If we can't otherwise divert them--

COUNCIL MEMBER CROWLEY: [interposing] Right.

DANIEL TIETZ: --we can't keep them in their housing, that's what we have. What we prefer, of course, is first and foremost is prevention, to keep people in whatever they have now so we've increased legal services. We've increased rental assistance. We've done a host of things, as I've described in testimony about how we avoid having folks from the shelter at all. But failing that and they're actually needing shelter, ideally we would want purpose built shelter. We want genuine shelter that has all the services that folks can need that—that is built for this purpose. I'm not going to argue your point that commercial hotels are not ideal, but in the absence of other—of other available shelter, then we have to meet our legal and moral obligation to shelter folks with what we have.

COUNCIL MEMBER CROWLEY: I agree, and I know that we have to meet that--

DANIEL TIETZ: [interposing] I'm pleased to hear it.

COUNCIL MEMBER CROWLEY: --legal and moral obligation, and not just for the people who are either in the audience or watching, it is—in February we had roughly 59,000 people who were homeless. Today, we have 60,800. We have gone up approx—approximately 1,800. The number of people living in hotels has gone up twice that. So obviously you're closing down cluster sites because you said you're not closing traditional--

DANIEL TIETZ: [interposing] No, this is the absence—this is the absence of purpose built shelter. Were we able to site purpose built shelters, such as in your district, this would be different.

COUNCIL MEMBER CROWLEY: The--the point of the matter is even if you haven't sited any new purpose built shelter space, you're increasing the numbers going in hotels at a pace much greater than that going homeless, nearly double. So if only 1,800 more people are homeless today than back in February, then why do you have 3,600 more living in hotels? That's it. That's it. Thank you.

CHAIRPERSON LEVIN: Okay. I want to go back to push button the 90-Day Review reforms. The second reform that was identified was a city and state task force that was going to team up on—I think on—on—on mental health needs. What's the status of that?

DANIEL TIETZ: So we've had several conversations with our state partners, and over--

CHAIRPERSON LEVIN: [interposing] How's that going?

DANIEL TIETZ: Actually [laughs] that is a loaded question.

CHAIRPERSON LEVIN: Yep.

DANIEL TIETZ: I would say it's going actually reasonably well.

CHAIRPERSON LEVIN: Okay.

DANIEL TIETZ: So we'll have more to talk on that soon, but I think we're—we're—are in discussions about what kind of assistance we can get.

CHAIRPERSON LEVIN: Okay and what—which agencies are you talking about?

DANIEL TIETZ: So we're speaking principally with the Health and Human Services agencies.

CHAIRPERSON LEVIN: Okay, as well as OTDA?

DANIEL TIETZ: Yes.

CHAIRPERSON LEVIN: Wait, I'm sorry, and when do you expect to be able to have something to come forward on that?

DANIEL TIETZ: I couldn't give you a date today, but I think soon.

CHAIRPERSON LEVIN: Okay, we expect obviously we're going to be having a hearing as a—a year out from the 90-Day Review. At that point, we're going to be fully expecting that there's going to be a little bit more of a fleshed out update on that. You know, look, if it's not going to happen, we should know that as well.

DANIEL TIETZ: Absolutely.

CHAIRPERSON LEVIN: Do you think—I mean you ask any New Yorker in the city of New York that's in any borough whether or not they believe that the city is doing an adequate job providing mental health services to homeless individuals, and they would say no, right? I mean I think it's—it's on its face as any New Yorker can see. This continues to be a challenge just as it's always been challenge in New

York City providing mental health services. Do you believe right now that the provision of services is adequate for mental health needs of homeless individuals in New York?

DANIEL TIETZ: So I think there's a few things, and I may actually ask Dr. Belkin to weight in as well, but, you know, we've increased by—by as I noted in the testimony resources for mental health services broadly speaking in New York City quite significantly. We already had fairly extensive mental health services in shelter, and we've expanded those more, and I think there's more to come there including some—some additional resources via Thrive for that effort. The—some of the challenge here, of course, is that for the most part folks have to agree to be engaged. So they have to agree to services. I think access has been traditionally a problem. There haven't been enough services, and I think we're rapidly moving to improve on that, and then it's a—it's a matter of can we persuade enough folks to actually be engaged, and—and—and reduce the stigma of being engaged.

CHAIRPERSON LEVIN: How do we do that better? What—what have we identified as barriers to engaging people better on the street?

DANIEL TIETZ: Well, yeah. So in some instances, it may be a lack of—of—of, you know, understanding and knowledge. Maybe stigma so we can address those by—by consistently engaging in persuasion on this, simply providing the services. Sometimes frankly it isn't so much just referring to it, if you will, as mental health services as just as a service--

CHAIRPERSON LEVIN: Uh-huh.

DANIEL TIETZ: in an effort to—to just engage people consistently, but I also think that there are other efforts. So, for example, having more services on site. So, for example, a Drop-In, you know, street homeless. So Drop-In and Safe Haven just having more folks there on site. The same is true, by the way, in families with children shelters. We're adding those 368 social workers having more services that are readily on site, not referrals, not at a distance, but having it close—close by to simply consistently engage folks would really make a difference.

CHAIRPERSON LEVIN: In terms of qualitative delivery of services, I—I want to—I'm going to get to families in a minute here. So I just want to focus for a moment on—on individuals. In terms of qualitative delivery of care, what changes has this administration made that were not specifically—that were not in place under the prior administration?

DANIEL TIETZ: You mean in shelter or--?

CHAIRPERSON LEVIN: Both in shelter and in—with—and/or Drop-In Centers--

DANIEL TIETZ: [interposing] Yeah, so we--

CHAIRPERSON LEVIN: --or Safe Havens--

DANIEL TIETZ: [interposing] Right.

CHAIRPERSON LEVIN: --or with individuals on the street? What-what are the four—in terms of like what are qualitative changes? Like what is—in terms of different methods of delivery of care, not just in terms of hiring new—new teams, new folk, what are—what are--? What—for example, like what are—are we looking at other jurisdictions and finding innovative ways to establish new methodologies of delivery of care?

DANIEL TIETZ: Well, I would note that this is certainly we—just referring to HOME-STAT has certainly been, you know, innovative one of a kind sort of things in terms of the intensity.

CHAIRPERSON LEVIN: Right, but we don't—I mean, as you said, we just don't have any—we don't have any qualitative data on the--

DANIEL TIETZ: [interposing] Not yet, but I think it's--

CHAIRPERSON LEVIN: --or quantitative data on--

DANIEL TIETZ: [interposing] I think it's a per yearly, but I think that—that intuitively I would suggest that—that having those services in that intensive way [coughs] and available to folks, you know, on the street that we've seen, in Drop-In and Safe Haven, definitely makes a difference. It's that level of engagement definitely makes a difference.

DR. BELKIN: Just to—I think to address our question about what are we doing differently because--

CHAIRPERSON LEVIN: Uh-huh.

DR. BELKIN: --if we're going to connect people—people aren't connecting to care because often

they don't want to bother. We have to sell traditionally in terms of what that treatment is and what it looks like. So, several of the programs that were mentioned in—in Mr. Tietz's testimony, reflect actually new approaches to care, much lower thresholds and forms of delivering like care, which means thinking about what could be on site more. What could be co—what service could be co-located more in shelter, and that's part of the conversations that we're having with the state, and how much can we build out on that? But the specific programs that were mentioned like the Intensive Mobile Treatment Teams who—it's quite an innovative approach that wraps our head around the fact that the hardest to reach people are not going to go to appointments, and they're not going to go to Pathways of Cares as we have traditionally built them so they could build them very differently.

CHAIRPERSON LEVIN: And how many—how many? I mean, so in the Core Response Teams Mobile Crisis Teams is a—you—you identified 246 Mobile Crisis Teams referrals made 239 for Core Response. How many in the—in the Intensive Mobile Treatment?

DR. BELKIN: So Intensive Mobile Treatment Teams, are all within those other two options, which are sort of a moment in crisis points in time. So it's like engagements to try to connect people to other things. The IMTs are long-term wrap-around teams of professionals that are now the caregivers for this individual, and are highly mobile. They'll follow them to jail. They'll follow them in and out of shelters. They'll follow them in and out of—of any other housing. They'll meet them where they want to be met, and so it's a very different approach to care.

CHAIRPERSON LEVIN: Okay. How many individuals—

DR. BELKIN: [interposing] So those--

CHAIRPERSON LEVIN: --are we engaged with it--

DR. BELKIN: [interposing] Yes. So the initial investment--

CHAIRPERSON LEVIN: [interposing] so the—the range on it?

DR. BELKIN: Yeah, so the initial investment of that model was for the capacity of 75 or about 70 I think, and it just, you know, then

started to. We're now thinking to expand that, but that's—these are the directions that we're—we're—we're trying to go as well as working with DHS on how can we optimize co-locating more in shelters.

CHAIRPERSON LEVIN: Okay, I mean I—I think—what I'm trying to get at here I—I think broadly is that we—we're having a hard time identifying what percentage of the need we're meeting with any particular method of service delivery. So, you know, I don't know how many individuals are for—how many, 70 individuals right now that we're reaching through an IMT model, out of how many should we be reaching, right? If we're reaching 239 co-response teams, out of how many? Like what's—what's—what's the goal? Right now I just—it's—it's—it's-it's impossible—I feel like I'm a little bit in the dark here. I don't know how—how much of the need are we really—how—how far off the mark are we? We're going to be off the mark, right? We're going to be off the mark, but how far off are we, and that's—it's—and that to me is—is—is one way to measure our success, but unless we have clear data, and are looking at it with a very—I—I prefer to look at more self-critically than less self-critically, right? If

we're doing—if we're doing good things, but we're not—but we're, you know, and we're inevitable going to be off the mark, it would be helpful to know from our perspective how far off are we, and to be looking at it as clear eyed as path—as possible. So, I realize that you haven't come with—with that data and maybe it's—it's too early in the process to do that, but I think that in order for us to evaluate and for the public to evaluate, what this administration is doing. I mean it's—it's no secrete that this administration a year ago came under a lot of fire for what the public perceived to be an increase in street homelessness, or an increase in mental health incidents among individuals living on the street, and this was a matter that was instigated further by the New York Post, and—but it—it resulted in a—in a broad public perception that this administration wasn't doing everything that was—needed to be done. That wasn't accurate, but or it wasn't—it wasn't accurate in the sense that this administration certainly wasn't doing less than the previous administration. But in order for I think us and the public to fully understand how this administration is doing on this—on this measure, we're going to need better, clearer

data. That is—I—I feel very strongly about that. With the I guess moving over to families for a minute here--

DR. BELKIN: [interposing] Can I comment on something.

CHAIRPERSON LEVIN: Sure.

DR. BELKIN: I'm sorry, but I—agreed, and we have to know what the denom—denominators are. The challenge is there are lots of denominators. There are people at high risk for opioid overdose. There are people who have been disengaged in care, and we need to re-engage. There are people who have never been diagnosed before, and need to be engaged in care. So there are a lot of different denominators for which--

CHAIRPERSON LEVIN: [interposing] Uh-huh.

DR. BELKIN: --differences just make sense. Your—you opened with—with a question posed to a—a New Yorker on the street, how are doing, you know, in terms of meeting the needs of the homeless mentally ill. And I would say we're doing better than we have in prior years because we have never really talked about that issue this way, and the Mayor has never, ever owned it in this way. And we

have never ever built or had the audacity to try to build the kinds of things that we're building in this way. And as we build these dots and start connecting them, we'll be able to answer the questions, but nobody has before demanded those kinds of data, and that the city has a responsibility for that kind of knowledge. So we're building that, but we can't do it over night, but we are doing it, which has not been done before. And as we—we—we are as insatiable about a new patient, as was mentioned to see through how we're doing and, as we know, we will be the first ones to share it with you.

CHAIRPERSON LEVIN: Can you speak a little bit about the nexus between Thrive NYC and the homeless system a little bit further in terms of resources? So—but Thrive NYC has identified the many millions of dollars over the next ten years. How will those resources be delivered for homeless individuals?

DR. BELKIN: Right. So they are—so they are currently being delivered. The most clear overlap is—are these different mobile treatment options that we've—we've described.

CHAIRPERSON LEVIN: Those are all within the umbrella of Thrive NYC?

DR. BELKIN: Correct and including a substantial expansion of ACT Team capacity that the City itself has invested in. We—we require—it previously had the city resources. That's a substantial investment, and we're hoping to expand upon that even more. So that's the most tangible overlap, and that is now happening and people are getting services. There are other overlaps. For example, we have a real commitment of training peers, and we have been talking about—with DHS about how to use that peer workforce to support what's happening in shelters both as direct resources, but also to enable people to better be connected to things like cell phones and other services than that. So we're talking about how to take advantage of—of—of building out that workforce and capacity as well.

CHAIRPERSON LEVIN: Sorry, please identify who are we talking about here? What's—there were some people that were mentioned, peers meeting.

DR. BELKIN: Peers. So peer counselors are an established working role, as people with work

experience come with us to be trained and stay certified to provide--

CHAIRPERSON LEVIN: [interposing] And then employed by DHS, employed by DOHMH or employed by contractor agencies and contractor agencies.

DR. BELKIN: [interposing] So currently they are mostly employed by treatment providers at treatment sites, Health and Hospitals is—is actually leading employer peers, but we're looking at the ways they can evaluate. It has lots of settings, including our shelters where a lot of these outreach (sic) folks they're much more credible messengers and they're putting a face with it.

CHAIRPERSON LEVIN: And definitely how, you know, how many—how many people are we talking about?

DR. BELKIN: We're just—we're just starting to—to talk about that and other—other options. The Health Department and DHS, you know, our historical involvement has been in supporting some subset of services and some subset of mental health shelters.

CHAIRPERSON LEVIN: Uh-huh.

DR. BELKIN: And the Homeless Outreach Teams and their support. I think we both see a—a need for us for us to be more partnered in terms of and we were—for example as part of the 90-Day Review looking—we're looking at what should a model of care look like? How do we really think about what is the standard basis of—of—of performance of mental health shelter and so forth.

CHAIRPERSON LEVIN: But nothing is identified in the 90-Day Review in terms of the models of service within the mental health system, within the mental health shelter—shelter system in terms of a shelter, right? Is there a—is there a recommendation on the 90-Day Review that speak to that?

DANIEL TIETZ: [coughs] I don't think that there's a—a specific to that although we recognized when we came in [coughs] as part of the 90-Day Review that there wasn't a model per se. So there was—there were services certainly, and there were richer services at something called the mental health shelters and general population shelter.

CHAIRPERSON LEVIN: Uh-huh.

DANIEL TIETZ: What we've taken on is to create that model with DOHMH's help, you know, put that into contract, set those standards, create the performance deliverables and then track those.

CHAIRPERSON LEVIN: And how—[background comments]

DR. BELKIN: We're for example now co-convening with all the mental health shelters that directly face our agencies to—for service issues and—and frankly solutions that we can work on together so--

CHAIRPERSON LEVIN: [interposing] Now, you're evaluating performance.

DR. BELKIN: Well--

CHAIRPERSON LEVIN: Maybe through deliverables on contracts? What's—what's the—how, you know, obviously with—as in anything, there's going to be a range of quality between those different providers. How are we—how are you identifying who's good and who's bad, and what do you do with the bad ones?

DR. BELKIN: So, we're starting. For the first time we co-hosted a gathering of all the shelter directors as joint—jointly as agencies on

that surfaced various issues such as what were the opportunities for co-location? What were the opportunities that we're missing for better integrating people into other parts of the healthcare system like help lines. And so, those have created now work streams to try to act on them, and when they become new realities, we'll obviously be looking at performance.

CHAIRPERSON LEVIN: With the additional scatter site units of supportive housing, what's the—what is the referral system for those units? How are people going to be getting into units? They'll be coming out of the mental health shelters into those units or substance abuse shelters into those units or—or—weakening and closing. (sic)

DANIEL TIETZ: So it's the thing—for the moment it's the same HRA 2010 E-Application process for supportive housing that previously existed. So it will be a mix of folks, and certainly some coming out of shelters.

CHAIRPERSON LEVIN: Sorry. I'll take a step back. Is there—are there any issues around case record sharing between DHS and HHC or is—is there

issues around case records not being publicly shared? What's the problems with that?

DANIEL TIETZ: No, not necessarily. So for the most part we can obtain consents for this, but we also have existing MOUs for sharing data and, those are actually being expanded. So right now the Law Department is working with us on—on cross-agency expanded MOU.

CHAIRPERSON LEVIN: So, no like—no—no issues that are identified or no—no barriers that need to be addressed?

DANIEL TIETZ: No, I think that we thought that—that—that were actually. So, it's part of what we believe that a broader MOU would be useful as among certainly DHS and Health and Hospitals, but even a few other agencies, and so that's being worked on now.

CHAIRPERSON LEVIN: You spoke about the administration and Naloxone in shelters. Is—what is the—there are—Naloxone is obviously for a—a—a—an overdose, acute situation. What does—how does DHS and DOHMH coordinate the administration of—so Suboxone not being long term or Methadone for opioid

addiction. It's just kind of long-term preventive care.

DR. BELKIN: So for example this idea of what might be more co-located in—in shelters. That could be one—one option we're exploring, and we would relocate that administration, too.

CHAIRPERSON LEVIN: But obviously if there were--

DR. BELKIN: [interposing] Currently, what we—we—what we would be doing is—is trying to connect people who are—who are screening and assessed to the process described for those services in the community, but can we optimize exposure by bringing it closer to the site? It's something we're trying to see if it's possible.

CHAIRPERSON LEVIN: Okay. I mean how many--are—are we quantifying how many—how many people are coming into the system with—with identified opioid addiction?

DR. BELKIN: So there--

CHAIRPERSON LEVIN: [interposing] There were 79 ODs in a year. That's a lot within the system obviously. You know, and it's—and as you had indicated, 66 lives saved and 13 deaths. It's not,

you know, it—it does—even Naloxone is not going to necessarily save every life. So, what are doing to get people into long-term addiction maintenance that are in the shelter system?

DANIEL TIETZ: So just to answer your first question, so as part of that assessment, on the way in in that assessment shelter, there's a pretty thorough look at who has what need, and hence as they get referred to appropriate shelters to the greatest degree possible. I mean obviously there are folks who have mental health or substance use challenges who are in other shelters, but there are services on site for those. As—as Dr. Belkin just mentioned, our goal is to have move of that. It's being able to co-locate that—those—those needed services to a greater degree because it actually would be helpful.

CHAIRPERSON LEVIN: You mean like, but when you say co-located, you mean like doctor on site that's going to be a prescriber? Is that what you're saying or--?

DR. BELKIN: That's what we—that's what we have to work through. It's actually having to do—

CHAIRPERSON LEVIN: [interposing] But right now, how does it—is it so—?

DR. BELKIN: Right now it's a referral to a program—to—to a program.

CHAIRPERSON LEVIN: Okay, one of the challenges with Suboxone prescriptions is that doctors are very limited with the number of prescriptions that they can— They can have I think up to 30 prescriptions at any—at any time, 30—30 patients. Are we—are you making sure that anybody that comes in with an—with an opioid addiction are identified as—as being referred to a—a doctor that is able to prescribe—prescribe to them?

DR. BELKIN: We wouldn't be referring people to places that can't provide the service. So, yes, we would be providing—we're referring people for Suboxone to ultimately prescribers of Suboxone.

CHAIRPERSON LEVIN: Uh-huh.

DR. BELKIN: Another Thrive overlap there is a commitment to increase by a thousand the number of prescribers in—in New York, but to also try to push different models of delivering it that can bring it more up to scale. Like can we do more primary care based--

CHAIRPERSON LEVIN: [interposing] Uh-huh.

DR. BELKIN: --prescription with other kinds of extending your healthcare workers and you service there. (sic) So, we're trying to amplify all of that, including this idea of co-locating to increase access. This is—these are higher at-risk population. The leading cause of death of people in shelters are a drug overdose.

CHAIRPERSON LEVIN: Yes.

DR. BELKIN: So we clearly see this as a public emergency, and want to open up the ways people are passing. (sic)

CHAIRPERSON LEVIN: And when can we expect a status update in terms of that expansion for that matter? I mean just in terms of that's—that's—that's--

DR. BELKIN: Well, of—of the training of—of providers in the city--

CHAIRPERSON LEVIN: Uh-huh.

DR. BELKIN: --that we report, I think it's part of the--

CHAIRPERSON LEVIN: Yes.

DR. BELKIN: --Mayor's—that's—that's reported regularly.

CHAIRPERSON LEVIN: No, but in—in--

DR. BELKIN: [interposing] In terms of--

CHAIRPERSON LEVIN: --in Thrive you mentioned the—the—expanding the number of these drivers.

DR. BELKIN: Yeah, that—that is currently publicly I think reported in—the Mayor's—it--

CHAIRPERSON LEVIN: Is it part of the MMR or is it not?

DR. BELKIN: I thought it was, but I—we could—we could verify that.

CHAIRPERSON LEVIN: Thanks.

DR. BELKIN: That's—that's something we—we tracked as part of the Thrive effort. If—if it's not publicly reported, we can get you that information. In terms of the idea of—of creating more gateways toward people in shelter, that's what we're trying to go.

CHAIRPERSON LEVIN: In a July 2015 article in the New York Times by Winnie Hugh, had run the article that New York City takes steps to increase the safety of employees at homeless shelters. It says, city officials have also set up an interagency task force to examine efforts to provide shelter to high risk populations, which

include people who exit seriously mental—a least a bit serious mental illness and violent behavior. The task force will have representatives from homeless services, the Health and Hospitals, police, probation and correction departments and the Mayor's Office of Criminal Justice. Is that—is that correct? Is that task force currently meeting? Any meetings with the task force?

DANIEL TIETZ: Yes.

CHAIRPERSON LEVIN: It is. Is that entering—how frequently is it meeting?

DANIEL TIETZ: It—well, with great frequency. I mean I'd say that there's a meeting pretty much every month.

CHAIRPERSON LEVIN: Is it a formal task force? I mean is it something that—is it—or is it there? Are these kind of just—how would you describe it? How would you describe the task force?

DANIEL TIETZ: Well, there's a lot of work going on. So I would say that there's—there are--

CHAIRPERSON LEVIN: [interposing] Structurally, how would you describe it?

DANIEL TIETZ: They're representatives from a host of agencies. So, from each of our agencies, Health and Hospitals, we and MOCJ. I think there's—there's a---a host of agencies involved.

CHAIRPERSON LEVIN: And is it for—I mean is it producing any findings? I mean is there a—are there minutes of meetings that we could see? What—what—what is produced from these meetings that—that would be accessible to the public?

DR. BELKIN: Neither—none of us manage that work, but we can get you more information for that.

CHAIRPERSON LEVIN: [interposing] Who's managing it?

DR. BELKIN: It's been convened by MOCJ--

CHAIRPERSON LEVIN: Okay.

DR. BELKIN: --and the--

CHAIRPERSON LEVIN: Why MOCJ if it's—if it's for, you know, shelter or mental—people with mental health issues?

DR. BELKIN: Well, it's about coordinating a lot of—trying to divert the pathway of some of those folks through a criminal justice path. I mean to a treatment path. I think that's been the

main—a part of bringing these agencies together is troubleshoot that and to try to make sure--

CHAIRPERSON LEVIN: This is part of HOME-STAT or was it--? No.

DR. BELKIN: No. So for example, our role in that is—is to try to optimize getting people into the sorts of services we've just been talking about, and creating as many points of entry and awareness among these other services. How to refer and how to get the money. So that's some of the—some of the work that happens in those conversations.

CHAIRPERSON LEVIN: I—I'd like to—I think the committee would like to see what—what recommendations are coming out of that task force and if there's an ability to provide us with—with the minutes of those meetings, that would be I think very helpful to see. I want to just ask very quickly about the—the LMSW program that you mentioned. How many of those have been hired so far?

DANIEL TIETZ: It's—it is a [coughs] modest number to date. There's a back and forth that's happening with OTDA on the budget.

CHAIRPERSON LEVIN: Because structurally it's the state has been paying for it.

DANIEL TIETZ: We are paying for it, but the budgets require approval from OTDA.

CHAIRPERSON LEVIN: I see and what's the total budget that is—when—when fully staffed up?

DANIEL TIETZ: I don't have it with me. I-I believe that our share is $14 million.

CHAIRPERSON LEVIN: Okay, and this would be available so that's—that's—okay so 368 LMSWs. That's—that—that—is that in every single Tier II? Are they on site in Tier IIs? Where—where are all these people working out of?

DANIEL TIETZ: Yes, in part and then, of course, the other—other bits of the system that aren't Tier IIs, the--the social workers for each of the providers. So these are already essentially, you know, employed by the—by the shelter providers, and then deployed from there.

CHAIRPERSON LEVIN: Okay. So, then these are new budget lines for—for shelters providers?

DANIEL TIETZ: Uh-huh. Yeah.

CHAIRPERSON LEVIN: And so who does the hiring? Do they do the hiring?

DANIEL TIETZ: They do the hiring.

CHAIRPERSON LEVIN: Okay. A child goes into the shelter system, a child goes into PATH today and is placed at a hotel. Explain to us what is the process for how services provided for that child in an off-site setting like that?

DANIEL TIETZ: So they get the same sorts of evaluations and, you know, case management interventions that other folks do in other shelter settings. So there are—we take space for essentially an office or a program area in—in—in those hotels. So that the provider actually has a place to be on site at that hotel provide services. So it's not just--

CHAIRPERSON LEVIN: [interposing] And they are there for—what's like what kind of hours are we talking about?

DANIEL TIETZ: Well, there's—there's, of course, staffing around the clock. So there's case management and—and security, but then, of course, the social worker and other program staff are there during, you know, usual business hours or at times, you know, it's dark out. (sic)

CHAIRPERSON LEVIN: Okay, so that—that actually presents a challenge, right, if children are in school. So say—say they're in school at their old

school, right, and that commute is now an hour and ten minutes from their hotel, and so that child, you know, gets back to the shelter at 5:30.

DANIEL TIETZ: Yeah.

CHAIRPERSON LEVIN: And who's providing services for that child?

DANIEL TIETZ: The provider is obligated to provide the service. So whether it's—whether it's hours, you know, 9:00 to 5:00 or it's some other hours, they've got to provide that service. So their obligation is to find a way to serve that family at whatever hour they need to serve that family.

CHAIRPERSON LEVIN: Just from a practical perspective, like how do you provide services to children if there are 30 children in a hotel, and all of them are only really—I mean you're—you're not providing services for them at 8 o'clock at night, right. And so pretty much all of them are requiring services, you know, they're tired. They've just had a long day at school, and then, you know, probably some hectic type of commute to get back to shelter. This is a very traumatic experience for them in general, and when you've got 30 kids that you have to see in an hour and a half, how does that work?

DANIEL TIETZ: Yeah, challenging and I should note that the—their case ratio is good. So, it may not—we're only talking about one social worker in some of these instances, right so--

CHAIRPERSON LEVIN: [interposing] What's the ideal case ratio?

DANIEL TIETZ: I thinks it's 1 to 25 for the—per family.

CHAIRPERSON LEVIN: That's a good line, right?

DANIEL TIETZ: Indeed, but you're not--

CHAIRPERSON LEVIN: [interposing] It's all about kids.

DANIEL TIETZ: --but, you know, not—not all families need all service all at once. So—so there's certainly options there, but I think we're never going to argue that being a commercial hotel is ideal. What would be ideal is good purpose built shelter, and so to the degree that we are able to site more of that, we'll have less of the other.

CHAIRPERSON LEVIN: By all means.

DANIEL TIETZ: We're taking offers.

CHAIRPERSON LEVIN: What is—are—are you using—are there evidenced based models in place for

like trauma informed care for children in the shelter system? So, you know, we at the Council so proposed by this committee fund an initiative for trauma informed care with a—a number of the family shelter providers that you work with. What is—what type of trauma informed care is DHS paying for?

DANIEL TIETZ: Yeah, yeah so that's part of what we're paying for as I noted in my testimony that there is trauma informed care as part of the—what the social workers do. I can certainly get you details. I don't have—I don't have it personally here today.

CHAIRPERSON LEVIN: So you're saying that those MSWs that that's going to be paying for the trauma-informed care?

DANIEL TIETZ: Yeah, there's actually quite a bit of detail in what those care coordinator positions look like, and what they—what kind of experience they'll have to have and what kind of services they'll deliver and that's included.

CHAIRPERSON LEVIN: When do you expect to be staffed up at 368?

DANIEL TIETZ: I don't have a date. We're hoping soon to be—to be done with our discussions with OTDA to make this happen.

CHAIRPERSON LEVIN: In FY17 there is allocated $3.8 million for a public health diversion center. It's under DOHMH intended to provide short-term shelter, substance abuse treatment, peer counseling and community care as a result of the hospitalization and arrests. There's an additional—this is in addition to $1.3 million already allocated to diversion centers in FY17, and $4.5 million in out years. However, three hasn't been an identified location for any diversion centers. Can you report just the progress on identifying space for these?

DR. BELKIN: And so it proved very difficult to find a location, as you know. So what we actually did was started over and using a different procurement process that allows more favorable terms to the vendor, more long-term ownership of the site, and some other features that I—I can—we can get details to you on, but in essence, it made it a little more doable, and we're now working with identified members to find locations. It is still like a struggle. We do not have sites

yet. We're more optimistic this time around for the reasons I mentioned, but it's been frustrating to everyone that real estate is—is this kind of what remains there.

DANIEL TIETZ: I want to ask a little bit about NYC Safe, and I'll turn it over to—to Council Member Crowley for—for a second question, and second series of question, and then I'll ask those.

COUNCIL MEMBER CROWLEY: And just a point of clarification, I haven't gotten an answer for my first question yet, but I did the math myself, and back in February, March, April right around the same time where the Mayor concluded his 90-Day Review. It was at that time. He realized he needed to do a significant review. There were 4% of the total population of homeless people living in hotels. Today, there's 10%. So somewhere your purpose shelter housing population shrunk in percentage or your cluster housing has shrunk in percentage, but you don't know that and DHS is failing to tell me the truth about those numbers. Unless you want to answer that, I'm going to go to the next question. I received a phone call today from somebody who's living within my hotel shelter in one of my—one of

the hotel shelters in my district, and—and I have too. So, he was transferred from one hotel shelter in a different district to this particular shelter and told that he would be able to see a housing specialist--and mind you, he has no counselor in this hotel—within 45 days. He's been there for much greater than 45 days, and has not seen any specialist. He was woken up in the middle of the night and told specifically that he was not to use the front door of this hotel, only the back door, and that if he continues to use the front door, as he's been told—as he told the people that worked there, he feels totally degraded using the back door. He was told that he's going to be moved and transferred again. And he says in the hotels there are no hotel bell—beds that—that would be normally in a hotel, that they removed those types of beds and they put prison style beds, and they don't have the towels that hotels usually have. So, although you're saying that people are getting services in hotels, not according to this constituent who's living with and on the street right now.

DANIEL TIETZ: Is there a question?

COUNCIL MEMBER CROWLEY: Well, I still haven't had the first question answered. Do you want to tell me how many—what the percentage is of people living in clusters today as opposed to six months ago?

DANIEL TIETZ: It was less.

COUNCIL MEMBER CROWLEY: Right.

DANIEL TIETZ: I—I don't have the percentage.

COUNCIL MEMBER CROWLEY: Okay. So there is somewhat of an—an answer I've been looking for for a few months.

DANIEL TIETZ: Yes, it's intended to be low. So we're closing clusters.

COUNCIL MEMBER CROWLEY: Right, and—and at the same time when the Mayor announced that in April, he said the same would be true for hotels.

DANIEL TIETZ: Right, he said that—that we would reduce--

COUNCIL MEMBER CROWLEY: [interposing] Right.

DANIEL TIETZ: --clusters first.

COUNCIL MEMBER CROWLEY: [interposing] But it was right on the same priority.

DANIEL TIETZ: And then he said that we would—and then there would—then there would be commercial hotels.

COUNCIL MEMBER CROWLEY: [interposing] So, this is my last question—this is my last question.

DANIEL TIETZ: So I'll—I'll note Council Member that to the degree that we can build purpose built shelters then we'll use less--

COUNCIL MEMBER CROWLEY: Department Yeah.

DANIEL TIETZ: --in terms of hotels.

COUNCIL MEMBER CROWLEY: Well, earlier my colleague referenced the Wall Street Journal, which said that you spending $1.6 billion, which is up 60% since de Blasio has taken office. Yet, the rate of homelessness has gone up 20%, and in it the former Deputy Mayor is quoted, Lilliam Barrios-Paoli says, Sometimes it is easier to get caught up in the immediate crisis and forget that you need to step back and create more permanent solutions. So, I would use that as my last remark, and encourage you to—and your administration, Department of Homeless Services work with the Mayor to achieve more

permanent solutions, which is really permanent housing. Thank you.

CHAIRPERSON LEVIN: Council Member Grodenchik.

COUNCIL MEMBER GRODENCHIK: I just want to reiterate the Chair's remarks that we will be expecting better answers and better information when we meet again soon. It is a little frustrating that we don't get answers to our questions, and I will note based on that Wall Street Journal article we're spending over $26,000 per person in the system. That doesn't include the cost of the children being educated. It doesn't include probably health and hospital costs, and those costs are staggering, and we need to move in a better direction. Thank you, Mr. Chair.

CHAIRPERSON LEVIN: Thank you, Council Member Grodenchik. A few more questions. First, can you tells us families without children what is the— the method of service for mental health services for families without children and families who have children?

DANIEL TIETZ: You mean the adult families?

CHAIRPERSON LEVIN: Yes.

DANIEL TIETZ: It's similar to what it is in the rest of the system. There are on-site services. There's always case management. There's always housing placement systems. There are some social work staff, and then it's via connections to, you know, referrals in the community to providers in the community.

CHAIRPERSON LEVIN: So everybody that's—we-so, but there's no—but in—for adult families there aren't specific adult families in mental health shelters, right?

DANIEL TIETZ: No.

CHAIRPERSON LEVIN: So—so it's and those—those are all general shelters?

DANIEL TIETZ: Yes.

CHAIRPERSON LEVIN: Right, but not everybody is getting referrals to community based providers for mental health services?

DANIEL TIETZ: Typically they are determined to meet them and they agree to participate in them. Yes.

CHAIRPERSON LEVIN: You know--

DANIEL TIETZ: [interposing] I don't think we compel them. No, we cannot.

CHAIRPERSON LEVIN: No, no, no, what I'm saying is that in, you know, it bears. So we could talk offline. Obviously, I have which one?

DANIEL TIETZ: [interposing] Would you like to thank the person there? (sic)

CHAIRPERSON LEVIN: There's on there in my district. I can't imagine that anybody in that—in that particular shelter is getting referrals to the community based services in the neighborhood.

DANIEL TIETZ: The obligation of that--

CHAIRPERSON LEVIN: [interposing] And that's one that I haven't heard actually.

DANIEL TIETZ: The obligation of that provider is to connect them to either an existing provider service and many of those folks already come for example with, you know, third party payment often Medicaid--

CHAIRPERSON LEVIN: Uh-huh.

DANIEL TIETZ: --and have connections to existing providers, and we look—we—the—their to—the provider is expected to make those connections. So make additionally for all those needed, and to

encourage folks to participate in that—that care and services. If they don't have that or they don't wish to return to that provider, then it's any provider they wish. Then the—the—in this case, the location you're talking about that provider has linkages with several health and mental health providers and then they offer those up to the clients who are interested.

CHAIRPERSON LEVIN: I'm going to have to follow up on that and see if that's actually happening. Before moving over to NYC Safe, just—just briefly, can you explain what separates a mental health shelter from a substance abuse shelter from a general population shelter for single adults?

DANIEL TIETZ: Yeah, so in the mental health shelter we have Greater Mental Health Services. So there's usually psychiatrists on staff or a psyche MP or both in addition to better case ratios. So there are lower case ratios for the social work and case management staff to provide greater services. So there's both the additional services on site, and then additional referral services, and that's pretty much true as well with the substance abuse. It works much the same way. So

it's—again, it's case acts or other substance use disorder professional and the case ratios are lower.

CHAIRPERSON LEVIN: And then in terms of general--?

DANIEL TIETZ: They all have similar services. They just may have higher case ratios, just because it's not used in the same way. So for example if you got, you know, a plurality of a single men's shelter where they're employed, and—and, you know, there are in, if you will, reasonably good shape, then you wouldn't need the same level of—of service.

CHAIRPERSON LEVIN: Okay, and—and moving over to NYC Safe, obviously there's been an allocation of additional resources as part of—of NYC Safe. Can you describe some of the obstacles that DHS has faced in—in implementing measures on the NYC Safe? Some of the challenges? [pause]

DR. BELKIN: I don't want to speak to your challenges, but I—I [laughs]. One thing NYC Safe has done is put our two agencies in fairly constant communication about individuals that are in shelter that they're really are looking for a connection to the—the Care Opportunities that we—

we're responsible for within that several of which we've talked about including most recently the establishment of new Forensic ACT Teams, which is a—is a substantial expansion capacity, and I think we had some kinks working on it and back and forth information, but I think eventually now clearly and you can tell me how it is from your end bringing people into those—into those options that are identified within the shelter system.

DANIEL TIETZ: Yean, I think that's gone quite well that our providers are fully aware of the services, and the—and the opportunities for getting folks who—who appear to need more intensive services that serve inspector, the ATM et cetera. All of those services know how to make those connections. We work closely with them in terms of training and resources to make sure that those connections are made. So I think it—it goes reasonably well from our perspective.

CHAIRPERSON LEVIN: How about in terms of security measures at—at the DHS shelters?

DANIEL TIETZ: So we've added, as I noted in my testimony, we've have a lot of DHS peace officers as well as the private security. So that's

the expansion that is true at really every shelter on Green. This turns a great deal on the NYPD's security assessments and their weighing in with us about how to—you know, what kind of staff do we need. And so we take the guidance from them in terms of staffing.

CHAIRPERSON LEVIN: Have—have you seen a decrease in violent incidents in shelters compare to previous years for like one type of person?

DANIEL TIETZ: I—I haven't done the point in time comparison. I'll just note this is a few months on. So I don't know that we have a long enough period to say, and I don't—I would just note that for mind—I don't have personal experience in this in terms of being able to see the—the difference, but we can send it to you.

CHAIRPERSON LEVIN: [interposing] Certainly you can compare October of 2016 to October 2015.

DANIEL TIETZ: I wasn't—I wasn't in this mix then, but I—I don't have that data with me, but we can certainly get it.

CHAIRPERSON LEVIN: And what was the result of the NYPD assessments? I mean is that—is that made public shelter by shelter?

DANIEL TIETZ: I don't think it's actually been completed just yet, but I don't—I don't have it here today but I can certainly get you what we have.

CHAIRPERSON LEVIN: And we're expecting that that's being made public?

DANIEL TIETZ: I—I expect we'll make a statement on it, yes.

CHAIRPERSON LEVIN: Okay. I mean we'll be interested in seeing, you know, the warts and all version, if that's possible.

DANIEL TIETZ: Yes, we're happy to share it with you.

CHAIRPERSON LEVIN: Okay. I am appreciative of the amount of time that you've dedicated to this hearing. I look forward to having some follow-up questions with you and, you know, upon the 90-Day Review hearing I hope to have some—some clear data on some of the issues that we've spoken about in this hearing, but I appreciate to hear that. Thanks much. We'll take a two-minute break and then

we'll—we'll have our first panel, which will be—excuse me, Dr. Bouchard Burns from NYU-NYU Lutheran Community Medicine Programs; Stephanie Gendell, Citizens Community for Children; Catherine Trapani from Homeless Services United; and Nicole Bramstedt from Urban Pathways.

[Meeting in Recess]

CHAIRPERSON LEVIN: Welcome back. Thank you all very much for your patience. Whoever would like to testify first, go ahead. [pause] You can go ahead. Just make sure the red light is on.

DR. BOUCHARD BURNS: Okay. Good morning Chairperson Levin, Chairperson Johnson and members of the General Welfare and Health Committees, members of the City Council, Department of Homeless Services, and colleagues. Thank you for the opportunity to speak today. I am Dr. Bouchard Burns. I am a Board Certified internist, psychiatrist and addiction specialist. I am the Behavioral Health Director of the NYU Lutheran Community Medicine program. I have been working for the homeless in New York City since 2000. I have worked at the shelters that house the mentally ill, and chemically addicted men and women, shelters that house the medically frail, shelters for

the working poor, and single room occupancy sites. I come here today with the resource of 17 years of in the trenches experience. My testimony represents the thousands of conversations I've had with some of New York's most vulnerable fellow human beings. I can testify that the people we treat are facing many mental health problems that are not being adequately addressed. One of the reasons these problems are not being addressed is that they simply are not known to agency that assigns the addresses. Increased data collection and reporting are first steps to understanding the nature and scale of problems facing the shelter system. As such, NYU Lutheran Community Medicine Program strongly supports the bill proposed by Council Member Levin and Corey. We commend you for taking the initiative. I'd like to begin today by giving a voice to the homeless, and tell you what it's like from their point of view from their words to my ears to yours. Typically, when you enter the shelter system, you have nothing, no family, no friends, no money, no spare clothing, no hope. Immediately, you encounter staff that are often—too often insufficiently trained. There are, therefore, not sensitive to your situation. They can even be

hostile to you, and you are left feeling traumatized and further degraded. Drugs treat you like a criminal. You are given a room with sometimes 20 to 40 other people, and are left alone at night to fend for yourself. Battles are waged, and the strongest prevail and dominate. The rules are not law, but of power. Patrols are inadequate. We do not feel safe. The bathrooms are dirty. We get little sleep because someone wants the lights on, someone wants to play music, someone stinks or smokes crack or K2. Every morning you are forced to leave your room, and either go to a rating—waiting room where prison dynamics continue to play out, or leave the shelter. Ex-convicts report that the food is better in prison. Anger and frustration sets in, and conflicts between residents is rampant. Exposed daily to this chaos, shelter staff burn out and direct their frustrations at you. Where is the support? Where is the peaceful environment where healing can take place? Why are the shelters not at par with other government run facilities that service the most fortunate? Where is the warm handoff to medical and mental health services that can facilitate their journey out? Where is the hope? Prior to addressing some of these

issues we have identified, I would like to acknowledge Mayor de Blasio's initiatives to address mental health issue. I would also like to acknowledge the hard work of HRA, DSS, DHS in the face of the cure—cure in PATH and to improving the care of homeless families and individuals. Some of the issues that we have identified that most hamper delivery of mental health care for our clients include the following five:

1. Patients are made to leave the shelter before the clinic opens, and are permitted to return only at the end of clinic hours. We as providers, nurses, doctors, nurse practitioners, drug abuse counselors, social workers, navigators are on location, but there are very few patients. Even when stationed in the Micah Shelter where there are 200 daily clients, we can't enough clients to conduct a group for therapy once a week. So management of care is almost impossible since delivery—delivery is made inaccessible. So close yet so far.

2. Physical and mental wellness are not a priority for a door. Primary care and mental health screenings should be mandatory, and shelter clients should be encouraged to attend their follow-

up. Such screenings should be part of contracts with the DHS.

3. Measures of the implementation of trauma informed care should be part of this bill's tracking system. The city's effort to roll out trauma informed trainings for staff are a commendable first step. These efforts must continue, and improve shelter based observations and approaching of staff working in shelters.

4. The City should promote a complaint site where shelter patients can place complaints, and have their concerns addressed without fear of retribution. Currently, abuses by staff are not taken seriously when clients are promoted—provided an easily accessible avenue whereby their complaints can be recorded, investigated and addressed. Clients are inappropriately villainized if they speak out against the injustices being encountered in the system. Some are even sent to the ER basically for complaining. This is a huge cost to the system.

5. Mental health services provided inside the shelters are critical to mitigating the impact hold (sic) people within the community. Using group therapy, groups, prescribing and managing

medication and providing link—linkages to physical care among others. So, these are crucial to providing acute and transitional care. We cannot overlook that there is nothing like rapid return to housing to create the conditions that stabilize mental health. We know because of published research that housing first is critical. Housing is a healthy prevention and medicine in and of itself. We must continue to advocate seriously for this. We as a society need to acknowledge the devastating effects—devastating effects being homeless has on the mind and body of a human being, that these human beings are our fellow citizens. It is common for the homeless to be looked upon as some type of aberration, as not part of society. It is imperative that understand that people fall on hard times, and hopelessness is an integral part of the evidence of community existence.

Our vision is that the homeless system is one of the homeless systems that nurtures people so they can reach their potential. A shelter should be a place where someone can find temporary respite, regain their footing, and for the majority of people who proceed with become a contributing member of

society that they once were or for the first time. Of course, there are those that find themselves in the unfortunate situation of not being able to achieve this goal, and we provide—and we need to provide avenues for these people to live a meaningful existence. We look forward to the annual reporting that this bill would mandate, and encourage the bill to measures efforts of mental health promotions as it would allow us to more accurately understand the situation and allow for better distribution and implementation services. We need a healthy shelter system if we want—if we want to expect the outcome of healthy people. We at NYU Lutheran Community Medicine Program ask for this bill to be passed. It is an element. (sic) Thank you for listening.

CHAIRPERSON LEVIN: Thank you very much, and I look forward to working with you and your organization on the past amendments to the bill that can make it even more helpful and impactful.

DR. BOUCHARD BURNS: [off mic] Yes, thank you. I think it's great. [pause]

CATHERINE TRAPANI: Good morning or afternoon now. Thank you for the opportunity to testify. My name is Catherine Trapani. I'm the

Executive Director of Homeless Services United, and we've submitted testimony jointly with the Coalition for Behavioral Health of New York City, and Christy Parque sends her regrets. She's traveling so you've got me for the both of us this morning.

CHAIRPERSON LEVIN: We've had many, many hearings with Chris Parque's testimony so--

CATHERINE TRAPANI: Thank you. So—so onward, but her—her imprint is on this---

CHAIRPERSON LEVIN: Yes.

CATHERINE TRAPANI: --and—and we do support the rules particularly with respect to this topic. So, thank you for holding the hearing. HSU did last week submit testimony regarding the importance of conducting a comprehensive news assessment to identify the health, mental health and other service needs of New Yorkers, but we can adequately plan for the shelter capacity and service provision, and we encourage the city to convene a task force of government and community stakeholders that include homeless service provider, medical and behavioral health service providers to conduct that assessment, and identify gaps in needs as well as to coordinate access to care, and we've heard a lot

about where those gaps are, and this is the bill of what goes, some ways for addressing some of the misinformation. I'm going to start really quickly by talking a little bit about homeless families' assessment and treatment. There are specialized shelters for mental health for single adults, but not for families. There are many homeless families who could benefit from these services. Domestic violence, as you know, is a leading cause of homelessness for families in New York City and the trauma coupled with the—trauma—trauma domestic violence coupled with the trauma of homelessness can have serious repercussions for children's—children and adults alike, and can be associated with health problems like PTSD, anxiety and depression. Identifying these problems and offering access to care can greatly enhance family wellbeing, which is essential to achieving other goals that securing needs in employment and permanent housing. In recognition of these needs, you've heard some testimony today about Thrive New York City and the effort to identify persons in need of services or connect them to care. And thanks to Thrive and other initiatives, family shelters are soon going to be

staffed with licensed clinical social workers who can assess homeless families' mental health status, and make referrals for ongoing clinical services as needed. This is a welcome addition to the family shelter model, but providers have reported that additional guidance and support on how best to integrate these staff with existing models of care would be helpful to ensure that we can max—maximize the benefits to families. Additionally, because so little data on the mental health status of families with children is available, we actually don't know the extent of it of what they need, and what, if any, additional specialized care should be offered either on site or via community care. We encourage the city to collect, track and regularly report data to providers as Thrive is fully implemented and initialed their system to the needs so families could be appropriately accessed and addressed. For single adults, persons with disabilities including behavior health issues are dis—disproportionately at risk of victimization. As a city, we must ensure we are doing all that we can to enhance their safety and offer appropriate services to help them avoid or escape homelessness and maintain wellness.

Unfortunately, many adults who suffer from mental illness maybe be reluctant to enter the shelter system out of fear. DHS does have specialized shelters for single adults in need of mental health services, but more data is necessary to determine whether or not there's enough capacity to meet the needs of all those individuals who require and desire those services, and which settings are most appropriate for persons with behavioral health issues. Client feedback suggest, and we actually just heard about it a moment ago that the Safe Haven model, which offers more privacy and less restrictive beddings and less sharing is preferred by many clients, who would otherwise refuse shelter services or feel unsafe in a more congregate shared style shelter, and we applaud the expansion of Safe Haven shelter model, and we think that there should be more of those. There is also a small number of people who despite the efforts of homeless outreach teams and others attempting to engage under fee services. Outreach providers must do everything they can to respectfully engage with such persons and both respect their autonomy and honor their civil liberties while also affecting what, if any, danger

they may present to themselves or others. In very rare cases it may be necessary to involuntarily remove people from the streets and refer them to hospitals or other services. Kendra's Law establishes a protocol being an assisted outpatient treatment for AOT to coordinate care for such persons, but some homeless services providers have reported difficulties navigating the system, referring clients, or attracting progress is based that they refer. But we encourage DHS, DOHMH, and Health and Hospitals Corporation to work with homeless service providers to address these challenges associated with AOT and ensure that all parties can effectively serve persons with acute needs. In regards to aftercare and the community stabilization we strongly encourage the city to move forward with implementing their supportive housing plan, and with the continued use of rent—rental assistance vouchers. Critical to the success of those exiting homeless is ensuring that they have the resources and the goal of—and supports available to them to help avoid re-entry or unnecessary obstacles to housing stability. Enhanced after care plans for persons exiting shelter including robust behavioral

health discharge plans are necessary so that those living with behavioral health issues have a clear pathway at a shelter with connections to services that will help them thrive in their communities as independently as possible. When appropriate desire by the client, there should be a ward handle between trusted shelter staff, and community based providers to help—to help them address the individual or family's mental health and substance disorder needs. Regular information, case coordination and overall coordination on initiatives between DOHMH, HRO, DYCD, ACS and the HS system especially prevention outreach of Home Base will serve to strengthen the safety net of homeless and formerly homeless New Yorkers.

Workforce Support and Training. Homeless Services United, the Coalition for Behavior Health and our members are fully committed to ensuring access to permanent housing for all New Yorkers in need through the provision of high quality shelter and Behavioral Health Services. This commitment can only be fulfilled by ensuring that there is sufficient resources and budget to meet the costs of providing these typical services. I'm going to go off script for just a second because we did hear

about, you know, from the previous presenter dirty bathrooms, filthy conditions, with bathroom. It's worth noting that now that the cluster violations are down 83 systems (sic) of care and it's thanks to a large investment and the Council backlog and the care and assistance for shelters. So we're hearing a lot this morning about increased spending, and I understand that there is trepidation. Will we see the size of the addressed budget? But I also want people to understand that the system is different investments and for over 20 years where it's our shelter provider knew that they needed maintenance in the building. They just put in a new deeds request to DHS, and it would get ignored. So for the first time in two decades we're beginning to process those, and so we're making progress, but I agree that there is a lot more to do. So the funding is really important. Please don't get scared over a price tag because frankly that's just what it costs to do high quality services that New Yorkers frankly deserve.

So—so back on script in terms of services, the value of what we provide to New Yorkers in crisis today as we help restore them to becoming daily housed is truly incalculable. However, we can

start by contracting and paying for the true costs of operating the programs today. So this does include cost escalation over a duration of contracts when we have contracts for things like insurance, rents and other fixed costs, along with offering competitive wages to ensure it was gaining an improvement in staff. The strength of our work relies on our big hearted and highly capable staff who everyday, and I think I'm speaking to them of services step into the fear, chaos and unknown to our clients' world and they need a ray of hope or possibility, and most importantly show them their modeling in their struggle. We owe to them and their clients that they are fairly compensated, supported and trained to reflect the value of their work in society. This includes offering a living wage, regular cost of living increases, affordable benefits, and education and career opportunities to create a strong pipeline of persons pursuing careers in shelter services, and that serves where the hope might be. The Coalition through its widely recognized experience of designing, delivering evidence based behavioral health trainings and Homeless Services United would are deeply an operational model of experience

conducting trainings. We welcome the opportunity to collaborate to create and deliver effective and sound training for homeless services providers. In conjunction with our many partners, we are confident that we can create an academy targeting homeless program staff with a training curriculum that supports the paradigms we're working with and raise unassigned clients with behavioral health needs. We propose that the city's financially support this investment to create this training academy and career pipelines of homeless services and health programs staff. We would be happy to work with the Council and their government partners to realize this investment in our workers, which will lead to stronger outcomes for those served by the homeless shelter system. We look forward to working with the Council, the Administration officials, and the Health and Behavioral Health community to strengthen an existing partnership, and fortunate ones to promote the wellness and stability of all New Yorkers in need. Thank you for the opportunity to testify.

CHAIRPERSON LEVIN: Thank you.

STEPHANIE GENDELL: Good afternoon. My name is Stephanie Gendell. I'm the Associate

Executive Director for Policy and Advocacy at Citizens Committee for Children, this multi-issue advocacy organization, and advocates on behalf of children and families and thus my testimony only focuses on the families with children in the shelter population, and I'm just going to summarize it. But first I wanted to thank you for holding today's hearing for the very thoughtful questions that you and your colleagues asked today, for introducing the bill that should hopefully give us more information about the behavioral health needs of children and their parents as well as your investment and the Council's investment in the services to help address trauma for children and families in shelter. As DHS said today, every single parent and child in shelter has undergone trauma by the very nature of being homeless. So one of the things we wanted to talk about today was actually not only the need to address behavioral health needs of the children and their parents in shelter, but actually to have a system that doesn't make their behavioral health needs worse, and actually does work to make it better. That starts with the some of the issues that others have touched on like the conditions in shelter, the

issue of whether children and families are in hotels, cluster sites or to a true shelter. As we've all talked about today, we need to stop using the shelters as far as stop using the hotels, and the clusters and figure out how to right size the DHS system. We think that there needs to be an assessment of children and their parents and their needs when they're at PATH, but it looks at more than whether or not they're eligible and homeless, although that's obviously part of it. But also once they are found eligible, what type of placement and location would best meet their needs. And as part of that, would be looking at whether or not any of the family members have a behavioral health need that's being served by a service provider, and if so, not disrupting that relationship and maintain a family in their community. Similarly, when we look at school, we have gone obviously in the wrong direction in terms of keeping children and families placed closed to school We need to turn that around and figure out how to do that. We create additional trauma and stress for families when we place children far from their schools regardless of whether they transfer to a new school or are commuting all the way back and

forth. While I mentioned schools, the administration put in for money for this year's budget to add MSWs to schools that have high levels of homeless children in them. They—they put in 33—money for 33 social workers. We have been asking for money for 100 social workers last year. So we—we asked for that, but in addition the money for the 33 social workers was not baselined last year. So we'll be looking to see that money continue, and to hear more about what the work of the social workers has been. In addition, we think that there are some—there are some additional things that we could do for families in shelter to help alleviate some of the stress, trauma and address their behavioral health needs like expanding the use of home visiting programs in shelter be it Nurse Family Partnership or Healthy Families New York. Baselining and expanding your initiatives that bring trauma informed services into shelters, training every single person who works for DHS at PATH, and in shelters in trauma informed care be they the intake worker, the social worker or the driver or the clerk or any person who is interacting with the very traumatized family and how to make that a positive experience for everybody. Thank about how

we might be able to modify the no visitor policy, in a way that's both safe for families and children, but also does not socially isolate families and their support network, and ensure families with open ages are able to maintain continuity care with their service providers. And then the last thing that I'll just suggest for now is in relation to the bill. We support the bill. We would just suggest that you might want to consider adding the children and families who are in a domestic violence shelters to the bill, all in agency anyway. They should be able to report altogether. Thank you.

CHAIRPERSON LEVIN: Thank you. One—one of the questions is you mentioned the DOE, the—the MSWs in—in our schools, but that's a—that's a—a DOE funded initiative?

STEPHANIE GENDELL: Yes, it wasn't the assigned.

CHAIRPERSON LEVIN: Okay, but it's in the DOE budget?

STEPHANIE GENDELL: It's in the DOE budget.

NICOLE BRAMSTEDT: Good morning. My name is Nicole Bramstedt, and I'm the Director of Policy

at Urban Pathways and Pathways is a 40-year-old human services non-profit. We serve the single homeless adults. Typically, those chronically homeless. A lot of questions have been directed to this morning. I want to thank both committees for having this hearing. It's a very important issue, the opportunity to testify as well. We're going to testify—talk a little bit about what's going on with regards to single homeless adults, those outside of the shelter system. Mainly those are at our Drop-In Center and we operate all the very Drop-In Center at 30th Street in Manhattan. Also, single homeless adults in our Safe Haven. We operate two Safe Havens one in Midtown Manhattan, Travelers Safe Haven and one in Brooklyn, Hegeman Safe Haven. I'll talk a little bit about that. As we know, mental illness typically—disproportionately impacts this population, and this is really what we see at our Drop-In Centers and our Safe Havens. So just to give you an idea, in September of 2016 37 of the 92 Drop-In Center clients about 40% were diagnosed with a mental illness by a psychiatric assessment. This is 40%. Last month in October 2016, 12 of the 25 new Drop-In Center clients were diagnosed with a mental illness or MICA, Mental

Illness Chemical Addiction, and that was based on intake assessment, nurse assessment or psychosocial assessment. Regarding Hegeman Safe Have last month, three or four new clients were diagnosed with a mental illness or MICA by psychiatric assessment. These data are really a snapshot of what we collect at Urban Pathways on the mental health issues of unsheltered clients. So for example the Drop-In Center monthly reports on the number of clients on medications, psychotropic and non-psychotropic. The Drop-In Center, the Safe Havens they also monthly report on the number of psychiatric referrals both internal project renewal psychiatric referrals and outside referrals. With respect to psychiatric referrals both sites—they tabulate project renewal appointments kept and no shows, as well as referrals our first time evaluations or follow-ups, updates, et cetera. In addition, the Drop-In Center sends a monthly report to DHS, which reports on the number of clients with a mental illness, and the number of clients with a substance abuse issue. In addition, each of our sites at Urban Pathways we monthly report on the number of new clients at each site with a mental illness or substance abuse issue and MICA for

Robin Hood Foundation grants. So as you can tell, we do monthly look at this information, and some of it is reported to the city. One of the things I talk about in my testimony is how we assess for mental illness. I'm not going to go through all that. It's in my testimony. One thing I do want to note and an issue we do encounter is so all clients at our—our Drop-In Center and our Safe Havens do get a psychosocial assessment and psychiatric assessment, and that's because mainly the HRA on 2010 Supportive Housing application requires that. It's important to note that not all clients were referred for psychiatric assessment keep their appointment. For example, last month 22 of the 41 project renewal psychiatric referrals, 54% of the Drop-In Center were kept. So you're seeing about half of the individuals keeping those initial psychiatric assessments. And that's somewhere we can definitely do better, and there needs to be conversations on that, and talk a little bit about the end. Also, last month with regards to Travelers Safe Haven clients, again, you saw about the same percent. About half of the clients who maintain their psychiatric assessment about half don't. Also, we do very robust assessment

with regards to mental health at the Drop-In Centers and Safe Haven. One client—one population at the Drop-In Center we could touch on better. With individuals who come at night, and who don't come in the day, and enroll in services those individuals get more of a—a 24-hour intake questionnaire with regards to mental health. So we could touch on that better. This will be close. (sic) I have a few recommendations. We generally support this bill. However, we think it can do better with regards to reporting on the unsheltered population, particularly given the prevalence of mental health in this population, particularly given the prevalence of mental health in this population. Also, as we talked about earlier, the city has made a tremendous investment, and there should be applied for such in HOME-STAT. But if we stop there, we're really neglecting our duties. We've got to continue assessing that population, and the city can do a better job of that at the Safe Havens and the Drop-In Centers. So we really should enhance reporting on mental health issues of individuals outside the shelter system. Not just enhance the reporting but also regularly assess that. So, one of the things is

two recommendations for—of this bill: Include mental health information for unsheltered by type or point of service. So for example not just provide mental health data on the unsheltered, but look at we'll drop based that by Drop-In Center, by Safe Haven, and by shelter system, as well as by outreach. And look at what are the needs there because we're not currently doing that, and that would better assess us. Also, Intro 932 there is something about the most commonly occurring mental health issues for homeless adults outside city shelter systems. That's-we should even think that—that the most commonly occurring should be for that population as well. It currently has—it requires information for adults and children in shelter. We also need to look at the most commonly occurring for those outside of the shelter system. Again, more data without assessment is insufficient. Last year the Mayor had a great supportive housing task force. Perhaps mirror that with the mental health homelessness task force consisting of providers where providers talk about the intersection of homelessness and mental health, and come up with recommendations on that. One topic for discussion could be how we improve the

number of clients who fail to keep their psychiatric referral. Also, DHS should really invest more in mental health services at the Drop-In Centers and the Safe Havens. Mainly, it should increase the knowledge of its contracts for psychiatric and nursing consultancy with these services. So at each Safe Haven we have a part-time nurse who comes one day a week for three hours a day. It's—it's insufficient. We—both sites would do better to have a full-time nurse. We know about the entrenched not only of physical health, but also mental health issues in this population, and besides that a nurse, a licensed medical professional like that, they add a lot more expertise that's really required for this type of assessment of this population. So that would and then also the Drop-In Center we have currently a contract out with at Carter Denolia Afrie,(sic) a psychiatric—a psychiatrist that clients can see in addition to their outside psychiatrist if they so prefer. We have three there. Two are 9:00 to 5:00 basically. The other one is three hours a day. Increased money so we have three full-time would be great. There's a waiting list to see that project renewal psychiatrist. Perhaps it's that waiting list

that doesn't get people to follow up and see the psychiatrist. We could be doing better there. So, we really thank you for the—this opportunity to testimy—testify. We'd be very interested in showing either of the committee chairs or committee members of the Drop-In Centers to talk more about what we do there because I think there's a whole, you know, untapped need in terms of unsheltered adults. Thank you.

CHAIRPERSON LEVIN: Thank you very much for testifying. I'd be eager to come out and, you know, that—that's—that's--as a result of this hearing, I mean I—I—I do want to see more information and more data coming out about how we can address the needs of our shelters and individuals. You just said that—you said three hours a week for a nurse in your Safe Haven, is that right? Three hours per week? Okay.

NICOLE BRAMSTEDT: Yes, that's three hours a week.

CHAIRPERSON LEVIN: And—and that's your only--?

NICOLE BRAMSTEDT: So we have—one is—we're both part-time. We have at the Safe Haven in

Brooklyn. She comes three hours but she's very nice apparently and she stays the whole day.

CHAIRPERSON LEVIN: Very nice?

NICOLE BRAMSTEDT: Yes, she's very nice, but that's what human service workers do as you know.

CHAIRPERSON LEVIN: Right.

NICOLE BRAMSTEDT: The other one at Travelers is also part-time three hours a day, but she does—they do benefit from the fact that all vary—we have a full-time number.

CHAIRPERSON LEVIN: Okay.

NICOLE BRAMSTEDT: So at the Drop-In Center we have a full-time nurse.

CHAIRPERSON LEVIN: Right but if they're—they're on--

NICOLE BRAMSTEDT: [interposing] But at the Safe Havens we do not have full-time nurses. We cannot.

CHAIRPERSON LEVIN: But just not—not three hours a day, three hours per week?

NICOLE BRAMSTEDT: Three hours per week.

CHAIRPERSON LEVIN: Three hours per week. Okay. Per week additions.

NICOLE BRAMSTEDT: So one day we have part-time.

CHAIRPERSON LEVIN: Per week position?

NICOLE BRAMSTEDT: Yes.

CHAIRPERSON LEVIN: Per week position. Okay. Alright, and that's the same across the board for all Safe Havens?

NICOLE BRAMSTEDT: I--

CHAIRPERSON LEVIN: [interposing] Or is that just you could just speak to yours?

NICOLE BRAMSTEDT: I just speak to mine.

CHAIRPERSON LEVIN: Okay.

NICOLE BRAMSTEDT: But my—my assessment would be that the money in the budget for that line is not—you know, we're trying to kind of--

CHAIRPERSON LEVIN: Uh-huh.

NICOLE BRAMSTEDT: --put money together. That's what we do. We come up with them. So first with the project renewal—renewal, psychiatrists referrals as well as the-the nurses.

CHAIRPERSON LEVIN: And you—you mind if I ask like do you—do you see it in—in an in—do you see an improvement as a result of HOME STAT in the—the quality and quantity of care for individuals that are

either on the street or in your Drop-In Centers or Safe Havens. I mean is—is—is HOME-STAT making a dent?

NICOLE BRAMSTEDT: I think HOME-STAT is good in the sense that it would be able to do more comprehensive outreach throughout the city. As—as Council Member Cohen noted earlier, the—the Bronx—the five boroughs are vast, right, and—and there's a lot of individuals we weren't meeting. I think the HOME-STAT can do a better job in terms of maybe assessing individuals with regards to mental health issues. So, for example individuals who come to our Safe Haven they have come with a brief psychosocial from the their outreach provider.

CHAIRPERSON LEVIN: Uh-huh.

NICOLE BRAMSTEDT: So that helps us, right, because that starts the ball rolling--

CHAIRPERSON LEVIN: Yeah.

NICOLE BRAMSTEDT: --and that helps us, but they're—they're probably—there could be more in terms of what they can do assessing that population.

CHAIRPERSON LEVIN: Okay.

NICOLE BRAMSTEDT: And then also with regards that's—we're not even touching upon, you

know, earlier we talked about when we send people to hospitals, and what hospitals do and how they are always— You're smiling and our Chairman--

CHAIRPERSON LEVIN: [interposing] No, no, no, no. I'm just--

NICOLE BRAMSTEDT: [laughs] Maybe you know about this--

CHAIRPERSON LEVIN: [interposing] No.

NICOLE BRAMSTEDT: --but the—the fact that they release individuals sometimes without adequate assessment and such.

CHAIRPERSON LEVIN: Right, and that's—that's HHC Hospitals or that's just any hospital?

NICOLE BRAMSTEDT: Any.

CHAIRPERSON LEVIN: Any and there's not that kind of standard across the board or there is and just not accurate? [background comments]

NICOLE BRAMSTEDT: [off mic] Standard across the board.

CHAIRPERSON LEVIN: In terms of the—if you said that they're—they're being released without adequate assessment from hospitals, is that—is that just because there's a standard that every, you know,

there's a minimum that everybody is meeting and that standard isn't adequate or is just approved?

NICOLE BRAMSTEDT: Well, so, and this was touched on I think last week, and a little bit earlier today that you can't actually compel someone to receive any kind of services including psychiatric services, unless they're a current present danger to themselves or others, and so if a person, you know, was exhibiting such behaviors and the cops arrive, they're not going to necessarily going to get admitted once the episode is I guess over. To the extent that it ever is over, there will be back onto the street in discharge planning may include for exampled we serve the medication to the person who's stable, but those—it's the appearance of the problem.

CHAIRPERSON LEVIN: Uh-huh.

NICOLE BRAMSTEDT: And so you had actually asked this question earlier talking about the challenges with confidentiality and so on, and my providers are HHC members do sometimes report that there is a disconnect between the hospitals and then the receiving shelter. So if they're going back to a shelter of origin, then I wouldn't necessarily know what those discharge instructions were.

CHAIRPERSON LEVIN: Uh-huh.

NICOLE BRAMSTEDT: Because the patient has a right to privacy. So, there has to be a better way to do some case conferencing and informed consent, and—and talk innovations about how you can improve on that. And I could also just go back a little to HOME-STAT, which I think complicates the matter for some of the outreach providers is that for the first time, they're actually targeting not just the chronically homeless street individuals, but also anyone that's encountered on the street, because they're put in home referrals, which is changing the major of the work. Right, it's a different client, somebody who is not necessarily cognizant and not necessarily known to people. So there's a learning curve happening there, and so the efficacy of HOME-STAT is a given species.(sic) We don't quite know what it would become there.

CHAIRPERSON LEVIN: And would that be helpful for you to understand the affidavits.

NICOLE BRAMSTEDT: I would just like to say that we do street outreach programs, but they're not city contracted. We have contracts with the Port Authority as well as in certain BIDS, and I think how

that interfaces with the HOME-STAT is also important in terms of having more of a one standard.

CHAIRPERSON LEVIN: Sure, sure because it's good to know and amazing, but I thank this panel—Oh, sorry.

CHAIRPERSON COHEN: [off mic] I know these folks who they are. As long as I'm—[on mic] As long as I'm back, and I apologize. I'm trying to juggle a couple of different hearings today. Is there a—and—and I realize you can't simplify down to this, but I mean the goal of getting people out of shelter into supportive house is there sort a—a ratio like if they get—if people get these kinds of services they are much more likely to make it into supportive housing, be successive in supportive housing? Are there particular types of services that you think are most likely to lead someone getting out of shelter and getting into supportive housing. [pause]

NICOLE BRAMSTEDT: Right now it's a matter of inventory. So there's currently I believe six approved supportive housing applications for every unit that's actually available. So it's not so much a service issue as a supply issue. Like we just

need the unit, and then what I can say from evaluations of the city of supportive housing, it really mentions that the lower threshold types of permanent housing programs had higher success rates. So— [background comment]

CHAIRPERSON COHEN: Which—which, yeah.

NICOLE BRAMSTEDT: So for example there is—there were two categories in New York New York Agreement for persons with substance abuse disorders. One required some duration of sobriety prior to being able to access it, and then there was another so-called harm reduction unit where you just had to have a diagnosed disorder, but they weren't as strict as saying documented X number of days of sobriety. So the harm reduction units were actually more successful in getting people in, and they had paradoxically perhaps, although not if you understand harm reduction, higher retention rates. And so I think that what we're finding is the more flexibility that you give people, the more you honor them and the more that you don't force them to achieve some sort of arbitrary milestone prior to housing, the better they do. That's why the safety of model for shelters is always successful, and I think that we can see

that on the permanent housing side similar low threshold come as you are and then we'll serve you works. Housing first works, and so to the extent that we can structure the new agreements to be easier to enter, I think it will do better as long s there is sufficient supply.

CHAIRPERSON COHEN: I believe you.

NICOLE BRAMSTEDT: Yes.

CHAIRPERSON COHEN: Thank you.

DR. BOUCHARD BURNS: [off mic] But, there is that part of it, but it's also the fact that the shelter environment is not a peaceful environment and we have—we have the resources there. We're just not making really good use of it. Part of the problem that I—when I did my testimony is that you're in the shelter, but the clients are outside. So you have your open clinic, and all the providers, but we're not connecting to them because they're forced to leave the shelter. So there's shelters that aren't like that like the BRC in Manhattan, and that's because the environment—the people in the environment don't want the people out on the street. So they—they allow them to stay in the shelter, and with those people they have more connections. So, if we

have more connections as providers, the people that like help people that are in trauma feel more peaceful and to be more resilient in the spaces with trauma. Then we can have a better outcome because of the shelter keeping these folks inside. People are getting more patients away for the housing because things have to be built, and then the whole system will run more fluidly. So that's part of it, too.

CHAIRPERSON COHEN: Thank you.

CHAIRPERSON LEVIN: Thank you very much to this panel. We appreciate your testimony, and look forward to working with you on this legislation. The next panel Josh Goldfein and Giselle Rivera of Legal Aid Society and Coalition for the Homeless; Bradley Rafana, Bronx Works; and Lynette Verges, Care for the Homeless. [pause]

GISELLE RIVERA: Hi. Thanks for the opportunity to testify. I'm Giselle Rivera, Policy Director of the Coalition for the Homeless. We've submitted lengthy written testimony. I'm just going to summarize the main points here. There are a lot of issues connected with mental health issues and—and being in a homeless shelter, and so I'm just going to touch on some of the big pieces. The first one is

staffing, and particularly staff training. Most shelters in our experience are not equipped to handle the needs of individuals with severe mental illness. Without proper training and support, shelter staff are often unaware of how to identify or respond to clients with psychiatric disabilities, improve staff development, and instruction to help staff whose interventions to de-escalate or other avoid conflicts, and engage clients in necessary services. And I include under this as well increased security that has been added to some of the mental health sites. I would encourage you to ask the administration how that security is trained because it's very important that they be trained in de-escalation techniques, and the presence of security and—and could either help or hinder access to mental health services. The others use hospital discharge. As we referenced in the medical hearing individuals are routinely discharged from hospitals to shelters without proper vetting for the appropriate permanence of the placement or actual planning for the placement placing them at risk for preventable—preventable re-hospitalization. Many times clients who have been discharged from a hospital typically wait well into

the night to find out if a bed would be available for assigned shelter, increasing emotional trauma. And there are a lot of issues here that overlap with state regulatory structures and other state priorities. So accessing emergency psychiatric help even for those that are willingly requesting it has become more difficult recently as a result of gate keeping, gate keeping inherent in Medicaid redesign. Notable changes include more limited access to inpatient psychiatric care, shorter hospitalizations and reduce access to preventive services such as well trained intensive case management and ACT Team. For instance, at the Coalition, we have seen clients wait for accessing services as long as year or more even for severely disabled individuals living on the shelters—living on the streets or in the shelters. So improving critical access to community based and inpatient mental healthcare will require the assistance of the state, which licenses both psychiatric facilities and Medicaid managed care plans, and as architect Medicaid redesign. But overall, a particular value for the long-term improvement solutions of supportive housing, which provides stable permanent housing on place support

services for individuals and families in need of extra support such as those with serious mental illness. Through the set path advocacy of hundreds of our partners in the campaign for New York New York Housing we succeeded in winning promises from both the Mayor and the Governor to created 35,000 units of supportive housing statewide over the next 15 years. The City is on track to open their first 500 units of supportive housing scatter sites as Dan Tietz testified, under the Mayor's 1600 commitment. And while the state has made some conditional awards for units, there's a stalemate in Albany currently, as many of you are aware, with respect to the release of the full $2 billion to—Governor Cuomo promised to fund the first 6,000 units of the 20,000 units. So I will also add to that with respect to the supply of supportive housing, the state commitment is all new construction only. So that means even if we get those—those units, roll the ball going on those units, it will be several years before they're available to occupancy. So that's a really crucial piece to actually addressing the issues of mental illness and homelessness. Thank you.

JOSHUA GOLDFEIN: I'm Joshua Goldfein from the Legal Aid Society. We are counsel to the Coalition for the Homeless, and we submitted joint written testimony with Coalition for the Homeless, and we submitted joint written testimony with Coalition for the Homeless today. I would endorse of those comments. I would just add that the Legal Aid Society on behalf of Coalition for the Homeless and Center for Independence of the Disabled—for the Disabled of New York has brought a case called *Butler vs. City of New York* challenging that city's discrimination against people with disabilities including people with mental health issues and disabilities, and we are hopeful that with that—with that litigation we can bring additional resources to bear in the form of the city's practices and improvements to serve clients with disabilities in the shelter system. I just also wanted to highlight a point that I believe Council Member Crowley was trying to make about the change in the census and her—her point seemed to be that there were the increase in the use of hotel units was greater than the increase in the shelter centers as a whole, and I suspect that what may be happening is that she's not

looking at—she's looking at one part of the shelter system but, in fact, the city has been trying to adjust to the tremendous fluctuation in the population in the shelter system. They have been taking certain sites and changing the use as to whether they are for single adults, adult family dependents with children. And so it's possible that someone of the—the map that she's dong doesn't take into account all those different systems, and that may be where there—where the answer to her question is. You can look it up.

CHAIRPERSON LEVIN: So if I could just ask one follow-up question on—you said that there with the—with the—the ACT Program, that you have—you have clients that have waited for over a year to receive the services. So they're willing, they're there, they're either in a Safe Haven, Drop-In or on the street, and—and they're known to be DHS and they're waiting a year for services?

GISELLE RIVERA: Yeah, so this is most of the clients who through our CAP Program, which is our Client Advocacy Program. So we don't run street programs (sic) but we—these are—these are folks that

are engaged with us, and are actually willing to engage in services, but these—

CHAIRPERSON LEVIN: [interposing] And where they're—they're—where are they—

GISELLE RIVERA: They could be in shelter. They could be in Safe Haven. They could be on the street. So it could be any number of things.

CHAIRPERSON LEVIN: Uh-huh, yeah, I know.

GISELLE RIVERA: But yes, and so we've seen these wait times to get actually close to ACT Team, be potentially this long. But—so this is—notably most of this is funded through the state. So I did just find out today that the city is also funding some increase in ACT Team. So it's unclear if that is helping the situation or how much it is. So—

CHAIRPERSON LEVIN: And the—and I'm sorry the—the delay is in lack of resources? The delay is in barriers due to Medicaid qualifications?

GISELLE RIVERA: I'd have to check with my staff specifically, but I think it's resources.

CHAIRPERSON LEVIN: It's not the same—and—and so there's—I mean there's multiple agent—you know, interfaces here. There's ACT, there IMT, Co-

Response Teams. These are all things that is spoken by the Mayor's testimony, the Mobile Crisis Teams. Do you get the sense that that's the case for all of those, or is—or is that something unique to the ACT?

GISELLE RIVERA: I think—I mean Medicaid Redesign is—they've been talking a lot of things, and we've been seeing just some initial data with access to in-patient site care even for those that are requesting it. It seems to be more difficult to actually access. What that—the reasons for that I think at this point are a little bit unclear because there's still some ongoing evaluation of Medicaid Redesign, and there are others on—on our staff who a little bit more in tune to that. We could try to follow up more on just giving you the data that we have, but this is a—just a trend that we've been seeing since the implementation there.

CHAIRPERSON LEVIN: It's very concerning. It's not as if they mentioned in their testimony there's a wait list for services.

JOSHUA GOLDFEIN: I'll just add that from the point of view of the Legal Aid Society, we have—as a public defender we have clients who are only able to be released with the condition of them

leaving incarceration that they have an action in place, that they have replaced the essential wait t of their existing ACT, that they access their ACT Team, and we've had to troubleshoot quite a bit on individual cases getting people released in such a way that their services are replaced for them, which goes to then the questions. I know that they're beginning to undertake if they can get through their kind of data sharing issues, which is the—the kind of revolving door between HHC, DHS and—and Corrections.

CHAIRPERSON LEVIN: Well, it's certainly identified we spoke about it earlier in the 90-Day Review and-and, you know, have yet to present a road map about that.

JOSHUA GOLDFEIN: It's—and—and their explanation has been that the data sharing issues among the agencies have—have been complicated essentially.

CHAIRPERSON LEVIN: And we asked about the data sharing, and they indicate that everything is copasetic on that. So we—

JOSHUA GOLDFEIN: [interposing] I heard them say the MOU was still—was—was being finalized--

CHAIRPERSON LEVIN: Right.

JOSHUA GOLDFEIN: --which doesn't mean that it is so--

CHAIRPERSON LEVIN: I look forward to—to working with you all moving forward, and I appreciate you identifying aspects and challenges that—that did not come up in your testimony.

JOSHUA GOLDFEIN: Thank you.

LYNETTE VERGES: Good afternoon. Thank you to Chairman Levin, Chairman Cohen and the members of the Health and General Welfare Committees for the opportunity to testify today. My name is Lynette Verges and I'm the Director of Social Work at Care for the Homeless. Our agency provides primary care and behavior health services for homeless individuals and families in congregate settings such as soup kitchens, Drop-In Centers, and shelters. I'd like to note that we don't directly operate any of the shelters. We, with the exception of Student Place, which is on of our 200-bed transitional shelters in the Bronx. So we are really on the treatment end of it, but our services are co-located in the facility. It is widely known that the prevalence of mental health issues is much higher among people experiencing homelessness than in general

populations. Yet, the majority of New York City shelters don't have co-located treatment services available. Mental health treatment in the community is often unavailable due to limited access and long waiting periods, and that's not to mention of the barriers such as transportation, lack of childcare. A lot of the parents that we see even to travel to their own treatment appointments don't have adequate childcare and they often have to take their children with them, which create additional barriers for them. In addition, I'm a bilingual therapist. A lot of my clients are monolingual Spanish speakers, and access and treatment in the community for them is even more scarce than the general population. So there are a multitude of factors why they don't access treatment in the community as readily as they should. With that being said, home--mental health homeless clients and families are often in crisis when they first come to the shelter system, and they need treatment and support to help them maintain stability. While this is the need, it is often not the priority in the midst of crisis as they work to ensure that their basic needs are met. Things like clothing, food and entitlements and other benefits that they need. When

individuals and families have treatment on-site, which is accessible and available, this translates into better health outcomes. Clients are able to speak and maintain employment, transition successfully into permanent housing, and do well in their community. Children and adolescents are able to perform better in school, and transition out of homelessness successfully. Homeless clients face many systemic barriers in accessing entitlements, health insurance and housing, but if treatment is available at all New York City shelters, it provides an essential opportunity for clients to receive the treatment needed to transition from clients—from crisis—excuse me—to stability. Please consider doing whatever is necessary to provide appropriate critically needed and co-located mental health treatment services at New York City Shelters. It is the right thing to do. It will provide far better outcomes for the families, children and adults in the shelter system, and far better outcomes for community. It is a cost-effective approach ensuring homeless people have the opportunity to achieve their highest potential. Thank you.

CHAIRPERSON LEVIN: Than you.

BRADLEY RAPANUT: Good afternoon, Chair Cohen, Chair Levin, Council Members, staff. Good afternoon and thank you for the opportunity to speak on this issue on the bill—the proposed bill for addressing the mental health needs of the homeless population in New York City. My name is Bradley Rapanut. I'm a Program Director with Bronx Works, and I over see one of our Safe Haven programs in the Bronx, which has 175 shelter beds for homeless adult men. We as an agency are large and worked across the Bronx since 1972, and we run a host of programs including after school community and senior centers, ESL classes, food stamp access and a bevy of homeless services, including prevention, family shelters, homeless outreach, the only Drop-In Center for homeless adults in the Bronx, Safe Haven programs and permanent supportive housing. We're proud of our collaboration with DHS. It has allowed us to provide innovative solutions that have helped reduce street homeless in the Bronx by 80% between 2005 and 2015. Since we provide a continuum of care for homeless individuals and families beginning from street outreach through traditional housing and successful place in deferment housing. We have an in-depth

understanding of the wraparound services that are needed in order to move someone from homelessness to permanent housing. Mental health care is an integral part of the necessary services to address the wide range of mental health challenges our clients face. The mental health needs of our adult population— homeless population are especially complicated and often contribute to individuals' continued homelessness. In our adult homeless facilities, we have found that approximately 30 to 50% of our clients self-report experiencing mental illness of which approximately one-third have a diagnosed serious mental illness such as schizophrenia or bipolar disorder. Additionally, between 30 to 70% report they currently struggle with or have a history of drug or alcohol use and 30 to 50% report disorder of both mental health and substance use disorders. Further, we have identified that about 10% of the heads of household in our family shelters experience a serious mental illness, and after care programs of our family shelters 68% of them report experiencing complex trauma. For these reasons, we support this bill because it will serve as a valuable starting point from which to drill down on the core issue at

hand, which is the inability of the shelter system and hospitals to effectively collaborate in order to best mental health needs and housing needs of homeless people in New York City. At this time, GHS and the hospital systems are unable to effectively coordinate in-patient care from the hospital to shelter and vice versa. Homeless individuals are often admitted to a psyche emergency department, and after being prescribed the medication and regimen, are often discharged after a few days. In the case of a person with co-defense (sic) order, often we find that they are discharged or that they're not even seen by a psychiatric unit, but rather treated directly for intoxication and then discharged from the ED. In another scenario, upon discharge individuals may end up returning back to the streets after being referred to a homeless intake center, or if they do make it to a shelter they're at risk of another mental health emergency because of the lack of information sharing and coordination regarding the client's diagnosis, medication and treatment. Homeless individuals with mental—mental illness often cycle through the same pattern repeatedly. One example out of many is a 65-year-old Hispanic male in

one or more programs who reports being homeless since the age of 16, and his documented shelter is ranging back to 1997. He has been diagnosed with Schizophrenia and Polysubstance Use Disorder as well as Diabetes and Cirrhosis of the Liver. The earlier psychiatric hospitalizations that he remembers was his early 20s during which time he reports he said that he heard voices. He has been in and out of shelters, Safe Havens, Drop-In Centers and treatment programs without reporting much success. While currently in one of our programs he's—we have seen him cycling in and out of hospitals while his ability to manage his medical and mental health conditions has not improved. Cases like this serve as a prime example of how the accessibility of information sharing throughout shelters and hospital systems could help to facilitate coordinated care and improve quality of for those who are most vulnerable. Further, there's a significant population of homeless—hospital homeless individuals who completely circumvent the shelter system due to the breakdown in communication. For example, during this year's Hope Count, which counts all street homeless individuals in the city, during one of the coldest nights in the

season, 47 individuals were counted on the street in the Bronx. However, the Bronx Health and Housing Consortium conducts a parallel count of all homeless individuals staying in hospital waiting rooms, hallways and emergency departments. The consortium counted 87 homeless individuals across nine Bronx hospital locations, which is nearly double the Hope Count total. The majority of these individuals reported more than 10 emergency department visits in the past year. As these are currently not including the Hope Count, the shelter system is missing the opportunity to provide services for these individuals. Unless an individuals is registered in the DHS Care System, and has a documented history of homelessness, there are unable to receive priority for permanent housing placement opportunities in the City that meet the criteria for being chronically homeless. For this reason, it is a vital that hospitals be required to report on the number of referrals it makes in the shelter system as some individuals referred to shelter did not successfully make it and returned to the street instead and thus fall through the cracks in the system. At present, the shelter system is often falling short of

providing appropriate wraparound services for these individuals to improve their mental health outcomes. The proposed bill will provide an opportunity to develop further insight into how these issues can be addressed, and would open up communication to help coordinate care of these individuals between social services and mental health providers. Since March of 2016, the Bronx Works Homeless Outreach Team has engaged over 500 homeless individuals in the Bronx, hospital emergency departments and of those, they transport over 120 to either shelter or a Drop-In Center. On average, Bronx Works receives over 28 per month from hospital staff regarding the discharge of homeless patients. This clearly dem—demonstrates the need for an open line of communication between shelters and hospital to ensure smooth discharges and lower the number of readmissions due to poorly coordinated care. One of the easiest ways to begin this collaboration is to grant hospitals access to DHS Cares' database system. This database provides information about individuals with street homelessness, medical and psychiatric conditions, and information about their last shelter stay. It is vital that the hospital be given access to this

system so that mental health providers in shelters can effectively share information to best serve homeless people with mental health needs. If hospitals could send a discharge summary through CARES when returning or referring an individuals to the shelter system. It would head off many of the mental health emergencies that force homeless people to leave shelter and re-enter the hospital. In addition, unless an individuals is registered in the DHS CARES system they may not have access to some permanent housing opportunities because of their length of homelessness is not documented. Granting— or this could be particularly problematic if the person has been circumventing the transition— traditional shelter system by using hospitals or other non-shelter facilities as a de factor place of residence. Many mental health providers including hospitals' access to the CARES system will allow for hospitals, social service and shelter providers to work together and build a comprehensive picture of the client's needs including the length of homelessness so that individual for more housing opportunities. Alongside access to CARES is both hospitals and the shelter providers should be able to

directly report clients to mental health shelters instead of forcing high needs clients to go through the normal intake and assessment centers. We have found that this can be extremely challenging for individuals with mental health needs especially if they have a serious mental illness. It often may be an experience that re-traumatizes the person. This current process is ineffectively using the expertise of mental health professionals at hospitals and shelter providers who should be able to direct these clients directly to program shelters when appropriate. Another issue that's presented by the current state of mental health services in the shelter system is that most psychiatric services provided in shelters are focused on documentation and diagnosing for the purpose of submitting the housing package versus providing ongoing psychiatric treatment. Often mental health treatment is left up to often referrals, which we have seen varying success in client follow-through. This balancing has been more closely considering DHS in order to better serving the health needs of clients. One additional area of concern between the shelter and hospital systems, one that is common, is the need for assisted

outpatient treatment or assertive community treatment teams. These services, which are outlined in Kendra's Law are aimed at supporting individuals with serious mental illness who are assessed by licensed professionals who present a danger—danger to themselves or others in the community, if not supervised and have demonstrated unwillingness to voluntarily engage in treatment or services. The use of AOT is to prevent the relapse or detour ratio in functioning, which would likely result in serious harm to themselves or others. These services are particularly challenging to coordinate for the homeless population as they require that individuals have a fixed address outside of the hospital. In our experience, we have often—we often have hospitals contacting us asking to use the address of our Drop-In Centers in order for AOT to be provided. A more coherent plan needs to be adopted for servicing the mental health and housing needs of the exceptionally vulnerable population. We are at a critical junction in this discussion, and the climate is right for mental health needs and homeless services to come together to address the mental health and housing needs of the homeless. Great information sharing

through hospital access to CARES is changing the referral process for program in mental health shelters, while closely examining AOT and ACT Regulations as pertaining to the homeless population and the reporting requirement listed in this bill are concrete solutions that can be implemented at this time to address the larger issues surround the social determinants of health. Once again, thank you for your time and attention to this testimony. Bronx Works looks forward to continuing our collaboration with DHS to find valuable solutions toward meeting the needs of New York City's homeless population. We welcome the opportunity to discuss these issues further with you and DHS.

CHAIRPERSON LEVIN: Thank you very much for that testimony. I—I want to thank this panel very. Oh, sorry. Andy.

CHAIRPERSON COHEN: I'm—I'm sorry. [laughs] I'm not telling Steve my last question. When I—I add for Legal Aid, are you collaborating? I forget you're—you're from the first?

GISELLE RIVERA: Yes, it is the Coalition for the Homeless.

CHAIRPERSON COHEN: The Coalition for the Homeless has experienced that it could take up to a year to get access. You know, are people staying incarcerated because they can't get ACT services?

JOSHUA GOLDFEIN: What we experience is that people who are—could be released, but have only shelter as homeless Corrections housing option. They may already be connected. Either they've been—their—their release is conditioned on them being connected to a particular service including ACT Team, or they've already been connected to a team, but that team could only serve a particular geographic area. And so, in order to keep everything together, DHS would have to prearrange for that person to be discharged into a shelter that is in—that can be served by that team. And so, yes, we have experienced delay of getting people released, and because of lining up all these services and—the—the—putting—integrating the services in a way that—that I think it would all really make sense.

CHAIRPERSON COHEN: Are we talking about a year? Are we talking about week? What are we talking?

JOSHUA GOLDFEIN: I—I should consult with—with our Borough Relocation staff and the social work staff, and the criminal practice, and—and on the civil practice in the homeless project, but we can absolutely get back to you on that.

CHAIRPERSON COHEN: I appreciate that, and I—I—I also just want to say for Bronx Works, my office has worked closely with Bronx Works, and—and- and I think the work that you do is vital and—and—and that you're a tremendous asset to the Bronx. I want to say thank you for that. I'm curious about, you know, your testimony about the Hope Count because again I—in fact, I'm pretty sure that—that Bronx Works is involved in the—in the case where we had a fellow living in—in Van Cortlandt Park, and—and this fellow was living deep in Van Cortlandt Park and—and he'd been there for quite a while because he was accumulating a lot of stuff. He was finding trash and things that he decided that he wanted to bring into the park, and by—by the time he was discovered, he had accumulate quite a lot of stuff, and I think that—again, I think that Bronx Works was—was ultimately involved in him getting out, and I think that ultimately—I'm not sure that he was ever

transitioned into the permanent shelter. He may have dropped off, but again I'm not sure, but I'm curious as to what you thing the-the accuracy of the Hope Count and, you know, in the vastness of the Bronx people sort of again become very obscure or, you know, hidden away places for, you know, for security or whatever, you know, whatever makes sense. Because that number seems very low to me, the number of street homeless in the Bronx. I'm curious that we think that—that we're missing a lot of people.

BRADLEY RAPANUT: I think there a couple of things around this issue. I think with the Hope Count obviously. You know, I participated awhile ago myself, and sort of there is predetermined routes that volunteer teams take to sort of address and look for people who may be street homeless during that night. So, you know, I—I don't know exactly how those maps are determined or—or predetermined. So that could play in effect on who's being captured. I would like to say, though, I think for average team, we do canvassing near Bronx and the other outreach teams, I want to give them their due credit. I do think that they do tremendous work. I do think they know their population, and their boroughs very well.

I do know that they—for a fact they go to the hard to reach places to find those people specifically because quite frankly these are the people who are the most in need, and who are most likely to not have access or to not want to have access for whatever reason. However, it's our—we find it's our job to then take those services to them directly as much as possible. So in terms of the—the accuracy of that count, you know, I think one of the—one of the things that was mentioned earlier today it's sort of, you know, I think it's—it's going to be accurate, but it's how much are we off, I think is—is the question, and to that I'm not really 100% sure. I do think we're going a great effort in trying to track that number, but I do think there's areas of challenge or areas that we are not fully exploring like the hospitals that are non-traditional that we should be paying a bit—a bit more attention to.

JOSHUA GOLDFEIN: If I could just add that the Coalition for the Homeless every year has published a critique and methodology of the Hope Count on its website. The Legal Aid Society also has a lot of concerns about how to—how it's conducting and -and we believe there is a significant

undercount. In particular, there's a separate count for runaway and homeless youth, and I sat through two days of depositions about the methodology for that count, which—in which the city determined two years ago that there were 188 homeless youth on the streets of New York, and last then they said it went down this year to 160 something. I think we all believe that's a—a dramatic undercount. The most recent estimate that we consider to be more accurate is in the thousands. So, that's a—that's also a population that is—has extremely high levels of—of needs for mental health services, and it's being underserved, as you know, [off mic] and it's really significant.

CHAIRPERSON COHEN: I should probably look into it more specifically because the Eleventh Council District, you know—you know, and—and many Council Members talked about the diversity of their district. But I also—I have tremendous economic diversity, and in, you know, in Riverdale like there's a neighborhood—I don't know if this is really the name, but I--I always refer to it as the Estate Section. I think people call it the Estate Section, but it—then there's this Riverdale Park, which is primarily like forest with trails, but I was there

not that long ago and I did see—and I didn't see anybody living there at the moment, but I did see evidence of somebody living there. And I thought to myself like this is a—really as remote a corner of the city as you could possibly get, and I wonder, you know, if—if we're able to, you know, and I know, you know, Pelham Bay Park is a huge park. People could go in there and—and again, Van Cortlandt Park itself has a lot areas that are forever wild, but—so it's—it's hard to find out what's going on there. Thank you very much for your testimony.

JOSHUA GOLDFEIN: Thank you. [pause]

CHAIRPERSON COHEN: The next panel Christina Sparek (sp?), Regina Clark, Esther Wilson, [coughs] Wendy O'Oshoed, O'Shed, O'Shoe. (sp?) [pause] Good afternoon. As soon as you're ready, please.

WENDY O'SHIELDS: Pardon me. I left my reading glasses at home. [laughs] So anyway. My name is Wendy O'Shields and I'm testifying for—as the safety net activist three years, five years, twelve years or longer are some of the time periods served by the Department of Homeless Services shelter residents who are mentally healthy. Many of the over

40 mentally health residents are residing in the DHS shelters because of lack of work or because their wages are not sufficient to pay market rent. The mentally healthy are overcrowded and mixed in with the mentally ill and mentally ill violent residents. The lack of proper treatment and services for these mentally ill—with mental illness creates an unstable environment that affects everyone, both those suffering from mental illness and other shelter residents. This environment is inhumane and criminal. This environment severely threatens the safety and lives of the mentally healthy residents. Many mentally health residents develop stress related physical illnesses as a result of their daily exposure to the unhealthy environment. There are many mentally healthy residents in the DHS shelter system. They have historically been hidden from the general public, or have been ground down over time into MICA as a result of the traumatic environment. DHS best practice of mixing all individuals with no services or treatment for the mentally has been in place for decades. They call it general population. Is the purpose of DHS policy to—to compromise the physical and mental health of an otherwise fully

functioning New Yorker? Does DHS believe that leaving mental illness untreated is acceptable? Does DHS prefer to take their chances with the beatings doled out by the emotionally disturbed persons? Are the occasional murders of DHS residents statistically acceptable for the City of New York? Mentally healthy, educated with a work history and current or former taxpayers should not be allowed to deteriorate in every way during long-term tenancy with DHS as their landlord. Instead, the mentally healthy should be fast tracked into independent permanent housing with housing choice vouchers, HPD, NYCHA and other permanent housing, which they are eligible. Mentally ill residents can be prioritized for some of the same programs or supportive housing as appropriate. Please enforce the DHS Homeless Priority Codes for HPD affordable housing, NYCHA and other New York City permanent housing agencies. Please consider my suggestions to correct the crimes and progress against all DHS residents. Thank you for hearing my concern.

REGINA CLARK: Good afternoon. My name is Regina Clark. I'm Deputy Director of My Time, Inc. (sic) This is—it's a little club of advocates and

it's been seen Spiral. (sic) I want to thank you for giving us the opportunity to be here to testify before you on the experience of one of clients from My Time, Inc. who is currently in this mental health shelter. Closely, My Time, Inc. is a not-for-profit organization that provides support, education, advocacy and emotional wellness wheelchairs for parents of a child with Autism and any developmental disability. We have been providing services to the community for nearly nine years. We are here on behalf of our parents speaking out on the need to provide effective mental health services to individuals or families in the shelters. We are here hopefully to provide the solution, which may aid in your decision making, or providing effective and efficient mental health services to individuals.

The Case: Hispanic woman age 43 is displaced from her home due to a domestic violence situation. Everything seemed to go wrong. First, the initial process of going into the shelter, asking the security guard a question, and not being told—not—and not being treated as a human being. Secondly, the intake process, and finally, being placed in the mental health service. While placed in dispenser

(sic) her refined story she tells of living there, getting minimum services, insulted and treated unfairly. When she asked questions to make inquiries of their programs, she was spoken to in such a belittling manner. This individual still lives in a shelter. She's in a different one right now because she felt her life was being threatened. She complies with the rules, but to no avail services demand. She finally gets a voucher, LINC card to find an apartment. She felt that—that this will change her life. Unfortunately no. There are many challenges she faced as she looks for the apartment. There are roadblocks, bureaucracy, and minimum support for the individual the individuals of the shelter. The team here is proposing three solutions: Show people what is the response—solution if the homeless shelter is the model of crisis respite center. What a crisis respite center provides an alter—alternative to hospitalization and even the center for people experiencing emotional crisis because even for persons who are experiencing domestic violence, while the family was placed into shelters with mental health individuals, even though you're going through a crisis, yes you're going through emotional problems

or emotional situation, but being planted in mental health shelter is increasing more of the emotional instability. By having these crises respite centers and accepting their warm place and supportive homes like places to rest and recover. DHS accepts to one week, and provides an open door setting where people can continue their daily activities. The staff will be trained peers and non-peers who work with individuals to help them successfully overcome emotional crisis or develop a plan to move forward. PS specialists are people who lived with the experience to focus on the work of recovery.

Solution to which is the main thing, affordable housing. That has always been a big problem here in New York City, and now I live in Brooklyn. We can't even afford to live here any more even affordable housing. So I think that issue has to be dealt with, and even I remember your Councilwoman Crowley has asked DHS, you know, if it's coming from the budget, why are these things not being done. Like one of the clients she said we're having a cell phone, we think what for free cards works the best is. If they give you a voucher, find me the property and you can have a—a better improved and home to live

in. So one of the big the crisis for housing. I have another solution. Another solution is education. Let's talk about it. There should be workshops and forums giving people the tools to know how to ask for help when they—where they seemed stress all over them. Let's talk conversations where people can feel safe, and not threatened because of their mental illnesses. Some mental health professionals I know they're compassionate or empathetic to the needs of these individuals in the shelter. There should be more training in dealing with an individuals with a mental disability. Proper senses of support and resulting of them made available. Sometimes the language has to change. There is such a title on one with mental illness. (sic) Let's focus on emotional wellness. Let's really start checking in on all emotions than ever. Thank you so much for giving us this opportunity to speak, and I know that the City Council is on top of everything, and it's really important to be here to learn more about the mental health crisis in our communities. And as we work with families' with disabilities we're seeing more for a family in crisis, emotional crisis, but even being displaced of

their homes with landlords or whatever, they're disabilities. So I want to thank this piece to offer them. Opening solutions we did. It is something possible.

CHAIRPERSON COHEN: Thank you. In both of your testimonies just rang very true as being from the frontlines and based on natural experiences, and I—I felt that. I appreciate you taking the time and giving your testimony.

REGINA CLARK: Thank you.

CHAIRPERSON COHEN: Are we—no more pals. Chair Levin, I'm going to conclude this hearing unless there's something else you want to say.

CHAIRPERSON LEVIN: I just want to say to this panel I apologize that I just stepped out for a moment.

REGINA CLARK: It' alright.

CHAIRPERSON LEVIN: I will—I will—I will review your testimony. We have this recorded for online viewing--

REGINA CLARK: Thank you.

CHAIRPERSON LEVIN: --and I will as soon as it's up on line, I go back and I—I do apologize. I had to step out the room.

CHAIRPERSON LEVIN: I know you're being here. [laughs]

CHAIRPERSON LEVIN: But very—I look forward to working with you all and seeing the report on this legislation.

REGINAL CLARK: Thank you so much.

CHAIRPERSON LEVIN: Thank you.

[gavel]

C E R T I F I C A T E

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

Date December 14, 2016