

CITY COUNCIL
CITY OF NEW YORK

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TRANSCRIPT OF THE MINUTES

Of the

COMMITTEE ON MENTAL HEALTH,
DISABILITIES AND ADDICTION

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December 17, 2025

Start: 1:18 p.m.

Recess: 3:03 p.m.

HELD AT: 250 Broadway - 8th Floor - Hearing
Room 1

B E F O R E: Linda Lee,
Chairperson

COUNCIL MEMBERS:
Public Advocate Williams
Shaun Abreu
Erik D. Bottcher
Tiffany Cabán
Shahana K. Hanif
Farah N. Louis
Darlene Mealy

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

Rebecca Linn-Walton
Assistant Commissioner for the Bureau of Alcohol
and Drug Use

Dr. Jean Wright
Executive Deputy Commissioner for the Division of
Mental Hygiene

Jamie Neckles
Assistant Commissioner for the Bureau of Mental
Health

Sofina Tanni
Asian American Federation

Yuna Youn
KCS

Zarin Yaqubie
Arab American Family Support Center

Dr. Van Yu
Center for Urban Community Services

Irvin Dana Beal
Act Up

Bridgette Callaghan
Institute for Community Living

Paula Magnus
Northside Center for Child Development

Christopher Leon Johnson
Self

Alex Stein

Grace Nicholas

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2 SERGEANT AT ARMS: This is a microphone check for
3 the Committee on Mental Health, Disabilities and
4 Addiction recorded on December 17, 2025, located in
5 Hearing Room 1 by Nazli Petuvie(SP?).

6 SERGEANT AT ARMS: Good afternoon and welcome to
7 today's New York City Council hearing for the
8 Committee on Mental Health, Disabilities and
9 Addiction. At this time, please silence all
10 electronic devices. If you would like to testify,
11 you must fill out a witness slip with one of the
12 Sergeant at Arms. No one may approach the dais at
13 any time. Chair, we are ready to begin.

14 CHAIRPERSON LEE: Okay great. [GAVEL] Good
15 afternoon everyone. My name is Council Member Linda
16 Lee, Chair of New York City's Council Committee on
17 Mental Health, Disabilities and Addiction. Before we
18 begin, I'd like to recognize that we are joined here
19 by Council Members Cabán, Bottcher, our Public
20 Advocate Jumaane William, oh Council Member Mealy,
21 who I think stepped out and also Council Member Hanif
22 on Zoom.

23 Today, the Committee will discuss the Department
24 of Health and Mental Hygiene systems for measuring
25 outcomes and equity in city funded mental health

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2 programs. Accurate, complete and consistent data
3 collection allows policy makers to assess whether
4 programs are meeting their intended goals. Robust
5 data collection and transparency, not only helps to
6 identify what's working and what isn't but also
7 ensures that resources are directed to programs that
8 provide the greatest benefit to communities.

9 When we talk about mental health specific
10 programs, the evaluation of program outcomes is
11 especially salient given the direct impact that these
12 programs have on New Yorkers lives. By
13 systematically measuring outcomes in equity, we can
14 make evidence based decisions that improve
15 accountability and ultimately strengthen the impact
16 of mental health services across the city.

17 Every improvement in a programs outcome is an
18 improvement in someone's life and it's our role as
19 the City Council to make sure those results are
20 reliable and transparent. I look forward to learning
21 more about the ways that DOHMH evaluates programs in
22 its mental health portfolio and the ways that the
23 Council can continue to support and strengthen their
24 program analysis and data collection.

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2 In closing, I want to thank the Administration
3 for being here today as well as members of the public
4 for taking the time to testify on this important
5 topic and I would also like to thank the Committee
6 Staff who work to prepare this hearing as well as my
7 own staff and on a just personal note, I love this
8 topic of data, so I'm actually really excited about
9 this hearing. Not to sound a little nerdy on this
10 but I think data really does help us inform a picture
11 of what's happening in the landscape of the city our
12 mental health program. So, thank you so much for
13 being here and without further ado, I will pass the
14 mic over to the Public Advocate.

15 PUBLIC ADVOCATE WILLIAMS: Thank you Madam Chair.
16 I just want to make sure on the record; I say
17 congratulations to New York Knicks. They're the best
18 team in the NBA today, so I had a great night.

19 Good afternoon. As mentioned, my name is Jumaane
20 Williams, Public Advocate for the City of New York
21 and I thank Chair Lee and the members of the
22 Committee on Mental Health, Disabilities and
23 Addiction for holding this important hearing. Almost
24 one in four adult New Yorkers experience a mental
25 health disorder in a given year. Mental illness

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2 effects people across all communities and
3 demographics, wealthy and poor, young and old, Black
4 and White. Not everyone is able to access treatment
5 and not everyone who accesses treatment gets the kind
6 of care they need.

7 There are many reasons why New Yorkers who need
8 mental health care either do not or are unable to
9 access it including cost, stigma, language barriers
10 and logistics. A report published this year by DOHMH
11 found that in 2023, about 14 percent of New Yorkers,
12 almost a million people, reported that they were at
13 one time in the past year, that they did not get the
14 mental health treatment they needed.

15 Many people face barriers accessing treatment
16 because they do not have health insurance, which
17 makes city resources all the more important,
18 especially with Medicaid cuts looming. As is the
19 case across the healthcare more broadly, Black, Brown
20 and indigenous people feel worse when it comes to
21 receiving effective mental health treatment. The
22 vast majority of psychologists in the United States
23 are White and most offer services only in English.
24 This can make it difficult for people with more color
25 and in the midst to find the culturally competent

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2 provider which has consequences, including
3 misunderstandings, diagnosis, under diagnosis,
4 discrimination, and ultimately ineffective and
5 misguided treatment. One US Surgeon General report
6 found that people of more color experience a greater
7 burden of disability for mental illness. More likely
8 suffer from prolonged chronic and severely
9 debilitating depression that effect their daily
10 lives. Compared with their White counterparts
11 because they often receive less care and poor quality
12 care.

13 The reasons why mental health professionals are
14 disproportionately White or varied in complex but
15 include a historical racism in the mental health
16 field and the high cost of the higher education
17 required to enter the field. The federal
18 government's recent announcement that nursing, social
19 work, and other public health fields are no longer
20 designated as "professional degrees" and is
21 ineligible for a higher limit on federal student
22 loans will only raise a financial barrier to graduate
23 with education for perspective health workers.

24 During this time when "DEI" has become a culture
25 flash point in efforts to increase diversity in

1
2 various fields are being undermined or entirely
3 eliminated, we must step up to ensure that our mental
4 healthcare workforce is diverse, not only in identity
5 but in experience. LGBTQ+ people in New York and
6 across the country, especially trans people are under
7 threat by this presidential administration. The
8 LGBTQ+ community and transgender people in particular
9 are at higher risk for suicidal thoughts and suicide
10 attempts with 40 percent of transgender adults having
11 attempted suicide in their lifetime.

12 With growing barriers to gender affirming care,
13 we would like to see that number increase. A brief
14 from DOHMH published this year reported the
15 prevalence of Serious Psychological Distress, SPD was
16 higher among LGBTQ+ New Yorkers when their
17 heterosexual or heterosexual counterparts are
18 transgender adults were two to three times more
19 likely to experience SPD than cisgender adults.

20 Those with multiple marginalized identities like
21 queer and/or transpeople of more color may experience
22 even more heightened stress.

23 Last, my office released a 2025 update to our
24 original 2019 report improving New York City's
25 responses to individuals in mental health crisis,

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2 which we also updated in 2022. In it, we
3 acknowledged where the city has improved and
4 resources for those in crisis but there are too many
5 places where we must and can do more. We tend to
6 focus on the moment a person is in crisis and needs
7 assistance but we also must dedicate resources far
8 before that happens, when young people are considered
9 whether they wish to pursue a career in the mental
10 health field.

11 Scholarship and loan forgiveness programs
12 creating jobs that pay a living wage and expanding
13 training opportunities prepare us to work in mental
14 health will encourage additional people with more
15 color and those with lived experience to pursue this
16 as their career and the unique perspectives and
17 talents to the people of New York City.

18 Looking forward to hearing the data as well,
19 seeing how we can improve care. Thank you.

20 CHAIRPERSON LEE: Thank you Public Advocate and
21 on that note, I totally fully support those
22 statements because in a lot of the work that we did
23 in my former role as a nonprofit leader, uhm it was
24 frustrating because we often couldn't send our
25 constituents and community members to services where

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2 they would receive you know in language services or
3 culturally competent services and part of it was we
4 need to help build that pipeline and make sure that
5 they're looking at these careers. I know when I told
6 my parents I wanted to go to social work school.
7 They're were like, what? What's that? So, I have to
8 you know we have to educate our own communities and
9 make sure that we're creating a pathway to them
10 that's affordable as well, so that they can get wages
11 as well. So, thank you for those statements.

12 Uhm, I will now turn the mic to the Committee
13 Counsel to administer the oath to the members of the
14 Administration.

15 COMMITTEE COUNSEL: Now in accordance with the
16 rules of the Council, I will administer the
17 affirmation to the witnesses from the Mayoral
18 Administration. Please raise your right hand. Do
19 you affirm to tell the truth, the whole truth, and
20 nothing but the truth in your testimony before this
21 Committee and to respond honestly to Council Member
22 questions? Thank you. Prior to delivering your
23 testimony, please state your name and title for the
24 record and you may begin when ready.

25

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2 DR. JEAN WRIGHT: Good afternoon. Can you hear
3 me, okay?

4 CHAIRPERSON LEE: Yes.

5 DR. JEAN WRIGHT: Excellent. Good afternoon
6 Chair Lee and members of the Committee. I am Dr.
7 Jean Wright, Executive Deputy Commissioner for the
8 Division of Mental Hygiene at the New York City
9 Department of Health and Mental Hygiene, the Health
10 Department. I am joined today by Jamie Neckles,
11 Assistant Commissioner for the Bureau of Mental
12 Health, and Dr. Rebecca Linn-Walton, Assistant
13 Commissioner for the Bureau of Alcohol and Drug Use.
14 Thank you for the opportunity to testify today.

15 The Health Department recognizes that mental
16 health and well-being are central to overall health.
17 The Mental Health Division puts this into action by
18 employing a public health approach to supporting the
19 mental health and behavioral health of all New
20 Yorkers. We serve as the city's mental health
21 strategist and work with more than 200 community
22 providers to deliver over 800 mental health programs.

23 First, I'd like to share our vision for mental
24 health for New York City, which shapes our desired
25

1 outcomes, divisional strategy, and day to day
2 operations.
3

4 A public health approach to mental health aspires
5 to a future where every single New Yorker lives with
6 dignity and meaning. Everyone has access to the
7 resources they need to thrive, to live and to live
8 their full potential. New Yorkers understand the
9 importance of mental health, have access to service
10 they need, and know how to access them and where New
11 Yorkers are free from stigma, oppression, and the
12 consequent health disparities.

13 The Health Department is organized around this
14 ultimate vision. I want to uplift what Acting Health
15 Commissioner Dr. Morse shared in her testimony on
16 Healthy NYC, the city's campaign for improving life
17 expectancy. Most New Yorkers did not live to see
18 their 50th birthday when the Health Department first
19 started calculating life expectancy in the early
20 1900's. Today, our latest data shows that New
21 Yorkers can expect to live into their eighties.
22 Transformation has happened and remains possible,
23 especially when there's support for public health
24 infrastructure.

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2 I'll now turn to our work today in the Mental
3 Health Division. The Health Department is the city's
4 mental health strategist. We stand at the nexus of
5 the city's mental health system - serving as a
6 linkage between the state, the city, hospitals,
7 providers, peers, communities, and experts. We
8 provide decision makers, and the public, with
9 population health data on mental health outcomes,
10 paired with guidance and collaboration in acting on
11 it.

12 First and foremost, we look to health outcomes to
13 measure the wellbeing of our communities and inform
14 program strategy.

15 For example, Healthy NYC identified key drivers
16 of life expectancy, including two mental health
17 outcomes, suicide deaths and drug overdose deaths.
18 The Health Department developed ambitious goals to
19 reduce both drivers and closely monitor progress in
20 these outcomes.

21 Suicide is one of the top ten leading causes of
22 premature death. After a slight reduction in the
23 suicide rate in 2018 to 2019, rates climbed during
24 the COVID-19 pandemic. Provisional data for 2023 and
25 2024 show a slight decrease, a 2.5 percent decrease

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2 compared to year 2021, showing a return to the
3 previous levels. Overall, suicide rates remain
4 mostly level over the long term. We are committed to
5 our goal of reaching a ten percent reduction by the
6 year 2030.

7 Regarding overdose, our most recent data shows
8 progress with reduction in drug overdose deaths.
9 Following years of increases that cost New York City
10 nearly 20,000 lives since 2016, the number of
11 overdose deaths decrease by 28 percent in 2024.
12 Residents of all five boroughs saw decreases, while
13 significant racial and geographic inequities persist,
14 overall deaths decreased among Black and Latino New
15 Yorkers for the first time since 2018.

16 This information is essential for understanding
17 the health of New Yorkers and guiding our
18 programmatic investments. Our mental health programs
19 are diverse, ranging from direct services to systems
20 change interventions. We identify unique outcomes
21 for each program to measure service quality impact
22 and successful program implementation.

23 For example, the Intensive Mobile Treatment or
24 IMT program was created almost ten years ago because
25 we saw an unmet need and responded with innovation.

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2 IMT serves individuals with high service needs that
3 are not being met in traditional mental health
4 outpatient settings. IMT consists of teams working
5 in the community who provide long term support to
6 people with serious behavioral health concerns and
7 complex life situations that may include transient
8 living situations and housing instability and/or
9 involvement in the criminal legal system.

10 Stable housing is a program outcomes we monitor
11 in IMT because many referred individuals are unhoused
12 at the time of enrollment. In Fiscal Year '25, the
13 proportion of those stably housed increased by 23
14 percent the first and most recent year of enrollment.

15 Individuals referred to IMT often have a history
16 of involvement in the criminal legal system. So,
17 this is another key program outcome we monitor. IMT
18 teams provide support to prevent participants further
19 involvement. Among IMT participants served in FY25,
20 the proportion of those with jail admissions in the
21 New York City Department of Correction system
22 decreased by five percent between pre-enrollment and
23 the most recent year of enrollment.

24 If we look at supportive housing, the program
25 outcomes are different. The mission of supportive

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1 housing is to provide dignified, safe and affordable
2 housing as a platform for health and recovery. While
3 we monitor aspects of service quality and tenant
4 outcomes, the number of supportive housing units
5 available in itself is a critical program outcome.
6 We currently contract for 12,817 units of supportive
7 housing and are on track for 13,000 units by the end
8 of the calendar year.

9
10 Lastly, I'd like to highlight the Outreach and
11 Syringe Litter Teams. These teams conduct outreach
12 to people who use drugs in public in order to provide
13 naloxone and connect people to treatment, healthcare,
14 and resources to meet their basic needs. They also
15 respond to community concerns of syringe litter.
16 There are currently six teams, operated by five
17 contracted Syringe Service Programs. In 2024, these
18 teams cleaned up and safely disposed of more than
19 199,000 syringes, initiated over 25,500 participant
20 engagements and made more than 8,000 referrals to
21 additional care services. To expand on this work,
22 soon all 16 Syringe Service Providers in the city
23 will have Outreach and Syringe Litter Teams.

24 I've highlighted a handful of the 800 plus mental
25 health programs we support to illustrate the

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1
2 thoughtful, evidence-based approach to measuring
3 success we employ for each unique program.

4 Across all programs, equity is always a critical
5 consideration and desired outcome. Health equity is
6 central to our vision for mental health in this city.
7 Thank you so much. We recognize that historic and
8 contemporary injustices in government, healthcare and
9 other institutions have deepened distrust and
10 contributed to individual and collective trauma,
11 while exacerbating inequities across health
12 conditions. We aim to eliminate inequities in mental
13 health outcomes. The Health Department is dedicated
14 to supporting the mental health and behavioral health
15 of all New Yorkers.

16 I am proud to share these impressive outcomes
17 today and pleased with the progress we have made. We
18 look forward to continually improving our programs,
19 expanding our partnerships and embracing our supports
20 for New Yorkers in the greatest need. We welcome
21 feedback from Council and community members today as
22 we continue to improve and adapt the city's mental
23 health infrastructure to better meet the needs of New
24 Yorkers.

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2 Thank you for the opportunity to testify. My
3 colleagues and I look forward to answering your
4 questions.

5 CHAIRPERSON LEE: Uh, quick question. Uhm, did
6 you want to go over some of these numbers in the
7 appendix or I wasn't sure, or maybe it's hard to put
8 on the screen right? Yeah, okay, never mind.
9 Because they're very - okay either way - oh, as
10 needed okay. Okay, uhm so I think first of all thank
11 you for this information and I think uhm, in general,
12 I'm going to just ask a few questions about what
13 defines success and impact and how you measure those
14 things across different programs and if there's any
15 standardization because I think as you all know, one
16 of the things I've talked about in previous hearings
17 is how often times it's hard to track data because
18 not all of it is collected in the same way or not all
19 the uhm measurements are the same across different
20 programs depending on what they are.

21 And so, uhm really quickly let's in the first
22 question, uhm, so how - this is very broad. How does
23 DOHMH currently define success and impact across the
24 mental health programs it funds and what core outcome
25 metrics are standardized agencywide?

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2 DR. JEAN WRIGHT: Thank you for the question
3 Chair. The Health Department is committed to
4 protecting and promoting mental health for all New
5 Yorkers. Our vision for mental health, for the city,
6 is ultimately to have all New Yorkers receive the
7 treatment and services you need and that's the
8 success we're striving for. At the day to day
9 programs, we've held in the city, the Health
10 Department and division specific standards, we all
11 use a measure to impact success. So, the divisions
12 may use a different bureau, may use a different
13 health department and the city so the programs are
14 very unique and very specialized and so, they may
15 have different ways of measuring.

16 At a minimum, every city, human services
17 contractor receives a passport contract rating. This
18 serves as a baseline measure of success and service
19 delivery and my colleagues can give you more detailed
20 information across bureaus, the bureaus that they
21 represent but also the programs that they evaluate.

22 CHAIRPERSON LEE: And is there a specific uhm,
23 like if you can give examples of like the basic
24 demographics that you usually ask for across all the
25 different programs, that would be great to.

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2 DR. JEAN WRIGHT: Yeah absolutely. Can we start
3 with the Bureau of Mental Health and then we'll go to
4 that? Thank you.

5 JAMIE NECKLES: Yeah sure. So, for all of our
6 programs, we're collecting information about the
7 volume of work provided, right? We need to
8 understand that like the city is contracting,
9 purchasing right the delivery of human services. So,
10 we're going to keep track of the volume of people
11 served and characteristics of those folks coming in.
12 So, we're looking at gender, gender identity, race
13 and ethnicity, as well as age group. Those are the
14 most common measures that we're looking at, among
15 programs where we have that information.

16 There are some programs that are really high
17 volume. For example, NYC 988, we had a hearing about
18 that a couple months ago, right? We wouldn't have
19 that sort of demographic information on every person
20 who calls. It's not practical to collect. But I
21 know there are programs where there is more direct,
22 you know person level contact. We're collecting that
23 sort of demographic information on everybody who
24 comes in. And then some information about the
25 services that they receive right, based on the

1 intention of the program. Is it a rehabilitation
2 program focused on education and employment goals?
3 We're going to look at that. Is it focused on
4 housing stability? We're going to look at that. Is
5 it about deescalation in the community? We're going
6 to look at that. And then some level of disposition,
7 right? So, referrals in, characteristics of the
8 people in. What they're getting tailored to the
9 program type and then the disposition or the outcome,
10 right? What is it on a crisis intervention where for
11 example, mobile crisis, we're going to want to
12 understand to what extent the crisis has deescalated
13 and the person remains in the community safely.

14 Uhm, in a housing program, following periods of
15 chronic homelessness, we're going to want to measure
16 whether the person stays in the housing program. And
17 in IMT program for example, focused on - on highly
18 transient folks who are homeless, but also moving
19 around a lot and have criminal legal involvement,
20 we're focused on attaining housing stability and
21 reduced criminal, legal involvement.
22

23 So, it's really tailored to the intention of the
24 program type.
25

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2 CHAIRPERSON LEE: Okay and then even in the
3 programs that you just mentioned, are you - are there
4 proactively data sets that you're asking for? For
5 example, even if I'm going into the housing program,
6 uhm, maybe there's some other for example, domestic
7 violence or gender based violence situation that I'm
8 facing, uhm, which is the root of the trauma of why
9 I'm homeless right? So, are those things also being
10 asked proactively? Even though it may not
11 necessarily fit into the bucket but are there ways to
12 get to that information as well that are proactively
13 being asked as well?

14 JAMIE NECKLES: Sure, so that question uhm, I
15 don't know if you mean it generally or specifically
16 but there's a very specific answer. So, our housing
17 units, for example, Dr. Wright talked about almost
18 13,000 units. They're focused on various specialized
19 populations. One of them is families who are in
20 shelter and victims of intimate partner violence.

21 So, there's a subset of our units for whom that
22 is the entirety of the population. So, we know
23 that's essentially their qualifying criteria for
24 entering into the program and then the services
25 provided are sensitive to that trauma experience.

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2 CHAIRPERSON LEE: Okay. Oh, go ahead, sorry.

3 DR. REBECCA LINN-WALTON: I mean the only thing
4 I'd add to that is I think part of it is always that
5 balance that I'm sure was your balance also in
6 nonprofit, is how much are we collecting versus how
7 much are we prioritizing time with the individual.
8 And so, we try to really make sure that the data
9 we're collecting is on that program and the
10 programmatic goals, so we can show that it was
11 effective. But we certainly do a lot of things like
12 training and last week, I was part of an outreach
13 team summit for all of the contracted vendors we work
14 with and we're continuing to do that and they brought
15 up things like training for things that they didn't
16 know about when they came into that service. And so,
17 I think in that way, it may not be data we're
18 providing but technical assistance and training, so
19 that people are getting that response whether or not
20 it makes into an excel spreadsheet.

21 CHAIRPERSON LEE: Right, okay, good to know. Uhm
22 and I know that the Council recently passed a Data
23 Disaggregation bill, which is something that folks in
24 the community have been working on for a while
25 because often times for example, when you Asian,

1 there's a lot of sub you know ethnicities within that
2 group. And so, because I remember being part of a
3 meeting with a previous health commissioner, not this
4 one where we were looking at maps of chronic diseases
5 across New York City and the population breakdown
6 ethnically was Black, White, Latino, other. And this
7 wasn't that long ago, and so, I know that there have
8 been a lot changes and strides made to be more you
9 know diverse in how we're categorizing some of these
10 populations and so, just wanted to see, are there
11 things, are there - how is that being broken down in
12 terms of ethnic population or age group? And is it
13 consistent across all different DOHMH programs and is
14 there a sort of standard of you know how you're
15 measuring that?

17 JAMIE NECKLES: So, we have more specificity in
18 the race and ethnicity data that we're collecting
19 then your previous experience. So, we're looking at
20 non-Hispanic Black, non-Hispanic White, Asian,
21 American, uhm Native, Hawaiian, Pacific Islander,
22 Hispanic and unknown are the most common categories
23 that we're collecting and then we do look at that
24 upon for all the people that we're serving, right?
25 So, of those who we're serving, what are the race and

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1 ethnicities but then also, for the outcome of the
2 program, measuring looking at what those outcomes are
3 experienced by people equally across gender
4 identities and race and ethnicity and age for
5 example.
6

7 CHAIRPERSON LEE: Hmm, hmm, okay. Uhm and what
8 systems or platforms do you use to collect, store and
9 analyze mental health program data and what gaps or
10 limitations exist in the systems as well?

11 DR. REBECCA LINN-WALTON: I'm happy to start this
12 one off. Yeah, that's - so when people think about
13 what are people doing at the Health Department, a lot
14 of our funding goes to community providers and then
15 the bodies and the Chairs analyzing the data, that's
16 often coming together and adding together a lot of -
17 we can't ask all of our nonprofit providers to be
18 able to afford very expensive platforms. So, we have
19 a wide variety and we're stitching it together so
20 that we can better tell the story of the programs
21 going on and so, we have analysts. We also do a lot
22 of cross bureau work so that we're making sure how is
23 our data that we're receiving from Syringe Service
24 programs where people are also involved in supportive
25 housing and how is that speaking to one another and a

1 lot of our improvement projects have come out of
2 things like that and better wanting to understand how
3 people are experiencing across programs.
4

5 So, a lot of stitching together of disparate
6 platforms or probably think of like ten off the top
7 of my head that are used across programs but that's
8 part of the job of the Health Department is to be
9 able to then share that back to the programs as well.

10 CHAIRPERSON LEE: Got it and are there certain
11 barriers? Like, when you're first getting all that
12 incoming data, do you physically have to yourselves
13 sort of input and then also like you said, stitch it
14 across or are you looking into certain platforms or
15 AI or tech or something that will actually help
16 organize or better analyze some of that data?
17 Because I'd be curious to see how that would look,
18 only because you know one of my things also is
19 there's so many silo's and even within the different
20 program areas, there's a lot of silo's. And so, like
21 you said, I'm curious to see how if you were to break
22 that down, what maybe the story would - how the story
23 would look different for someone from your
24 perspective in terms of how to better serve some of
25 the community members.

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2 DR. REBECCA LINN-WALTON: I think one piece
3 that's important is that we have community advisory
4 boards as well and so, that's another place where we
5 can check that story against what community members
6 are experiencing. I think yes, we're always looking
7 for technology and there's definitely people who have
8 a lot more expertise than I do as a social worker in
9 that and so we definitely rely on them but also our
10 teams are incredibly well steeped in how to stitch
11 that data together. So, I think they're constantly
12 thinking about - and we work with our state partners
13 and other city agencies and it's really a
14 conversation that's ongoing and can absolutely always
15 improve.

16 JAMIE NECKLES: Yeah, I couldn't agree more and
17 there is you know you asked about AI. Our agency has
18 a really, a clear policy for use of AI and our
19 research and evaluation staff are using it to check
20 code, to write the data check and there is a sort of
21 a whole scale of data, integration you know effort
22 across the agency right? We're talking about mental
23 health here and there's other parts of the Health
24 Department as well. So, that work is underway.

25

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2 CHAIRPERSON LEE: Okay perfect and then in terms
3 of quality of data, because I'm sure that again,
4 people are reporting things perhaps differently or
5 not as consistently. And so, how are you uhm
6 ensuring the data quality and consistency across the
7 contracted providers that you work with, who may use
8 themselves very different internal data collection
9 systems?

10 DR. JEAN WRIGHT: Yeah, so as we said before, we
11 have over 800 programs and so, that's quite a bit and
12 we have - that's just in mental health. And so, we
13 have an ecosystem of data analysts as Rebecca
14 mentioned, researchers, epidemiologists within our
15 division and these folks are really their job is to
16 make sure that the core infrastructure, the data that
17 is brought in is brought in. We have the center for
18 population health data that helps us coordinate all
19 of that across the whole agency, and as Jamie and
20 Rebecca said, we can always improve it. That is a
21 central focus for the Health Department is how we
22 collect data, the quality of the data and then making
23 sure that the programs within our division
24 specifically are able to share that in ways that are
25 if it's feasible and if it's permissible and if it's

1 something that is useful, we're able to do that in a
2 meaningful way but that center for Population Health
3 data is really helpful but it's again, it's ongoing.
4 It's something that we're going to continue to move
5 toward, so thank you.

7 CHAIRPERSON LEE: And uhm, what is your process
8 for evaluating whether a program with poor or unclear
9 outcomes should be redesigned, scaled down or
10 discontinued? What does that process look like?

11 DR. JEAN WRIGHT: So, I think we can speak to
12 bureau level then I can give you an overall view as
13 well.

14 JAMIE NECKLES: Yeah sure, so we're looking at
15 uhm the overall contract rating that Dr. Wright
16 mentioned earlier, the passport rating, excellent,
17 good, satisfactory, poor, unsatisfactory, right?
18 Those are just very broad terms for use across human
19 service contracts citywide. And if a program is
20 given an unsatisfactory you know if a contract is
21 given that unsatisfactory rating, uhm that's likely
22 to be a contract that we do not renew, right?

23 Where does that unsatisfactory or poor rating
24 come from, right? That's all the work that our teams
25 do. So, our contracts require providers to report an

1
2 all timely and accurate data. They entered into data
3 systems. We look at their outcomes. We also visit
4 all of our programs at least once a year on site and
5 visits to check, spot check their own data systems to
6 make sure it sort of aligns with the data they're
7 reporting to us to speak to their staff, to speak to
8 their consumers, to understand what's causing the
9 problems and try to fix it, right? Where we're not
10 looking to uhm, to just immediately end a contract,
11 right? We want to provide technical assistance and
12 understand what's causing the challenges to the
13 service delivery, provide technical assistance
14 training, extra support, where we can to improve that
15 care. Because these are providers who know their
16 communities, that relationship with clients. We want
17 to support that.

18 Ultimately, if that technical assistance doesn't
19 work right and we need to request a corrective action
20 plan, we'll do that. Give providers time to make
21 improvements and if that's still unsuccessful, right
22 you'll get that unsatisfactory, a passport rating and
23 we can discontinue contracts, which we do from time
24 to time.

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2 CHAIRPERSON LEE: Yeah, see this work I'm
3 assuming with MOCS on that, right to make sure?

4 JAMIE NECKLES: Yup.

5 CHAIRPERSON LEE: Okay. Uhm and how often does
6 DOHMH conduct internal audits, which we all love of
7 reported program data and what are the most common
8 discrepancies or challenges uncovered during those
9 audits? Just out of curiosity.

10 DR. REBECCA LINN-WALTON: Yeah, I can answer on
11 the bureau level. I mean, so it can be something as
12 simple as like not a formal audit but saying, "hey, I
13 noticed your data. It says you had a participant who
14 is 250 years old, maybe that was a typo." And so,
15 you know that's how we're looking into it to make
16 sure that the data is correct and knowing that
17 there's error and so, we always are coming from a
18 place of trying to check with someone and so, that's
19 where those you know weekly conversations with
20 programs and monthly and visits and I know I've been
21 out to lots and lots of place in the year and a half
22 I've been here and it's really important work but I
23 think - I would say all of that does fit into audits
24 because we want to make sure that we're helping
25 people be successful and have the resources they need

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2 and give them a chance to correct things if they -
3 maybe they do have 250 year old participant and then
4 we will have met all of our Healthy NYC goals so
5 that's great.

6 CHAIRPERSON LEE: Yup, that would be a flag, yes.
7 Uhm and how do you ensure that community feedback
8 including from clients and families because I feel
9 like it's always important to have their voices at
10 the table.

11 So, how do you ensure the community feedback is
12 integrated into the evaluation of the mental health
13 programs? Is that something you integrate into some
14 of the outcomes or?

15 DR. JEAN WRIGHT: Sure, thank you Chair.
16 Definitely we get a lot of feedback from our
17 community service boards and also our satisfaction
18 surveys and I know we have a broad variety of how
19 that takes place again at the bureau level.

20 And so, each of our AC's can speak to that but we
21 have a lot of feedback from the community in those
22 three areas as well. Maybe break down on how it
23 works in each of your divisions would be helpful.

24 JAMIE NECKLES: Sure, so contracted providers uhm
25 conduct consumer satisfaction surveys right, of their

1
2 programs directly with their consumers. We, our
3 staff, when we go out and do these visits, we meet
4 with program participants. We also convene a
5 community services board where we have
6 representatives from various geographic and
7 experiential and programmatic disciplines speak to us
8 directly. We have youth and adult advisory boards as
9 well, consumers that come and speak to us directly
10 and then when we - we often - not often, we always
11 establish the outcome measures in the procurement
12 process right. We release a concept paper. We get
13 public feedback to that. We issue an RFP and the
14 measures of success for that program are specified
15 really straight clearly in that RFP. And we get lots
16 of public feedback on those concept papers and RFP's
17 as well. So, to make sure that we're sort of
18 establishing the best measures.

19 DR. REBECCA LINN-WALTON: I think the only thing
20 I'd add to that is the importance of having people
21 with lived experience at every part of the Health
22 Department. I think we have one of the largest pier
23 workforces I'm aware of but it's also important to
24 understand that there's even barriers for people
25 accessing that certification, so we want to make sure

1
2 we have both those formalized mental health and
3 substance use peers but also really recognizing the
4 importance of all types of lived experience and I
5 don't think there's any part of the bureau - of the
6 agency where I'm not aware of people talking about
7 their lived experience to inform the work.

8 CHAIRPERSON LEE: That's great that you guys have
9 that staffing within the department that have lived
10 experience as well because that's going to be key in
11 informing some of the strategies and programs, so
12 that's great to hear.

13 Uhm, okay, I'll take a quick break from myself
14 and Council Member Bottcher, do you have questions
15 you wanted to ask?

16 COUNCIL MEMBER BOTTCHEER: Good afternoon. I want
17 to ask about staffing shortages and unfilled
18 positions in the department. You have so many great
19 programs, both on the government side and on the
20 nonprofit side. Are there unfilled staffing
21 positions within these programs and if so, how many?
22 And has that affected your ability to collect and
23 analyze data as we're discussing today?

24 DR. JEAN WRIGHT: Thank you for the question
25 Council Member. Certainly, work vacancies are always

1
2 a challenge across not just for us but across the
3 board for all city agencies and frankly, even the
4 private sector. I'm happy to report though that we
5 have the right amount of people in the essential
6 positions that we have to make sure that these
7 evaluations and gathering of data, like I mentioned,
8 the epidemiologists, the researchers, analysts, to do
9 their jobs.

10 We certainly are open to any help we can have in
11 filling those positions but they have not to this
12 point caused us to lose anything in terms of our
13 ability to evaluate or analyze programs or the
14 quality of programs. And in terms of the specifics
15 of your question, again, we have differences at the
16 bureau level that certainly my colleagues can speak
17 to but I'm very comfortable with the fact that we're
18 able to do our jobs with the staff that we have.

19 COUNCIL MEMBER BOTTCHEER: With respect to mental
20 health programs, where are the vacancies? Where are
21 the most unfilled positions?

22 DR. JEAN WRIGHT: I think again, it's going to be
23 different across but I would start with maybe social
24 workers.

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2 COUNCIL MEMBER BOTTCHEER: Maybe just move the mic
3 a little bit.

4 DR. JEAN WRIGHT: I'm sorry, I said it's probably
5 going to be different across.

6 COUNCIL MEMBER BOTTCHEER: Pull it right in.

7 DR. JEAN WRIGHT: Closer, is that better?
8 Alright, I said that I think it's going to be
9 different again across our whole division but I would
10 say that what I've seen, social workers is a key
11 number but I would leave it to my colleagues to speak
12 for their bureaus in terms of the challenges that
13 they're seeing but across the board, I would say
14 social workers.

15 JAMIE NECKLES: Yeah, I think workforce turnover
16 is a challenge. It's better than it was during the
17 pandemic, so I can tell you that much. It's not as
18 bad as it once was but there's periodic turnover
19 across all of our programs, housing, crisis,
20 treatment, care coordination. Typically, we find
21 those jobs that require travel, right? Visiting
22 people across the city are harder to fill than
23 others. They're physically demanding. Where do you
24 go to the bathroom, right? Those things. Where do
25 you have lunch? Those are challenges when you're 100

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2 percent mobile treatment. You have an office to go
3 back to but it's grueling work. We attempt to
4 compensate that right, higher salary sometimes for
5 these positions but we're competing against like a
6 telehealth job. So, that's our hardest positions.

7 COUNCIL MEMBER BOTTCHE: With respect to the -
8 since this hearing is about data and reporting, how
9 are you analyzing those shortages across the mental
10 health continuum? How are you reporting them
11 publicly? How do we get a handle on where the
12 shortages are? And best strategies to fill them?

13 DR. JEAN WRIGHT: That's a great question. Thank
14 you Council Member. I know that in our division of
15 Bureau of Management, that we keep track; this is
16 specific to mental health, keep track of the
17 vacancies and across which bureaus and what positions
18 that those vacancies occur. And so, we do have the
19 ability to detract those vacancies and what the
20 challenges are. We're able to talk to the AC's and
21 ask them where they're seeing the biggest challenges
22 in their bureaus and what we can do to help support
23 getting those folks hired and getting those positions
24 filled. And so, it's a very organized process.

25

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2 COUNCIL MEMBER BOTTCHE: I know a big focus of
3 the incoming administration is going to filling
4 vacancies. So, we look forward to partnering with
5 you in that effort.

6 DR. JEAN WRIGHT: Absolutely, thank you Council
7 Member.

8 CHAIRPERSON LEE: Awesome, thank you Council
9 Member. Okay uhm, so switching gears, more about
10 specific programs and data collection. Uhm, for
11 programs like club houses, intensive mobile treatment
12 IMT or assertive community treatment ACT programs.
13 How does DOHMH measure reductions in psychiatric
14 hospitalizations, justice involvement, homelessness,
15 and crisis episodes and I know there's a lot in that
16 question, so.

17 JAMIE NECKLES: That one's me. Yeah, so I spoke
18 a little bit earlier about the measures we collect
19 across all program types, right? That people serve,
20 the race, ethnicity, characteristics of them, how
21 long they're in the program. The benefits and the
22 outcomes they achieve related to their enrollment in
23 the program.

24 So, I'll take - I think you had named three
25 different program types. So, for clubhouses for

1 example, that intervention is designed to provide
2 psychosocial rehabilitation services, helping people
3 develop skills related to education and employment,
4 and living a satisfying life.
5

6 So, we're measuring first of all active
7 participation in the clubhouse, right? It's a
8 membership, the life model so we can't just sort of -
9 anybody whoever enrolled, we can't reasonably call
10 them a member forever. We'd have a cumulative
11 account for 40 years. And so, we're measuring how
12 much time people are exposed to the intervention
13 essentially, right? So, we now know for the first
14 time ever. We've never known this. 30 years of
15 contracts. That people go to clubhouses on average
16 five days a month, in person one day virtually. So,
17 that's important for us to understand the sort of -
18 the amount of intervention they're getting associated
19 with the outcomes that it's designed to provide.

20 So, education and employment are really important
21 goals of clubhouse services participating in the
22 operating of the clubhouse is designed to build
23 skills that will transfer to employment. And so, I'm
24 excited that we have for the first time ever the
25 outcome data, the report on the 13 clubhouses that we

1
2 have in contract with us. Of those who are
3 interested in employment, right? Not everybody is
4 interested in employment. For example, if you're of
5 retirement age, you may not be interested in
6 employment, right? If you're in school, you may not
7 be interested in employment but of those who are
8 interested in employment, I'm going to read it here
9 so I get it right. The proportion of those employed
10 increased by 24 percentage points. From 31 percent
11 in enrollment to 55 percent at the end of last fiscal
12 year. That's a huge increase in employment. And
13 then we look at that; we stratify by race to
14 understand if those gains were experienced by all
15 groups. So, we looked at it and we see API.
16 Clubhouse members had higher rates of employment to
17 begin with, less gain over time. Hispanic and Latino
18 identifying folks as well as non-Hispanic Black folks
19 also saw the greatest gains in that employment. So,
20 that's one way that we're able to use the data to
21 understand if our impact is equitably experienced
22 across all groups. That's Clubhouse; you had some
23 others do you want me to -

24 CHAIRPERSON LEE: Yeah, just - yes, IMT, ACT and
25 then also in terms of the justice involvement, uhm,

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1 is there a partnership with you know corrections or
2 DOJ when it comes to looking at recidivism or if
3 there are other measures like that that are sort of
4 showing that someone is you know receiving the help
5 and if these programs are being effective?

7 JAMIE NECKLES: Yes. Uhm, so I'll take the IMT
8 right? In that program, we are aiming to increase
9 housing stability and reduce jail time. And so, we
10 have New York City Department of Corrections data to
11 match with the information we have for people in IMT.
12 And so, also I got to read these ones. I don't have
13 them all committed to memory. We can see that among
14 those folks who were served in IMT last fiscal year,
15 so FY25, the proportion of those with jail admissions
16 decreased by five percentage points between pre-IMT,
17 pre-enrollment and the most current year, right? So,
18 that's exactly the result that we'd like to see among
19 this population.

20 We're also looking at housing attainment for that
21 IMT group. Uhm, we're seeing even a greater benefit
22 there showing that among those served in FY25, the
23 proportion of those stably housed increased by 23
24 percentage points. And stably housed, we defined as
25 stably - as housed for six consecutive months or

1 longer, right? And this is pulling from a groups
2 that's 100 percent housing transient, right? That is
3 a qualifying criteria. So, achieving that level of
4 housing stability, among that, many people is
5 extraordinary.
6

7 CHAIRPERSON LEE: And according to this chart, so
8 you think the supportive housing - I see that it's -
9 you know it's grown in FY25 but is it growing at the
10 rate that you think is meeting the populations needs?

11 JAMIE NECKLES: There will never be enough
12 supportive housing in New York City or affordable
13 housing.

14 CHAIRPERSON LEE: Yup.

15 JAMIE NECKLES: So, uhm, no it's never enough.
16 We have an affordability crisis and so people with
17 mental illness and substance use disorders are no
18 different then any other New Yorker. They're
19 struggling to find affordable places to live but the
20 supports that we bring to those affordable apartments
21 are really valuable and they're growing. So, we're
22 on track. It's an MMR indicator and we're meeting
23 that indicator. Where actually, it was, I just a
24 count this morning, 12,998. I was really hoping it
25

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2 would 13,000 at this hearing but I'm two off that
3 number.

4 CHAIRPERSON LEE: Two off, we'll get there. Uhm,
5 okay perfect and let's see, sorry. Uhm, and what
6 data does DOHMH collect from providers of community
7 based organizations receiving funding through the
8 mental health initiatives and how is the data
9 validated?

10 DR. REBECCA LINN-WALTON: I can start us on that.
11 That's what I talked about before when we get data
12 from folks and we're checking is anything, are there
13 outliers? We're doing quality assessments and we're
14 really trying to figure out at a bureau level; I know
15 I'm also focused on how people are going between
16 different programs. For example, the harm reduction
17 programs, people have been in treatment programs
18 before. They may go back to treatment. They may go
19 to the recovery centers. And so, some of the
20 analysis we're doing and working with the programs to
21 be able because some of what we're talking about is
22 actually a full academic evaluation. So, we also
23 have academic partners who can do those long term
24 multimillion dollar outcome evaluations to
25 demonstrate impact. And so, we're incredibly

1
2 grateful to have their expertise for that because
3 that's all they're doing is working on things like
4 that but then how do we tell on the sort of day to
5 day level that people are. And that was the summit
6 that I mentioned before; I mean I know it's not data
7 analysis but it's gathering people in a room to talk
8 about how they're connecting with one another and is
9 there a way for them to better share connections
10 between the organizations.

11 Also, we work very closely with DHS for example,
12 and we had a meeting recently about we were talking
13 about people being unhoused in a different way they
14 were. So, they kept saying, why are we finding
15 differences and how many people are unhoused in this
16 certain area? And so, by having shared language
17 around how we're classifying or identifying people as
18 housing needs and what the different interventions
19 are for it, we were able to better understand what
20 the true experience of the people we're serving are.

21 CHAIRPERSON LEE: And how do you count those
22 folks that are sort of in and out you know, if
23 they're the same person are they being double counted
24 or how are you tracking or following someone through
25

1
2 their recovery or through the different services that
3 they use?

4 JAMIE NECKLES: I think the short answer is
5 there's always going to be double counting but the
6 good news about that is that each time they receive a
7 service, that's what we're contracting for and so,
8 that's how we pay nonprofit. So, maybe they are
9 being seen at both DSS services and our services or
10 maybe both in a recovery center and a harm reduction
11 program but they did receive - it's sort of like when
12 I go to endocrinologist and I go to my PCP, and so
13 they're both paid for it because they're both doing
14 different things and so that's again where if we want
15 to know how one person goes through the system,
16 that's those outcome evaluations but if we want to
17 see what is the scope of the work we're doing, that
18 tends to be more of what was provided to the person.

19 CHAIRPERSON LEE: Yeah and I just wonder how that
20 would track differently depending on what question
21 you want to answer I guess, right? Because the
22 number of units is the number of units, which is good
23 to know either way but then I guess the question
24 would be if we want to actually understand and know
25 better, how or if someone is receiving certain

1 services and then coming back less, right? Like how
2 do we track that and see if they're making
3 improvement, so. I guess I'm just wondering for that
4 - for those types of information or data that you're
5 looking for, how would that uhm, like how would you
6 approach that differently in terms of what you're
7 looking at in terms of data sets?

9 DR. REBECCA LINN-WALTON: Yeah, I mean so one
10 thing that we've been looking at is overtime, for
11 example, fewer people have been coming for methadone
12 services. And so, to counter that knowing that
13 people still need access to medication for opioid use
14 disorder, how do we bump up the access to
15 buprenorphine and other settings. There's fewer
16 restrictions and so, that's one way that we're using
17 data to inform. Are we doing the right types of
18 services? And that's where a lot of the opioid
19 settlement fund is going to the Syringe Services
20 Programs to have mental health and substance use
21 support and wrap around. That's where the data
22 definitely informs exactly what we're doing for New
23 Yorkers to make sure those same number of people are
24 served where they ultimately want to be served in the
25 way they want to.

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2 JAMIE NECKLES: Yeah, the only part that I was
3 going to add to that is uhm, how specific it can be.
4 So, it may not be that for every population, we want
5 more care or less care, right? Let's take housing
6 for example, where an average length of stay is about
7 eight years, right? The first year a person moves
8 into an apartment from a period of street
9 homelessness, we would expect more care, right?
10 They've come inside. They may be going to the
11 hospital more, maybe going to their healthcare
12 providers and that's good because there was a period
13 of time where they weren't interacting at all so we
14 might see higher utilization of expenses and valuable
15 in essential healthcare services. And then over
16 time, you know five years later, ten years later, we
17 would expect to see something different.

18 So, we really have to think about the context,
19 right? The focus of the population where that person
20 is in their lifetime, their age, their recovery
21 journey, etc., to understand what in fact is the - do
22 we want more or less of this particular indicator?

23 CHAIRPERSON LEE: Yeah and I guess to that point,
24 uhm, how do your systems allow for or maybe limit? I
25 don't know how robust it is internally within DOHMH

1
2 but if you were to look at different datasets and
3 dissect them differently, you know to look at
4 different outcomes. You know how easy is that for
5 you guys to do?

6 JAMIE NECKLES: I mean, it consumes our lives,
7 right? This is what we do and I'm so excited to talk
8 with you about it. It's really hard and we do it all
9 day, every day and we've got massive you know time
10 and expertise devoted to it but it's not simple,
11 right? Humans are really complicated and the city is
12 especially complicated right and you combine those
13 things, it's hard.

14 CHAIRPERSON LEE: Yeah. Uhm, and then actually
15 this is going to something that you had mentioned
16 before about coordinating with other agencies sort of
17 because I love talking about how we can sort of
18 better communicate between city agencies to get a
19 better picture and understanding of what's happening.
20 And so, how do you coordinate with other agencies -
21 this is going more so to the terms and conditions.
22 How do you coordinate when the terms and conditions
23 require shared data, joint reporting or cross agency
24 program tracking? Because I know that sometimes it
25 differs sometimes significantly across different

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2 agencies, depending on what you're asking for. So,
3 when the terms and conditions happen, how do you
4 coordinate with other agencies?

5 DR. JEAN WRIGHT: Thank you for your question
6 Chair. The terms and conditions in the Health
7 Department for the FY - I'm sorry about my voice, for
8 the FY26 budget, do not actually pertain to the
9 division of mental health but so I can't speak to
10 those specific reporting requirements. As an agency,
11 we adhere to all Council reports and we are required
12 to do our due diligence to provide information and
13 so, we take that very seriously. But specific to our
14 division, we do not have that requirement in terms of
15 the mental health.

16 CHAIRPERSON LEE: Okay. Uhm, which health
17 related performance measures are tracked for DOHMH in
18 the Citywide Performance Report and how do they
19 reflect the agencies effectiveness in promoting
20 public health?

21 DR. REBECCA LINN-WALTON: I can do this one. So,
22 it's units of supportive housing and death from
23 unintentional overdose.

24 CHAIRPERSON LEE: Uh okay. Wait, those are the
25 main two? The only-

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2 DR. REBECCA LINN-WALTON: Those are the two
3 indicators we report for the Citywide Performance
4 Report. The two main indicators for behavioral
5 health.

6 CHAIRPERSON LEE: Got it.

7 JAMIE NECKLES: Yeah, and I think we also report
8 on things like buprenorphine. We can follow up with
9 the exact list.

10 CHAIRPERSON LEE: Okay, perfect.

11 DR. REBECCA LINN-WALTON: It was the MMR, sorry
12 about that.

13 CHAIRPERSON LEE: Oh, MMR yeah. I know there's a
14 lot of different acronyms here. Actually, so let's
15 go to the PMMR and the MMR. Uhm, so which
16 performance indicators in the PMMR and MMR provide
17 insight into the effectiveness of DOHMH funded mental
18 health and behavioral health programs?

19 JAMIE NECKLES: Yeah, so this is where into the -
20 I'll let Dr. Linn-Walton talk about that but I think
21 we're talking about in the PMMR and the MMR, we have
22 people monitored by our assisted outpatient treatment
23 program, right? So, that's Kendra's Law or AUT, the
24 Supportive housing as we have in any other report.
25 Health led crisis responses and community based

1 deescalations, those are referrals to mobile crisis
2 teams, right teams of peers and social workers that
3 keep people in safely in the community and avoid
4 hospitalization and as well as those contradicted by
5 our co-response teams, right? Similar idea to keep
6 people in the community, avoid police interactions
7 and hospitalizations. And finally, on the mental
8 health side are those engaged in our long term
9 treatment services, the ACT and FACT and SPACT.
10 Those services, so we're reporting on all those
11 measures in the PMMR and MMR of course.

12
13 CHAIRPERSON LEE: Okay. Uhm, and how can trends
14 in the PMMR data help identify emerging challenges or
15 areas needing improvement in mental health and
16 behavioral health services?

17 JAMIE NECKLES: I mean the MMR; it's every four
18 months right.

19 CHAIRPERSON LEE: Right.

20 JAMIE NECKLES: And it's a little bit of a lag.
21 I wouldn't say that's where you're going to get sort
22 of emerging trends frankly. It's not that real time
23 so those are sort of the biggest picture, sort of
24 uhm, numbers that we can represent our work through.
25 I don't know if you want to add.

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2 DR. REBECCA LINN-WALTON: Yeah, I also think
3 change takes more time sometimes than that timeframe,
4 and so that's where our annual reports come in and
5 we're really trying to track both those short term
6 outcomes. Are we doing the things we said we would
7 and then what's happening over time? For example, I
8 always think of the example that we had a 50 percent
9 reduction in overdose deaths last year in Staten
10 Island and we immediately were like, "what is going
11 on and how do we do that everywhere?"

12 And we were looking at BUPE uptake and they've
13 been doing a tremendously successful job in getting
14 people connected and then staying on Buprenorphine
15 and so, that's my assignment for the year is figuring
16 out both how to continue that and then how to do that
17 elsewhere or if something else is needed elsewhere,
18 how to still do what's needed elsewhere.

19 CHAIRPERSON LEE: Right, okay.

20 DR. JEAN WRIGHT: I think additionally Chair,
21 uhm, in the fall we had a suggestion from the
22 Committee, the Council to add 988 as an indicator and
23 so, thank you for that suggestion and we're going to
24 be adding that in and so, we'll be able to report on
25

1 that and under Jamie's bureau and so, thank you for
2 the suggestion.
3

4 CHAIRPERSON LEE: Oh, that's awesome. That's
5 good to hear.

6 DR. JEAN WRIGHT: That's a positive move.

7 CHAIRPERSON LEE: Yeah, that's awesome.

8 DR. REBECCA LINN-WALTON: Yeah, I forgot that
9 one, thank you because it had been there years ago
10 and then it came out for a year and a half and I
11 misspoke in our last hearing, I thought it was still
12 there. But it will be back in and just keep in mind
13 that it's a different way of counting then it was in
14 the past. I spoke about that the last time a little
15 bit, so the numbers - it won't be like a continuous
16 uhm, impression. We'll start sort of fresh.

17 CHAIRPERSON LEE: Got it, which by the way, when
18 I'm at randomly in different spaces where we're
19 talking about mental health issues, I ask people
20 randomly in the audience to raise their hand if they
21 know what 988 is and a lot of them still have no
22 idea.

23 So, we - you know it's I mean it's great because
24 then I'm using those opportunities obviously as a way
25 to spread the word about it but I was like wow, I

1
2 can't believe we need to just, you know we still need
3 to get it out there but yes.

4 Uhm, okay and in terms of Comptroller audits, uh
5 one of the oh - uhm so one of the key recommendations
6 of the Comptrollers audit of the Citywide Doula
7 Initiative specifically was to supplement incomplete
8 programmatic data by matching CDI clients to more
9 complete datasets such as Medicaid data and that
10 would allow the agency to compare outcomes between
11 individuals that receive doula support and that's
12 that did not. Uhm, and so has DOHMH considered
13 applying this approach and how it evaluates its other
14 programs?

15 DR. JEAN WRIGHT: Thank you for your question
16 Chair. The Health Department is always looking for
17 ways to strengthen how we evaluate our programs and
18 how we include you know the data and so, we're
19 exploring these opportunities. To your question,
20 yes, we are exploring these opportunities and where
21 appropriate and feasible, we are considering linking
22 program data with broader health and administrative
23 datasets. And we want to improve our understanding
24 of the health outcomes and so, these approaches are
25

1
2 evaluated on a program by program basis. And so, we
3 certainly are taking all this into consideration.

4 CHAIRPERSON LEE: Perfect. Uhm and I think you
5 sort of spoke to this before, uhm in terms of the
6 client information or input but another
7 recommendation that emerged from that report was the
8 need to incorporate client satisfaction surveys into
9 the data collection process to analyze the
10 differences in satisfaction between vendors. So, I
11 know that you had mentioned earlier, that you're
12 doing some of this incorporation into your programs
13 and so, just wanted to see if there were further
14 comments based on the Comptroller's report.

15 DR. JEAN WRIGHT: Yeah, I think both AC's can
16 speak to the satisfaction surveys in their borough
17 and it maybe even across the overall community
18 service boards.

19 DR. REBECCA LINN-WALTON: Yeah, absolutely we
20 have all of our contracts are doing consumer
21 satisfaction surveys, right? There could be some
22 standardization of that tool. Although some
23 providers you know may want tools that reflect their
24 communities and their organizations mission. So,
25 it's hard to - we have to balance both of those

1 right? The value of the citywide data and also the
2 specificity and experience of our CBO partners.
3

4 CHAIRPERSON LEE: Okay, perfect and also in the
5 Comptroller's audit of the IMT program, uhm the issue
6 was raised that DOHMH does not verify and review
7 whether the client data reported to the agency by
8 providers is accurate and supported by client case
9 collected by providers. Does DOHMH have any plans to
10 assess and evaluate the accuracy of the data
11 submitted to the agency by the third party or you
12 know.

13 DR. REBECCA LINN-WALTON: Yeah, so I can speak to
14 that. Uhm, the Comptroller, you know audited I think
15 it was period of like 2016 to 2023 of IMT. Uhm, in
16 2016, 2017, 2018, there were 75 people enrolled in
17 IMT. It was the Demonstration Project. It was very
18 tiny at that time and we had just invented it. There
19 were no structures because we were testing out an
20 innovative idea and then uhm, it went well. We
21 reprocured it, reprocured it for the first time. It
22 was Demonstration Project and we expanded it up to
23 about 800 spots at that time.

24 During FY20 and FY21 in New York City, which as
25 most of us remember was the pandemic. So, yeah,

1
2 there were some I's that were not dotted and some T's
3 that were not crossed during a period of rapid growth
4 of a really innovative model.

5 Uhm, so I own that and we are working on that.
6 The model uhm has flexibility by design and so, we
7 want to preserve that flexibility and at the same
8 time, recognize the need to sort of uhm, ensure that
9 our providers are held accountable right for the
10 funding that we're providing for them to do this
11 really important work. And so, we have a data
12 reporting system. I cited a lot of the outcomes
13 earlier in responding to the Q&A based on that data
14 and we've uh added a team of folks to go out, a
15 couple of folks to be newly hired in the coming year
16 to spot check some of the actual data entry points
17 that the providers put into our data systems, which
18 was the feedback from the Comptroller.

19 CHAIRPERSON LEE: Okay, great and in the report,
20 I think they also touched upon some of the caps, the
21 corrective action plans and was that - were most of
22 those from the periods during COVID or was it just -
23 is this in general or can you speak to that a little
24 bit in terms of the process and implementation of the
25 corrective action plans?

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2 DR. REBECCA LINN-WALTON: Yeah, so it was during
3 the period you know that I just described, which
4 included most growth during the pandemic and so, we
5 have uhm updated our uhm, program guidelines first of
6 all, which we do periodically anyway. They include
7 all of our program types including IMT and clarified
8 the requirements around corrective action plans. So,
9 that improvement was made for the IMT programs as
10 well as all of our other contracted programs and
11 that's in place.

12 CHAIRPERSON LEE: Okay and then the last question
13 I had about the Comptrollers report specifically is
14 just related to the uniform reporting template for
15 its program specialists to ensure the complete and
16 consistent collection of programmatic data. I think
17 at the time, uh DOHMH responded that it would improve
18 consistency in the documentation of program reviews
19 and what is the status of this recommendation and
20 does it apply to the agencies other programs? And I
21 guess one other thing I would add is - is it possible
22 to do that given the difference in all these
23 different programs? So, I know that the report can
24 say one thing but then I guess what I would like to
25 know is in your opinion whether it is doable or in

1 the best interest of some of these programs to have -
2 I mean I know we talked about certain things being
3 consistent right in terms of uniformed reporting but
4 uhm, I just wanted to hear your thoughts on that.
5

6 DR. REBECCA LINN-WALTON: Yeah, thanks and I
7 appreciate the uhm, the nuance in your question right
8 because it is really challenging and what we've done
9 and I described it in parts of my answers already.
10 Where we have the citywide passport sort of rating
11 criteria and we've adopted that rating criteria for
12 our own program reviews, right?

13 So, every uh you know there's a contract with a
14 program - the requirements. We have guidelines by
15 program type. Those are shared with providers. They
16 have it. I'm happy to share that with you. You know
17 guidelines that apply to all programs and then
18 subsequent chapters that are specific to program
19 types because it won't be the same exactly for every
20 program.

21 We visit one program every year, conduct a
22 review, provide written feedback. This is the
23 template. We've - where with that feedback, giving a
24 rating that aligns with the passport rating to be
25 more clear, right? Rather than sort of a list, just

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1 a list of like problem, problem, problem, right?

2 It's like overall satisfactory program. Here's you

3 know a few things that could use improvement. Some

4 of those are small, some of them are big, right

5 depending on the program and so, we've standardized

6 the sort of the language to use that same passport

7 skills that we're giving a provider a heads up,

8 right? This is how - it's like a midyear report card

9 essentially right. This is how it's looking right?

10 Let's improve it so that at the end of the year, you

11 get a satisfactory passport rating. Uhm, otherwise

12 if there's an open PIP, that's going to be reflected

13 in your passport rating.

14 So, some standardization in that sort of topline

15 feedback but allowing room for nuance beyond because

16 there's so many different program types.

17 CHAIRPERSON LEE: Yeah, I was going to say uhm

18 because just knowing all the programs you have it's

19 like, even when I sit here and think about how you

20 would consistently uniform some of that reporting, it

21 would be I would imagine very challenging. So, but

22 obviously appreciate all the efforts that you guys

23 are doing to make sure that it is there.

24
25

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2 Uhm, and just a couple more questions about the
3 IMT Enact programs and if you - I know that some of
4 the funding is definitely new and probably is still
5 being worked out with the IMT that we provided for
6 example, but in the FY26 budget, the City Council
7 secured \$4.5 million to establish a step down pilot
8 program for ACT and IMT clients and what is the
9 current status of this RFP and what is the timeline
10 or anticipation of releasing the RFP?

11 DR. REBECCA LINN-WALTON: Uhm, so absolutely
12 appreciate the Council's interest in these programs.
13 We have to defer to OMB on the details of the
14 specifics. Those are still under review. Step down
15 is usually important though. We couldn't agree more.
16 There's a variety of programs out there doing this
17 work that we value. They're essential to our city.
18 We have our connect clinics that are receiving step
19 downs that there's a flexible act model and the state
20 is developed, right to expand ACT caseloads to help
21 with step downs and there's some innovative ideas out
22 there as well from our nonprofit sector. So, we love
23 all the above and we're talking with OMB about the
24 details of that funding.

25

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2 CHAIRPERSON LEE: Yes, that's like - I joked that
3 when I was a nonprofit, OMB is like the Wizard of Oz.
4 It's like I know someone is behind there pulling the
5 levers, I just don't know who.

6 But yes, hopefully, it will get decided soon and
7 what is the status of the \$11 million the City
8 Council secured to expand IMT teams or is this sort
9 of basically the same answer where it's related to
10 OMB? All world in, okay. So, hopefully we will get
11 some clarity on that whenever you know you have the
12 opportunity to chance to, that would be great.

13 Uhm, okay, I think that is it. That's it on my
14 part for questions. Uhm and I just want to say
15 publicly for the record, obviously we were entering
16 into a new session on the Council side. We have no
17 idea where we're going to land in terms of
18 Committee's. If I stay here, great, we get to work
19 together for another four years but if I don't, I
20 just wanted to publicly say thank you for your
21 partnership in this work and I'm definitely not going
22 away either way because I still want to work on these
23 ideas that we have but I just wanted to say thank you
24 so much for your partnership in this work. So, thank
25 you.

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2 PANEL: Thank you very much Chair.

3 CHAIRPERSON LEE: Okay, so while you guys are
4 transitioning out, I'll just read the statement on
5 the next part, which is going to be around public
6 testimony. Uhm, so just wanted to open the hearing
7 right now for public testimony. I want to remind
8 members of the public that this is a government
9 proceeding and that decorum shall be observed at all
10 times. As such, members of the public shall remain
11 silent at all times. The witness table is reserved
12 for people who wish to testify. No video recording
13 or photography is allowed from the witness table.

14 Furthermore, members of the public may not
15 present audio or video recordings as testimony but
16 may submit transcripts of such recordings to the
17 Sergeant at Arms for inclusion in the hearing record.
18 If you wish to speak at today's hearing, please fill
19 out an appearance card with the Sergeant at Arms and
20 wait to be recognized. When recognized, you will
21 have three minutes to speak on today's oversight
22 topic.

23 If you have a written statement or additional
24 written testimony you wish to submit for the record,
25 please provide a copy of that testimony to the

1
2 Sergeant at Arms. You may also email written
3 testimony to testimony@council.nyc.gov within 72
4 hours of this hearing. Audio and video recordings
5 will not be accepted. And I say this at every
6 hearing but believe me when I say our Committee staff
7 are amazing and they literally read every single word
8 of the public testimonies that get submitted. So, we
9 will definitely take all of your feedback into
10 consideration.

11 And so now, I want to call the first in person
12 panel. We have Yuna Youn, Sofina Tanni, and Zarin
13 Yaquobie. So, if you guys can come up to the dais,
14 the desk. Also, did you guys have a fourth person or
15 is it just the three of you for your panel? Three,
16 okay perfect and feel free to begin whenever you're
17 ready.

18 SOFINA TANNI: Alright, hello. Can everyone hear
19 me? Okay. Thank you Chair Linda Lee and the
20 Committee Members for providing us with the
21 opportunity to testify. My name is Sofina Tanni and
22 I'm the Senior Program Coordinator at the Asian
23 American Federation and we're here to testify as part
24 of the AF's Asian American Mental Health Roundtable,
25 which is a coalition of 15 Asian led Asian serving

1 organizations that advocate for increased access to
2 culturally competent mental health care.

3
4 So, when evaluating city funded mental health
5 programs, it's essential that the Department of
6 Health and Mental Hygiene value both quantitative and
7 qualitative data. While members help us understand
8 reach, they don't capture the depth or complexity of
9 care our communities need.

10 Across our roundtable, providers report that
11 Asian New Yorkers are presenting increasingly severe
12 and layered mental health challenges, often related
13 to financial instability, family conflict, trauma and
14 isolation.

15 Supporting class through these experiences
16 requires trauma informed, culturally competent and
17 time intensive care that can't be fully reflected
18 through just numerical metrics alone.

19 For many Asian New Yorkers, healing takes a lot
20 of time. Progress sometimes looks like reduced
21 stigma, stronger family relationships, simply I
22 believe to even seek help. So, these qualitative
23 outcomes reflect meaningful impact and should be
24 recognized as followed measures of success. Without
25 the evaluation systems risk overlooking the real work

1 that's happening on the ground. When outcome
2 measures fail to reflect the intensity and culturally
3 responsiveness of services, they limit our ability to
4 advocate for policies and funding that truly meet our
5 communities needs.
6

7 Clear and inclusive evaluation standards ensure
8 that Asian communities are visible in data and funded
9 programs are assessed in ways that advance equity.

10 So, we urge the Council to consider the following
11 recommendations: Number one, incorporate equal
12 emphasis on qualitative outcomes when assessing
13 program success, not just numerical outputs. Number
14 two, evaluate programs based on depth of support,
15 especially for immigrant communities facing cultural,
16 linguistic and systemic barriers. Number three,
17 reduce reporting requirements to allow organization
18 to dedicate more staff time to direct services,
19 especially for communities requiring trauma informed
20 and time intensive support.

21 Number four, providing a transparent outline of
22 how program success will be measured including
23 required outcomes, reporting expectations, and
24 evaluation metrics, so that organizations can plan
25 data collection, build appropriate infrastructure and

1
2 accurately track outcomes. And finally, offer
3 capacity building workshops and host ongoing office
4 hours on program evaluations for smaller Asian led
5 CBO's, ensuring that they have the tools and the
6 guidance needed to meet reporting expectations
7 without being disproportionately burdened. Thank you
8 for the opportunity to testify and more information
9 will be found in our written testimony and we look
10 forward to working with you all.

11 CHAIRPERSON LEE: Great, thank you.

12 YUNA YOUN: Okay, hi everyone. Thank you Chair
13 Linda Lee and members of the Committee on Mental
14 Health, Disabilities and Addiction for holding this
15 hearing and providing us with the opportunity to
16 testify.

17 My name is Yuna Youn and I'm a Director at the
18 New York State Mental Health Clinic at the KCS.
19 Where we provide clinical and psychiatric services
20 and a host of other programming incorporating
21 community psycho education, family therapy, art
22 therapy and more. We are here testifying as part of
23 AAS mental health, Asian American Mental Health
24 Roundtable. I'd like to start off with a briefing
25 when we interview clinicians, as expected they bring

1
2 up the market value for their position if they were
3 to work in institutional settings or in private
4 practice. However, when we can only provide a
5 nonprofit rate, our current staff have all mentioned
6 that they would like to work at KCS because they want
7 to serve Korean and immigrant clients, knowing the
8 barriers they face and the lack of access to trauma
9 informed, culturally responsive support in their own
10 language. This is rare.

11 Our providers are the bedrock of our clinic and
12 we want to make sure that their work is sustainable,
13 and that they're financially secure and not have to
14 feel they are sacrificing their own wellbeing and
15 financial safety over their clients. Our experience
16 with delivering services and matching them to grant
17 reporting requirements, directly matches the points
18 that AAF raised.

19 Our providers truly care and providing meaningful
20 care grounded in relationships that they build with
21 clients. Something that cannot be expressed in
22 numbers. We see the progress and the full spectrum
23 of needs that are met. Children who don't readily
24 communicate finally open up through art therapy and
25 eventually engaging in family therapy.

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2 Individuals and couples becoming better aware and
3 able to care for themselves and others. Those with
4 severe mental illness, gambling and substance use
5 issues mandate at the counseling. Suicidal claims
6 and new clients discharged from psychiatric
7 facilities. All of them have come through our doors
8 and left better equipped to handle their challenges
9 and connected to a wide array of other social
10 services and community supports.

11 This work takes much time, tremendous dedication
12 and team work. We were notified yesterday that our
13 OMH clinic was recertified. A process occurring
14 every three years but due to COVID, happened in six
15 years.

16 The intensive documentation process for OMH
17 clinics in addition to all the reporting for city
18 discretionary grants, requires buy in from all our
19 staff, including fee for service staff who work other
20 full time jobs.

21 KCS remains committed to providing equitable,
22 culturally competent care. These are a few examples
23 of why we need an evaluation system that value
24 qualitative outcomes and the intensive nature of this
25 work.

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2 Thank you for the opportunity to testify today.

3 CHAIRPERSON LEE: Thank you.

4 ZARIN YAQUBIE: Good afternoon Chair Lee and
5 members of the Committee on Mental Health,
6 Disabilities and Addiction.

7 My name is Zarin Yaqubie and I serve as the
8 mental health clinician and Arab American Family
9 Support Center, otherwise known as AAFSC. We provide
10 linguistically accessible, trauma informed and
11 multigenerational social services to New Yorkers all
12 across the city and we particularly have expertise in
13 serving the growing Arab, Middle Eastern, North
14 African, Muslim and South Asian communities.

15 As members of AAS- Asian American Mental Health
16 Roundtable, we are here today to underscore the
17 urgent mental health needs of New York City's Pan-
18 Asian and immigrant communities and to emphasize the
19 importance of valuing both qualitative and
20 quantitative data when evaluating city funded mental
21 health programs.

22 While quantitative data shows how many people are
23 served, qualitative data shows how our services
24 actually impact peoples lives. It captures our
25 clients real experiences and shows that healing and

1 progress cannot always be measured by numbers alone.

2 And at this moment, qualitative data makes clear that
3 our community members are struggling profoundly.

4 Cuts to vital social safety programs, coupled with
5 increasingly punitive immigration enforcement

6 measures have created immediate and deeply felt

7 threats to the family unity, economic stability and

8 overall wellbeing. Every day our staff witness

9 pervasive fear and anxiety among our clients.

10 Families delay or withdraw from the central services

11 despite urgent needs and parents are fearful of

12 sending their children to school. Community members

13 avoid medical care and hesitate to report violence,

14 abuse or exploitation. These realities are not

15 easily quantified but they are deeply consequential.

16 And then back to our community, mental health

17 status has been profound. Demand for mental health

18 services at our agencies have surged by more than 80

19 percent at the beginning of this year and have

20 continued to grow exponentially.

21 And while the state appointments important, the

22 contents behind is even more telling. Individuals

23 are seeking care amid compounding crisis's prolonged

24 uncertainty and sustained trauma, when they are
25

1 culturally competent and linguistically accessible to
2 them.
3

4 We urge the Council and the Department of Mental
5 Health and Hygiene to consider the following
6 recommendations: To incorporate equal emphasis and
7 qualitative outcomes alongside quantitative metrics
8 when assessing a program success.

9 Evaluate programs based on the depth of quality
10 of support provided, particularly for immigrant
11 communities facing cultural, linguistic and systemic
12 barriers. Reduce administrative and reporting
13 burdens so organizations can dedicate more time to
14 direct trauma informed services.

15 And lastly, to provide a clear and transparent
16 framework outlining how program success will be
17 measured, including required outcomes, reporting
18 expectations and evaluation metrics. City funded
19 mental health programs must be evaluated in ways that
20 truly advance equitable outcomes for immigrant New
21 Yorkers. Thank you for your time.

22 CHAIRPERSON LEE: Thank you and if you have not
23 submitted the written testimonies, definitely submit
24 them if you haven't already. So, okay thank you
25 everyone, especially for the work you guys are doing

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2 in the community. I know it's not easy, so we
3 appreciate you all. Thank you.

4 Uhm, okay, the second in person panel, Dr. Van
5 Yu, Bridgette Callaghan, Paula Magnus, and Irvin Dana
6 Beal.

7 Sure, which ever order.

8 DR. VAN YU: Sorry about that. Good afternoon
9 Chairperson Lee. My name is Dr. Van Yu, I'm the
10 Chief Medical Officer of the Center for Urban
11 Community Services, CUCS and its healthcare affiliate
12 Janian Medical Care. CUCS operates eight intensive
13 mobile treatment teams, serving more than 200 New
14 Yorkers who because they have been unable to engage
15 and sustain relationships with traditional providers,
16 have fallen through the cracks of our mental health,
17 housing, and criminal justice systems.

18 IMT works because we prioritize relationships
19 over everything else by building trust and nurturing
20 relationships over time, we create the safety
21 participants need to engage in care and to start to
22 build new lives. Our outcomes demonstrate this model
23 works.

24 In November 2025 alone, IMT psychiatrists
25 conducted 133 visits with 116 participants and

1 provided 226 medication prescriptions to 61
2 participants. Our participants demonstrate 72
3 percent medication adherence for schizophrenia, 57
4 percent adherence to medication assisted treatment
5 for opioid use disorder, which is compared to 25
6 percent nationally for unhoused populations, and 57
7 percent utilization of long acting injectable
8 medications for psychotic disorders compared to just
9 four percent nationally.
10

11 Let me give you one example. Mr. C. is a man in
12 his early 50's with a long history of trauma,
13 substance use, and debilitating medical conditions.
14 He was referred to us with frequent emergency service
15 utilization and a history of street homelessness. He
16 was initially aggressive with the team, including
17 throwing hot coffee at the team - at team members at
18 one occasion.

19 However, through repeated outreach and nearly
20 daily visits, he developed trust and became willing
21 to accept care including medications. His alcohol
22 use has decreased significantly. His physical health
23 has improved and ER utilization has significantly
24 decreased.
25

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2 The cost effectiveness with IMT is striking. Our
3 program costs about \$44,000 per participant annually.
4 Compare that to a two week psychiatric
5 hospitalization at about \$25,000 or incarceration at
6 Rikers at about \$507,000 per year.

7 Additionally, the kind of healthcare service
8 costs that go into these programs are remarkably
9 efficient. For example, street medicine costs about
10 \$2,400 per day, which amounts to about \$410 per
11 patient visit while primary care costs \$1,600 per day
12 or about \$250 per patient visit.

13 When you consider that, we are preventing the
14 costly crises that have defined these individuals
15 lives, the value is clear. So, IMT is proven
16 effective and cost effective but to scale what works
17 and address disparities, we need to access more
18 comprehensive data. I would like to acknowledge that
19 DOHMH has taken steps to share data to provide us an
20 intern for eight years and we really appreciate this
21 progress.

22 However, there are significant delays in
23 receiving housing retention data, housing placement
24 data and psychiatric hospitalization data and some
25 other kinds of data are lacking, all at which could

1
2 be used to both improve the IMT model and also
3 demonstrate IMT's impact on our healthcare system.
4 I'll stop there. Thanks a lot. We'll be submitting
5 -

6 CHAIRPERSON LEE: You can finish up.

7 DR. VAN YU: Okay, great thanks. Comparative and
8 logic data and data about trends and different
9 populations could shape and improve staff training,
10 address disparities, and guide utilization of
11 effective interventions. Here are three things that
12 could be helpful. First, access to data on days,
13 incarcerated days, hospitalized, ER visits and
14 arrests before IMT and add the connection time.

15 Second, access the data, that allow us to see
16 relationships between service provided and outcomes,
17 controlling for demographics, diagnosis and settings.

18 Third, real time dashboard tracking and
19 hospitalizations, incarcerations, ER visits, and
20 relationships between these outcomes and factors like
21 race, gender, diagnosis and housing type.

22 With the Council's oversight and DOHMH's
23 commitment you can ensure that city funded mental
24 health programs have the support and data needed to
25 keep improving and delivering equitable, effective

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2 secure to our most affordable New Yorkers. Thank
3 you. We'll be submitting written testimony also.

4 CHAIRPERSON LEE: Okay, perfect, thank you. You
5 can go ahead, yes, hi, how are you?

6 IRVIN DANA BEAL: Ah good. I'm - my name is Dana
7 Beal. I've testified to you before. I'm here
8 representing Act Up. I might note that uh the AIDS
9 Coalition to Unleash Power had to agitate for ten
10 years to get effective medications for HIV AIDS.

11 The advent of growth promoters, such as ibogaine,
12 completely changes the calculus of public health and
13 the treatment of substance abuse. It will save New
14 York money at every step. We, the research access
15 working group of New York Act Up, acknowledge that
16 New Yorkers with financial resources are already
17 accessing ibogaine in Mexico, Costa Rica and Brazil.

18 Being trained for a week or two and coming home
19 clean. While these programs can cost the patients
20 from \$5,000-\$12,000. We can do it here for about
21 \$2,000 per patient. Ibogaine researchers have found
22 that for opioid substance use disorder, 50 percent of
23 the ibogaine patients are able to stay opioid free
24 for six months after a treatment.

25

2 This is phenomenal compared to NA, peer support,
3 suboxone and methadone. The cost of lifetime
4 medication is canceled for cocaine and
5 methamphetamine. The only conventional
6 pharmacotherapy is Wellbutrin, effective for only one
7 in ten. Adding naltrexone increases that two percent
8 to twelve percent.

9 Since ibogaine regenerates dopamine directly, the
10 numbers for psychostimulants are a bit better than 50
11 percent. A bonus is that about 50 percent also
12 recover from their need to use alcohol and tobacco.
13 A leading cause of death and a huge social and law
14 enforcement problem.

15 This is hospital procedure, requiring medical
16 supervision during the acute phase about two to three
17 days. Patients must be screened for preexisting
18 conditions and any other meds before treatment.
19 Additionally, because the treatment is swift, it
20 frees up their bed for other treatments after a week,
21 unlike the 90 day treatment model for other detox
22 rehab programs.

23 This is a gigantic gift to our economy and social
24 service systems. Long drug offenders clog our
25 courts, fill our jails, and resist efforts to modify

1
2 their behavior. Addictions are a mighty driver of
3 social problems and a public health nightmare.

4 People use IV drugs also spread Hep C and HIV.
5 They are more likely to do so if they cycle in and
6 out of jail. The other principle sector of HIV
7 transmission is Kem sex with crystal meth.

8 During their lifetimes, people with HIV generally
9 cost our healthcare system and Medicaid programs
10 about \$500,000 per patient. If the patient is HIV
11 diagnosis is delayed for three years, perhaps because
12 our HIV prevention budget was just cut, that number
13 jumps to \$1 million.

14 We believe that offering this additional therapy
15 option will be meaningfully reduced transmission of
16 HIV and total HIV healthcare costs. In addition,
17 this is extremely important. Among people with
18 psychiatric disorders, ibogaine often also resolves
19 the underlying problems that are driving substance
20 abuse and homelessness such as bipolar disorder,
21 which it's extremely effective for.

22 In addition, the cost of keeping nonviolent
23 offenders in jail is astronomical. What if we could
24 offer a diversion program in the form of an ibogaine
25 treatment option? The Department of Corrections has

1 three hospitals, all rehabbed and ready to go. That
2 are not being used for Rikers patients because of
3 staffing issues. What if the Bellevue facility at
4 462 First Avenue was transferred to DOHMH, so that
5 people under court supervision as well as the general
6 public could benefit from this medical breakthrough?
7 That 100 beds could provide treatment for up to 5,200
8 people a year. One a week, more than enough to
9 address the treatment shortfall that's keeping us
10 from closing Rikers.
11

12 Let's support an ibogaine drug treatment
13 diversion option through the establishment of a
14 clinic with the oversight of doctors at Columbia
15 University with a background in this type of therapy.

16 I also might add, your aid John Wanny(SP?) has a
17 draft of a bill that we're trying to get you or Erik
18 or somebody to introduce. There are several
19 different ways of proceeding, however, we can do the
20 Rikers alternative or we could do an overdose
21 prevention center that is like ibogaine oriented.

22 CHAIRPERSON LEE: So, those - yeah, I can
23 definitely -

24 IRVIN DANA BEAL: When can we meet with you
25 personally?

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2 CHAIRPERSON LEE: Yeah, so I think John - is he
3 here? He may have stepped out but uhm yeah, we'll
4 set up a time to have that conversation because also
5 I mean without going into details, even if we have a
6 bill in the pipeline, it doesn't mean it's always
7 going to get introduced but we'll talk about that
8 offline.

9 IRVIN DANA BEAL: Okay, thank you.

10 CHAIRPERSON LEE: Thank you. Just wanted to
11 recognize we've been joined by Council Member Abreu
12 and also Bridgette, you're just on time. Thank you.
13 Go ahead.

14 BRIDGETTE CALLAGHAN: That's generous, I think
15 that I'm late and I very much apologize for that.
16 Good afternoon Chairperson Lee and members of the
17 Committee. Thank you for the opportunity to testify.
18 My name is Bridgette Callaghan. I'm the Vice
19 President of Intensive Mobile Treatment programs at
20 the Institute for Community Living, otherwise known
21 as ICL.

22 ICL supports New Yorkers with complex behavioral
23 health needs, fair housing, healthcare and recovery
24 services, reaching about 13,000 people each year
25 across more than 140 programs in New York City.

1
2 First, thank you Chair Lee for your leadership,
3 accessibility and via commitment to equity and to New
4 Yorkers who are struggling. Today's hearing is about
5 how DOHMH evaluates outcomes and equity and I want to
6 underscore both what's working and what needs to
7 improve.

8 ICL'S Intensive Mobile Treatment in our
9 innovative first of its kind step down program steps,
10 are models of distinction for reaching the most
11 acute, hardest to engage New Yorkers. People have
12 often spent decades on the streets and cycling
13 through shelters, hospitals and other crisis systems.
14 IMT meets people where they are and stays with them
15 through instability. Across ICL 6 IMT teams, 90
16 percent are connected to care. Housing increased
17 from 40 percent of the time of referral to now 83
18 percent of our folks are currently housed.
19 Medication adherence rise to 68 percent and in the
20 last six months 93 percent avoided a mental health
21 related emergency room visit or inpatient
22 hospitalization, 98 percent had no criminal justice
23 involvement. That's it for my data.

24 To sustain and strengthen these outcomes, we need
25 clear and regular IMT reporting. Our teams submit

1 detailed data to DOHMH every month through the system
2 but providers don't get the compiled information
3 back. Because of this, we can't track trends,
4 identify inequities or use the data for continuous
5 learning and quality improvement. We urge DOHMH to
6 match what's done for the states ACT program. ACT
7 data is reported and shared publicly through an OMH
8 dashboard that teams can review and learn from. IMT
9 deserves the same level of transparency. Providers
10 like ICL also already generate data regularly sharing
11 it back and publicly reporting it would strengthen
12 accountability, support equity, and improve outcomes
13 across the system.

14
15 Finally, we want to thank the City Council for
16 securing critical fiscal year '26 investments, \$11
17 million for IMT and \$4.5 million for related
18 intensive services. We eager to see these funds
19 procured and deployed so we can expand access to IMT
20 and ACT stepdown programs. Thank you.

21 CHAIRPERSON LEE: Thank you. That was a good
22 summary of what you submitted. Yeah, yeah, yeah, no
23 I appreciate it. Thank you. Okay, uhm, thank you
24 all for this panel and then okay, we're going to move
25 to the Zoom remote testimony. So, thank you so much.

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2 Oh, okay. I think so. Okay, we will now move to
3 Zoom testimony. Please wait for your name to be
4 called to testify and select unmute when prompted and
5 so far we only have one person on Zoom. It's
6 Christopher Leon Johnson. If you're there, oh there
7 you are, yes. So, feel free to start.

8 CHRISTOPHER LEON JOHNSON: Yeah, hello, my name
9 is Christopher Leon Johnson. Thank you Chair Lee for
10 being a great Chair for the past two years at the
11 Mental Health Chair. I know you'll be reappointed as
12 a Chair on the Menez Administration, so don't worry
13 about that. But I want to make - I know that in the
14 next session, uhm, there's going to be a more
15 moderate approach to the City Council, which will
16 make people believe in the government again, you know
17 as the City Council be at a special check and balance
18 to our incoming Mayor Zohran Mamdani but what I
19 request in the next session is that the City Council
20 starting with the Committee on Mental Health,
21 Disability and Addiction, have a hearing, a joint
22 hearing with DYCD and Public Safety when it comes to
23 the Cure Violence organizations in the city. Because
24 they're taking all this money for mental health
25 outreach and nothing is getting accomplished.

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2 All this - what they're doing is they're just
3 lining their pockets up with the money while you
4 still have the violence that's going on in the
5 communities. Look, I think you heard what happened
6 in Sandy Nurse's district, where six people got shot
7 outside of a sweet sixteen party.

8 Now, a Cure Violence nonprofits like Brownville,
9 they take matters and learners and uhm, the other one
10 that Chris Banks worked with, I think it's like a TMK
11 or something like that. TMK, I think uhm, they get
12 all that money from these Cure Violence for mental
13 health and this stuff is still going on. So, I
14 believe that you as Chair Mrs. Lee, you need to start
15 having like request a hearing from Menin and I'm
16 going to ask Menin to do this in the next session.
17 To have a special hearing and start asking these Cure
18 Violence nonprofits all these executive directors,
19 you all get all that money for mental health
20 outreach. What are you all doing with the money?
21 Because the violence is still going on in the
22 communities. People still get shot and killed.
23 People are still getting traumatized by these
24 shootings to where the point that they want to
25

1
2 eradicate shots splatter, so they can line their
3 pockets up.

4 So, I'm calling on you Mrs. Linda Lee, I mean I'm
5 going to do this myself when she becomes speaker,
6 when she going on the seven; the day after, I'm going
7 to make that request to the Speaker Menin that she
8 has a special hearing and call - and subpoena all
9 these nonprofits to come out and testify and ask
10 where this money is going.

11 But I want to end this right here, just say that
12 uh, like I said, that's basically - that's my
13 request. I think a lot of these other organizations
14 that was speaking today, they hit it on the money.
15 Like they need funding. They do need funding and
16 uhm, like I'm not against that but like I said
17 before, these Cure Violence nonprofits need to be
18 called out because nothing is getting accomplished.
19 It's just a grift and what it does and I know I have
20 three seconds left, is that all it does is that it
21 divides the community from the nonprofit and then it
22 helps divide the community from the government. And
23 it really lowers the trust between community and
24 government and I think we know in the past four years
25

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1 under this speaker, Adrienne Adams, she dropped the
2 ball. She dropped the ball heavily.

3
4 SERGEANT AT ARMS: Thank you so much. Your time
5 has expired.

6 CHRISTOPHER LEON JOHNSON: Hello.

7 CHAIRPERSON LEE: Yeah, if you could just wrap up
8 in a couple sentences, that would be great.

9 CHRISTOPHER LEON JOHNSON: All this does is just
10 divides the community from the government and I
11 believe that you - I think I see Shaun Abreu next to
12 you. Shout out to Shaun Abreu, he is going to keep
13 his spot too as the Sanitation Chair. But like I
14 said, I hope next year that Mrs. Menin, as a Speaker
15 and you, Linda Lee and Shaun Abreu, come together and
16 help rebuild that trust between this community and
17 the City Council. That starts with - especially in
18 the districts, let's start with all these corrupt
19 Cure Violence nonprofits, especially the ones I just
20 mentioned.

21 So, thank you and enjoy your day.

22 CHAIRPERSON LEE: Great, thank you.

23 CHRISTOPHER LEON JOHNSON: Thank you, thank you.

24 CHAIRPERSON LEE: Great, okay. So, we have Paula
25 Magnus. Sorry, because we called you earlier but I

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2 think yes, sorry about that but yes, not to rush you
3 but you know whenever you're ready, feel free. And
4 then let me just call a couple names, Grace Nicholas,
5 Alex Stein. I'm not sure if you guys are on Zoom.
6 If you are, please raise your hand.

7 PAULA MAGNUS: My apologies, thank you so much
8 Chairperson Lee and esteemed Committee for of course
9 convening this critical hearing. I'm Paula Magnus,
10 the Deputy Director of Northside Center for Child
11 Development. For over 75 years, we provided
12 comprehensive evidence based trauma informed mental
13 health services to children and family in Harlem and
14 surrounding boroughs. We currently operate two City
15 Council funded programs contracted with DOHMH. Based
16 on our experience, we offer three observations.
17 Consistency of engagement, tracking treatment,
18 contacts is valuable for children under five and
19 therapeutic contacts that bill secure, attachment of
20 course is extremely important.

21 For our court involved youth program, regular
22 contacts, correlated with better engagement and
23 sustained outcomes that consistency is so important
24 and data informed clinical practice, regular
25

1 assessments, allow us to adjust intervention as
2 needed based on the data that's received.

3
4 Data quality, rigorous practices are essential
5 when court child welfare system and schools rely on
6 provider reports to make critical decisions. So,
7 that's important and equity consideration is also
8 extremely important. Measuring equity across race,
9 ethnicity, and primary languages and the location is
10 vital and important. And the value of standardizing
11 that information. We encourage the Council to
12 collaborate with DOHMH and providers to establish
13 standardized outcomes, measurements across all city
14 funded mental health programs. And the fact that the
15 implication requires that it's fully cost rendered is
16 essential in the three areas, data infrastructure.
17 We need to have certain electronic healthcare
18 records, which compliments all the Microsoft SQL's
19 and all that server requirements to pull the database
20 and generate the reports and power BI to provide real
21 time viable productively and outcome information to
22 research. Staff capacity for data collection and
23 quality assurance.

24 And third, financial needed for training and
25 technical assistance from DOHMH. Our recommendation

1
2 is adequate funding for data infrastructure and the
3 reporting will demonstrate that small investments and
4 mental health produce meaningful outcomes for all
5 communities.

6 I'm sure you heard this throughout, I'm just
7 repeating it but thank you for your time and just
8 wanted to make sure we presented and we shared our
9 copy as well.

10 CHAIRPERSON LEE: Thank you so much and I'm glad
11 you made it in time.

12 Okay, uhm, if none of you folks are here, then I
13 think - oh right, okay sorry. Thank you to everyone
14 who has testified and if there is anyone present in
15 the room or on Zoom that hasn't had the opportunity
16 to testify, please raise your hand. And if not,
17 seeing no one else, uhm, I would like to note that
18 written testimony, which will be reviewed in full by
19 Committee Staff, may be submitted to the record up to
20 72 hours after the closing of this hearing by
21 emailing it to testimony@council.nyc.gov.

22 Thank you and with that, we are signing our for
23 the year but starting in January, so. Thank you
24 everyone and Happy Holidays. [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 January 15, 2025