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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HELD AT: REMOTE HEARING - VIRTUAL ROOM 1

B E F O R E: Farah N. Louis,
Chairperson

COUNCIL MEMBERS:

Diana Ayala
Alicka Ampry-Samuel
Joseph C. Borelli
Eric Dinowitz
Kevin C. Riley
Public Advocate Jumaane Williams

A P P E A R A N C E S

Susan Herman
Senior Advisor to the Mayor and Director of the Mayor's Office of Community Mental Health

Dr. Chinazo Cunningham
Executive Deputy Commissioner for Mental Hygiene at the Department of Health and Mental Hygiene

Dr. Torian Easterling
First Deputy Commissioner and Chief Equity Officer at the Department of Health and Mental Hygiene

Dr. Charles Barron
Deputy Chief Medical Officer, Office of Behavioral Health at Health and Hospitals

Dr. Rebecca Linn Walton
Senior Assistant Vice President Office of Behavioral Health and Health + Hospitals

Laura Kavanaugh
First Deputy Commissioner at the Fire Department of New York

Ravi Reddi
Associate Director for Advocacy and Policy at the Asian American Federation

Yu-Kang Chen
Clinical Psychologist at Hamilton Madison House

Natalie Reyes
Deputy Director at Midtown Community Court

Jayette Lansbury
Chair Criminal Justice for the National Alliance of Mental Illness

Kimberly Blair
Manager of Public Policy and Advocacy for NAMI NYC

Mackenzie Arnold
Legal Fellow at New York Lawyers for the Public Interest

A P P E A R A N C E S (CONT.)

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

P. Jenny Marashi
Correct Crisis Intervention Today New York City

Caitlin Becker
Managing Director of Social Work at the Bronx Defenders

Craig Hughes
Social Worker with the Safety Net Project at the Urban Justice Center

Kathryn Fazio
Poet who represented the USA at the Fifth World Congress of Poets

SERGEANT KOTOWSKI: Computer recording started.

SERGEANT PEREZ: Backup is rolling.

SERGEANT HOPE: Thank you. Sergeant Lugo, you may begin with your opening statement.

SERGEANT LUGO: Good morning everyone. Welcome to today's Remote New York City Council Hearing of the Committee on Mental Health, Disabilities and Addiction. At this time, would all panelists please turn on your videos. To minimize disruption, please place electronic devices to vibrate or silent. If you wish to submit testimony, you may do so at testimony@council.nyc.gov. Again, that's testimony@council.nyc.gov.

Thank you for your cooperation. Chair Louis, we are ready to begin.

CHAIRPERSON LOUIS: Good morning. I'm Council Member Farah Louis, Chair of the Committee of Mental Health, Disabilities and Addiction and I'd like to thank everyone for joining us today for this very important hearing.

This morning, we are holding an oversight hearing on Coordinating City Agencies to Address Mental Health Illness. Simply put, mental illness impacts every aspect of an individuals life. According to

the National Alliance on Mental Illness, a mental health condition is best understood as a multifaceted disorder with multiple linking causes. Mental illness can possibly and probably be understood within the framework of what is known as social determinants of health. Which according to the CDC, are conditions in the places where people live, learn, work and play that affect a wide range of health and quality of life risks and outcomes.

Specifically, the five domains of social determinants of health include: Access to quality health care, health literacy and health insurance. Access to quality education, including language and literacy skills beginning in early childhood development. The social connection and characteristics of where people live, and the prevalence of discrimination and rates of incarceration within that community. And factors of social economic stability, including the cost of living, food, security and housing stability. And neighborhood environment, including access to transportation, clean air and water, and proximity to crime and violence within the community.

While COVID-19 has disproportionately impacted communities of color, the unmet mental health needs of these communities were apparent long before the pandemic. And there is every indication that moving forward, the mental health needs of these New Yorkers will remain high. In general, there is a lack of access to affordable housing. Culturally sensitive care within Black and Brown communities and other communities of color in New York City.

Across the country, millions of Americans now live in mental health deserts. And mental health care professional shortage areas. Because there are too few health providers, relative to the needs of these populations. Unfortunately, this trend holds true in New York City. In the Bronx, 90 percent of residents insured by Medicaid, live in a mental heath desert and most are Black and Brown low income New Yorkers. And to make matters worse, during the height of the pandemic, as the demand for inpatient beds increased, mental health care beds and services became even larger to find for those already struggling to access quality care. Reportedly, mental health patients were at time discharged prematurely, even though many still exhibited

symptoms. Or even forced to stay in facilities far from their neighborhoods and communities.

When unsheltered New Yorkers are discharged without proper aftercare plans, the results can be disastrous for everyone. Often, several agencies can be involved in attempts to provide stabilizing resources for one person. But the question we hope to have answered here today is, how does agencies communicate with one another to ensure best outcomes for all? Does DHS, H+H, DOHMH and if necessary the justice system, have a common threat of discussion? A strategy to update the status of individuals who are at varying stages of receiving services within each agency?

How will the new office of Community Health improve the circumstances for these vulnerable New Yorkers seeking care and the coordination between the service— between the agencies providing these critical services?

At today's hearing, the Committee will be hearing from the Administration, providers, community-based organization and advocates about how New York City can provide effective coordination between all agencies to better respond and address mental health

crisis and emergencies that they still face so many in New York.

I want to thank the Administration, the Office of Community Health, DOHMH and others who are here today to testify. I know you are committed to working on this issue for all New Yorkers and to effectively address the mental health needs that arise in our communities. I look forward to hearing from you all today.

I also want to thank my colleagues, as well as my staff, my Legislative Director Kristia Winter, Legislative Liaison Alex Tymkiv, as well as our Counsel Committee Staff Senior Counsel Sara Liss, Legislative Policy Analyst Cristy Dwyer, and Financial Analyst Lauren Hunt for making today's hearing possible.

Now, I will turn to Public Advocate Williams who will make a statement. Thank you.

PUBLIC ADVOCATE WILLIAMS: Thank you so much. Can you hear me? Thank you very much Chair Louis for honoring me some time to speak today and for holding this hearing. As you mentioned, my name is Jumaane Williams and I'm the Public Advocate for the City of New York.

First, happy ten year anniversary to occupy Wallstreet for those who don't know. It's a good day to celebrate that. I very much appreciate holding today's hearing on how the city can do better to address serious mental illness. It is clear that more can be done to improve agency response and implement sensible policies to help New Yorkers struggling with mental illness. However, the Administration needs to overhaul its approach and be active in addressing mental health, especially in the last few months of its tenure.

On my visit to Rikers Island this past Monday, there was an ordinant amount of people who have mental health challenges. Add on top of that, they weren't even getting their medication. Some for many, many days. We all know the largest facility dealing with mental health. Probably North America is Rikers Island.

One program already in effect is the administration's new behavioral health emergency assistance response division or B-HEARD Program. This partner program was designed to address the problematic approach of sending the New York Police Department to mental health calls. As we all know,

calling the police for a person experiencing a mental episode can be fatal. Many police officers themselves say, they do not want to be in charge of responding to these calls.

In the first month of the pilot in Harlem, there were 532 mental health calls. We heard only responded to 107 or 20.1 percent of these calls. This is disappointing since the administration said that the NYPD would respond to between 30 to 40 percent of calls. In 31 calls, the NYPD responded instead of B-HEARD because of staffing issues. If the goal is to divert mental health calls from police, then we are not even close to being there.

Additionally, the administration needs to make sure we do not rely on 911 for mental health calls. As seen on the data on the pilots first month, 911 dispatchers believed a person with mental health was a threat that required the presence of a police or police officers. 911 operators trained to determine the best judgement for mental health calls, it is difficult to determine whether they are trained or not.

We need an alternative number to 911. Nationally, only 25 percent of 911 calls deal with a

crime. Is experiencing mental illness a crime? I do not believe that it is. And the administration should not use excuses to not implement a simple policy. I raise the creation of an alternative number for mental health calls to ensure mental health responders are present to mental health calls as seen in my bill Intro. Number 2222. Sadly, the Administration has not been supportive of this bill and the use the excuse that there is already a number. I think it's 1-800-WELLNESS, it may be another. It is long and it is not the easiest for people to use. And the national discussion is actually moving toward a three digit number instead of being a leader here, it seems New York City once again follow.

Meanwhile, the administration only has one support and connection sent to East Harlem. These centers help people experiencing mental health and or substance use challenges. Yet, the expectation was that there would be two centers. One in East Harlem and another in th Bronx. We do not know when the Bronx facility will be open despite the city acquiring the building in 2017. My office sent a letter to the administration on the status of the

facilities and when it would be available for use. I appreciate the response. They explained that it would be open this year. It is September 2021 and the administration only has until the end of December to make sure that it is open, otherwise, the next Mayor will be in charge of opening it and managing it.

I anticipate an update on the status of the Bronx facility at this hearing. If not, sometime soon. In addition, I am calling for an addition four new support and connection centers in our next budget. As I noted in my renew deal for New York City report early this year, the city must strengthen local community-based mental health infrastructure and an additional $20 million is sufficient for four new centers.

Finally, we need to ensure agencies provide more for communities of more color who are dealing with mental health. I, myself, have been open in how important mental health and seeking therapy has been for me the past five or six years. The Mayor's Office of Community and Mental Health knows the Black, Latinx and Asian New Yorkers are likely to be connected to mental health care compared to White New

Yorkers. COVID-19 has only amplified and exacerbated these disparities. Yet, there are not major programs to ensure equity to connect people with mental health care. We need to act aggressively in overhauling the city's infrastructure to respond to mental health. Part of that consists of new mental health centers, while also informing New Yorkers have programs available to them. I hope this work can begin soon.

We must also review the legacy of this administration including Thrive NYC. In April, it named itself into the Mayor's Office of Community Health, Mental Health and kept Thrive NYC's Director. The goals of Thrive NYC have been unclear and have elicited controversy. What can they accomplish in the next last few months in this administration tenure? Addressing mental health should not be a mayoral responsibility, it also must be community driven. The goal should not be speaking to communities but with communities.

I appreciate Thrive NYC's ability to raise issues like mental health. I appreciate that some people have received assistance through Thrive NYC. But I must say after more than $1 billion spent, I do not see a commensurate amount of productivity from the

program, sadly. Our city certainly needs to improve responses and create strong infrastructure for communities effected by mental health and mental illness. I anticipate today's discussion will show us some solutions that we can take. Again, I thank the Chair for today's hearing and the administration for being present.

CHAIRPERSON LOUIS: Thank you so much Public Advocate Williams for being here and for your statement. I would like to acknowledge Council Members Dinowitz, Riley, Borelli and Ampry-Samuel who have joined us this morning and I'll now turn it to Committee Counsel Sara Liss to go over procedural matters for the hearing. Thank you.

COMMITTEE COUNSEL: Thank you very much Chair Louis. My name is Sara Liss and I am the Counsel to the Committee on Mental Health, Disabilities, and Addiction for the New York City Council. I will be moderating today's hearing. Before we begin, I wanted to go over a couple of procedural matters. I will be calling on panelists to testify. I want to remind everyone that you will be on mute until I call on you to testify. At which time, you will be unmuted by the host. Please listen for your name to

be called. And for everyone testifying, we're still on Zoom, so please note that there may be a few seconds of delay before you are unmuted and we thank you in advance for your patience.

At today's hearing, the first panel will be the Administration followed by Council Member question and then the public will testify. During the hearing, if Council Members would like to ask a question, please use the Zoom raise hand function and I will call on you in order.

I will now be calling on the following members of the administration to testify. Director Susan Herman Mayor's Office of Community Mental Health, Dr. Chinazo Cunningham Executive Deputy Commissioner for Mental Hygiene at the Department of Health and Mental Hygiene, Dr. Torian Easterling First Deputy Commissioner and Chief Equity Officer at the Department of Health and Mental Hygiene, Dr. Charles Barron Deputy Chief Medical Officer, Office of Behavioral Health at Health and Hospitals, Dr. Rebecca Linn Walton Senior Assistant Vice President Office of Behavioral Health and Health + Hospitals and Laura Kavanaugh First Deputy Commissioner at the Fire Department of New York.

I will now read the oath and after I will call on each panelist here from the Administration individually to respond. Do you affirm to tell the truth, the whole truth and nothing but the truth before this Committee and to respond honestly to Council Member questions? Director Herman?

SUSAN HERMAN: I do.

COMMITTEE COUNSEL: Thank you. Dr. Cunningham?

DR. CHINAZO CUNNINGHAM: I do.

COMMITTEE COUNSEL: Dr. Easterling?

DR. TORIAN EASTERLING: Yes, I do.

COMMITTEE COUNSEL: Dr. Barron?

DR. CHARLES BARRON: I do.

COMMITTEE COUNSEL: Dr. Linn Walton?

DR. REBECCA LINN WALTON: I do.

COMMITTEE COUNSEL: And Deputy Commissioner Kavanagh?

LAURA KAVANAGH: I do.

COMMITTEE COUNSEL: Thank you all very much and Director Herman, you can begin when you are ready.

SUSAN HERMAN: Thank you. Good morning, Chair Louis, Public Advocate Williams, and members of the Committee on Mental Health, Disabilities, and Addictions. My name is Susan Herman and I am a

Senior Advisor to the Mayor and Director of the Mayor's Office of Community Mental Health. I am joined by several colleagues: Dr. Torian Easterling First Deputy Commissioner and Chief Equity Officer, and Dr. Chinazo Cunningham Executive Deputy Commissioner of the Division of Mental Hygiene, both at the Department of Health and Mental Hygiene; Dr. Charles Barron Deputy Chief Medical Officer, and Dr. Rebecca Linn Walton Senior Assistant Vice President in the Office of Behavioral Health, both at New York City H+H; and Laura Kavanagh First Deputy Commissioner at the NYC Fire Department. Thank you for the opportunity to testify.

Four percent of all adults in New York City, around 240,000 people, have serious mental illness, or SMI. SMI includes illnesses such as bipolar disorder, schizophrenia and major depressive disorder resulting in serious functional impairment. This means that the illness is severe enough to substantially interfere with one or more major life activities. These New Yorkers have a wide range of needs. And addressing these needs requires dedicated, coordinated assistance from many different parts of city government.

When we talk about serving New Yorkers with serious mental illness, we mean reaching the 80-year-old who lives alone and has been homebound during the pandemic. The high school junior experiencing the first symptoms of psychosis. The gun violence victim whose symptoms of PTSD and significant depression have lingered for months. And the person struggling with chronic street homelessness and bipolar disorder. And the person who after multiple psychiatric hospitalizations, is now connected to a mobile treatment team that brings clinical care to him or her.

In the past seven years, Mayor de Blasio in partnership with the City Council has significantly expanded services for New Yorkers with serious mental illness. Here are just a few example. Just a few. Before 2015, there were 41 city funded mobile treatment teams. Currently, there are 57. And now we are adding another 25 teams, totaling 82 city-funded mobile treatment teams. With these new teams, the total number of clients who can be served by a mobile treatment team, both those funded by the city and those funded by the State, will grow from just over 3,900 people in 2015 to over 5,300 people.

Mobile treatment teams provide ongoing, clinical care to people in their neighborhoods. People who have had difficulty staying connected to more traditional forms of clinic-based mental health care. There are several different mobile treatment team models, some of which offer more intensive support for people with recent justice involvement or escalating violent behavior.

Mobile treatment has made a profound difference. For example, around 90 percent of people served by Intensive Mobile Treatment teams, known as IMTs, remain in treatment consistently for at least 12 months. This is a remarkable success rate, given that one of the reasons clients are assigned to an IMT is because they have been inconsistently engaged in more traditional forms of care in the past. A high percentage of clients are experiencing homelessness when they begin treatment with an IMT.

Since 2015, 41 percent of all clients who were homeless at the outset of IMT treatment have secured permanent, non-shelter housing through their IMT. We have also expanded the number of supportive housing units for people with serious mental illness from 7,400 in 2015 to 9,600 at the beginning of 2021. And

as you know, housing is one of the most important determinants of someone's stability and mental health. These are just a few important accomplishments. Allow me to mention a few more examples.

Three years ago, people experiencing a behavioral health crisis, an urgent need, but not an emergency, waited an average of 17 hours for a mobile crisis team to come to their home, conduct an assessment, and provide care. We recently added six more mobile crisis teams, for a total of 24 for adults now operating citywide. These are teams of psychiatrists, social workers, peers, and nurses. And they arrive in around two hours, seven days a week, between 8 a.m. and 8 p.m. citywide.

This administration also created Co-Response Teams. Two police officers and one social worker. These teams offer a pre and post crisis intervention for people with mental illness and substance use disorders who may be at an elevated risk of harm to themselves or others. They connect people to care, including medical and mental healthcare, and legal, housing and other social services. Four years ago, New York City did not have Co-Response Teams. There

was no comparable proactive intervention for people who had been violent and whose mental health seemed to be worsening.

In the last four years, these teams have assisted over 2,200 people across the city, often meeting with them several times over a period of many months. We have also added capacity to the Assisted Outpatient Treatment Program, which provides mental health services to individuals who need court mandated treatment, also known as Kendra's Law.

In fiscal year 2013, there were 1,289 people monitored by the AOT program. By last year, we had nearly doubled that number to over 2,400 people on AOT. We are also now fundamentally redesigning our response to 911 mental health crisis calls. Beginning in Harlem and East Harlem, the neighborhoods that had the highest level of 911 mental health crisis calls last year. Teams of EMTs or paramedics and social workers are responding to 911 mental health calls.

So far, the results of this pilot are promising. During the first three months, these teams responded to over 280 mental health emergencies. We saw the clients were accepting medical assistance at higher

rates than with a traditional or NYPD EMS response. And people were transported to the hospital at a lower rate. Instead, whenever possible, these new teams provided physical and behavioral healthcare onsite or transported people to community-based care. Increasingly, we are helping people where they are and not activating our emergency departments, our ambulances, and our police resources unnecessarily.

As we learn from the pilot phase of the program, we are already planning expansion to other zones. In addition, to continue to enhance our focus on people with serious mental illness, in the spring of 2021, we announced $45 million in new intensive services for people with serious mental illness, including $4 million for clubhouses. Clubhouses are places where people experiencing serious mental illness can build social connections, access resources, and find a supportive community. This recent investment will support a 25 percent expansion of membership in clubhouses for people with serious mental illness, from the current 3,000 to 3,750 by January.

Funding will also help clubhouses increase their outreach to more places where they can encounter people who may want to join a clubhouse, such as soup

kitchens, shelters, hospitals, parks, and subway stations. This new investment also supports a new program, called CONNECT, that will provide intensive behavioral healthcare to 850 clients with serious mental illness with a new model of integrating mobile and brick and mortar treatment.

For the first time, some clients will be accessing services both in the field through mobile teams and at clinics. Prior to the de Blasio Administration, the city's mental health infrastructure was primarily funded by the State and Federal government. Over the last seven years, our city has invested in closing gaps in care, beyond what the State and Federal funding will support. Because of these strategic investments, New York City now provides far more mental health services for many more New Yorkers with serious mental illness in more places, and in more ways than ever before.

These new initiatives add to considerable work across city government. Let me briefly explain the role of each of the key city agencies that serve New Yorkers with serious mental illness and the connections between them. The Department of Health spends over $500 million annually for people with

mental health needs, substance misuse, and intellectual and developmental disabilities. DOHMH's services include supportive housing, mobile treatment teams, the Single Point of Access Program, which is a centralized referral system that connects adults and children with serious mental illness to appropriate services and providers. The Office of Assisted Outpatient Treatment, which coordinates court mandated care. And NYC Well, the city's 24/7 behavioral health helpline. New York City H+H invests about $800 million every year in acute inpatient and outpatient behavioral health services. These services are provided at 11 acute care hospitals, four psychiatric emergency departments, seven Comprehensive Psychiatric Emergency Programs, and 13 behavioral health outpatient clinics.

They also manage Correctional Health Services, which provide behavioral healthcare to people incarcerated in New York City. The Fire Department's Emergency Medical Services responds alongside officers from the Police Department, to around 150,000 911 mental health emergencies every year. When necessary, they also transport those in need to hospitals for additional care. Many other agencies

also play a critical role in serving New Yorkers with serious mental illness. The Department of Homeless Services has street engagement teams, and onsite mental health services in shelters and safe havens.

The Department for the Aging serves New Yorkers with serious mental illness through clinicians embedded into dozens of senior centers throughout the city. The Department for Youth and Community Development serves young people with serious mental health needs at all runaway and homeless youth residences and drop-in centers. And the Administration for Children's Services, serves young New Yorkers with serious mental illness by connecting parents, children and youth in its child protection, prevention, and foster care programs to a range of behavioral health services.

ACS also partners with H+H to provide mental health assessments and services in child welfare and detention facilities. Our office oversees a small fraction of the overall mental healthcare spending in New York City. The programs we work with were never intended to supplant the larger mental health system in New York City. Instead, they are meant to fill gaps in care through innovation. We also think of

our partnerships with agencies as an incubation period. We work with city agencies to test new ways to serve under served New Yorkers. Where an approach works, it is fully integrated into an agency and becomes a lasting way city government serves New Yorkers. And as programs leave our incubator, we identify new strategies to test.

Currently, we support 28 innovative mental health programs implemented by city agencies. With over 58 percent of our programmatic budget devoted to serving New Yorkers with serious mental illness and strengthening crisis prevention and response. In addition, we promote cross agency collaboration. A few examples: First, as I mentioned, we partnered with H+H, FDNY EMS, DOHMH, and NYPD to shape and launch the new 911 mental health calls response pilot, called B-HEARD. We worked closely with these four agencies throughout the spring of 2021 to reimagine 911 mental health emergency response. Together we developed new operational protocols and data sharing systems. We designed and delivered five weeks of training. Each agency contributed to the training along with several outside experts.

And since June, we have all worked together to implement this new approach. We worked with DOE and H+H to structure a new partnership, called Pathways to Care. In neighborhoods hardest hit by COVID-19, students with acute and ongoing mental health needs are now able to quickly connect to H+H's outpatient adolescent clinics. We are currently in five school districts and as H+H staffs up its Child and Adolescent Clinics, we will expand to more school districts.

We have also supported a new collaboration between FDNY EMS and DOHMH. This effort focuses on individuals who contact 911 for mental health crises frequently. For many, it's several times a month. If they are interested in more assistance, we connect them to teams of peers and social workers. These teams can connect people to care in order to prevent the next 911 emergency call. And, in order to create Mission VetCheck, we worked with the Department of Veterans' Services, the IDNYC program at HRA, the city's GetFood Initiative, and several veteran serving organizations.

VetCheck trained members of the veterans community to make supportive check-in calls to

veterans during the pandemic. Since April 2020, over 30,000 calls have been made. These calls have reduced social isolation and provided veterans with critical information on food assistance, housing and unemployment support, and COVID-19 testing. We also promote interagency collaboration by convening the Mental Health Council, which includes the leadership of 30 city agencies working together in common cause to promote the mental health of city employees and the public at large.

The Mayor's Office of Community Mental Health builds on the ground breaking work of ThriveNYC, which began as an initiative spearheaded by First Lady Chirlane McCray to create new and enhance pre-existing mental health programs spread across city government. In 2019, the managements of this initiative was consolidated in the Office of ThriveNYC based in City Hall.

Over the past two years it became increasingly clear that there was a long-term need for a dedicated office within City Hall to lead high-level policy development and promote interagency collaboration. Accordingly, the Mayor issued an Executive Order which took effect in May. Our office then took on

these functions formally and continued our oversight of innovative mental health programs as well. The agencies with me today, as well as dozens of others, provide mental health services to thousands of New Yorkers every year. We work together to serve New Yorkers with mental illness, and to address the often more complex needs of those with serious mental illness. This is as it should be. With COVID-19 exacerbating challenges for people with serious mental illness, it is more important than ever that city agencies bring their strengths and expertise to the table. This is the intentional, first principle of the de Blasio administration's approach to this issue. Activate every part of city government to promote mental health.

Let me be clear though, it's not enough to just deliver more care. We also want to ensure we are improving the mental health of our city. And science is guiding our way. In 2019, our office convened a Science Advisory Group of national and international experts in epidemiology, treatment, and the social determinants of mental health, co-chaired by Dr. Vikram Patel of the Harvard Medical School.

Their charge was to help me, us, sorry, was to help us understand the population level effects of our programs. For years, we have been tracking and publishing outcome data for every single program we oversee. Our reach and our impact data are on our website. The question we posed to the Science Advisory Group was broader. How is closing gaps in mental healthcare affecting New York City on a population level? Together, we came up with two population level metrics to help us determine our focus and chart the path ahead.

First, we want to see more people with mental health needs get connected to care. We can see some progress on this metric by looking at serious psychological distress. About 7 percent of adult New Yorkers experience serious psychological distress, defined as a mental health problem that results in functional impairment and requires treatment. Most adults with serious mental illness are included in this category but it's bigger.

In 2015, 45.9 percent of adults with suspected serious psychological distress reported that they received counseling or prescription medication in the past year. That's less than half of New Yorkers with

serious needs getting treatment. By 2019, that measure had shot up 13 percentage points to 58 percent. An increase that's not only statistically significant, but according to health experts, it's rare in epidemiology. 58 percent of adults in serious distress getting the help they need is not nearly enough but it is real progress.

We're also seeing measurable progress on our second indicator, that fewer mental health needs become crises. Our theory here is that when we invest in prevention, early intervention, better crisis response, and post-crisis stabilization, fewer crises will develop. When more people are connected to care they are not only healthier, but fewer experience emergencies. They don't need to go to an Emergency Room or call 911, and fewer families will have to worry about a loved one.

There is great urgency to this goal in New York City. From 2008 to 2018, the number of 911 mental health calls nearly doubled from 98,000 calls in 2008 to 170,000 calls in 2018. Now, the tide is turning. In 2019, 911 mental health calls went down by four percent for the first time in a decade to 163,000 calls. And in 2020, they went down even more by

another six percent to 153,000 calls. So far this year, even as we know the mental health of the city has worsened, calls are relatively flat.

As much as it's important to note the progress, and the great work that got us here, we cannot make the mistake of slowing down. Especially when the wide ranging mental health effects of the pandemic are likely to linger for years. We also cannot be satisfied by any progress that isn't shared by all. That's why for both population level indicators, we are also looking to see less disparity in outcomes. This is where we have the most work to do. The decline in mental health emergencies occurred throughout the city, with calls declining in precincts from Brownsville to the Upper East Side.

However, the significant jump in connection to treatment was almost entirely driven by increases among White adults. The percentages for Black, Latinx, and AAPI New Yorkers were largely unchanged. For the most part, people of color experiencing serious psychological distress have not experienced the greater connections to care that do now exist now in New York City. We can't accept this. More than

anything, this is the challenge that must guide our work now and in the years ahead.

About 70 percent of the new mental health services our office supports are located in federally designated mental health shortage areas. Like food deserts, these are neighborhoods without sufficient access to mental healthcare. We are also reaching deeper into high need communities, specifically the 33 neighborhoods with a history of health inequities designated by the city's taskforce on Racial Inequities. Over the past year, many of our programs, along with others across the city, have shifted or expanded to further align resources with these 33 communities. We are going where the need is.

Two examples, the School Mental Health Specialist program now offers onsite, trauma informed group mental health services to hundreds of schools in these neighborhoods. We are also actively working with the Department for the Aging to expand onsite mental health services in senior centers in the 33 neighborhoods hardest hit by the pandemic. This Committee can help. The mental health system, and the various services I mentioned today, can be

difficult to navigate. This summer, our office sent to every Council Member a guide to mental health resources in your districts. We invited you to request printed copies of these brochures, translated into the languages spoken by your constituents. And we asked for your help in distributing these guides to New Yorkers across the city, so that New Yorkers across the city can connect to free support right in their neighborhoods.

We also sent each of you multiple copies of our guide that lets New Yorkers know how they can help someone who needs mental healthcare. Published with the Health Department and H+H, this guide walks through how to get mental health support for anyone, at any level of need, including what to know, where to look, and who to call. With this one resource, New Yorkers can learn how to find a counselor, get in-person help for a behavioral health crisis, help someone with serious needs who is having trouble staying connected to care, and determine if hospitalization should be considered.

This guide also describes how to access support from peers, as well as support for families. There is a digital version on our site, but we've also

distributed over 33,000 printed copies to community sites across the city, including libraries, police precincts, hospital waiting rooms, and many others, NYCHA developments recently have gotten many copies.

We welcome orders from you so this guide can be distributed to your constituents as well. I thank this Committee for your ongoing partnership and commitment to serving New Yorkers with serious mental illness and we're happy to answer any questions you have.

CHAIRPERSON LOUIS: Thank you so much for your testimony Director Herman. I'm going to jump right in with the questions. Uhm, there are many points of entry for individuals seeking behavioral health services in New York City including some of the ones that you mentioned today at DHS, DOHMH and even the DOE. Can you share with us the existing framework for interagency collaboration when it comes to improving equitable access to mental health?

Like, for example, once a client begins to receive services, how do these agencies communicate with one another for coordination of services?

SUSAN HERMAN: So, within the very real uhm, restrictions of state and federal law, agencies talk

to each other all the time. We are taking a very aggressive multiagency approach to serving people with mental health needs and particularly people with serious mental illness. We are proactive in getting people with SMI into treatment and we're taking steps to treat mental illness at its earliest stages before someone has a severe problem.

We've added tremendous resources as I've mentioned but I would just say and I'll turn on this my agency colleagues, one of the hallmarks of this administration is an all government approach to promoting mental health. So, we have I mentioned SPOA, I think I'd like my colleagues from the Health Department to talk a little bit about what that means, when someone is referred to the single point of access. Uhm, and I'd like to ask uhm, my — well, lets start with the Health Department.

COMMITTEE COUNSEL: Uhm, Director Herman, if you could just name specifically who you want us to unmute.

SUSAN HERMAN: Dr. Cunningham, sorry.

DR. CHINAZO CUNNINGHAM: Great, thank you Susan and thank you for the opportunity to answer this question. Uhm, we you know in the Health Department

absolutely collaborate closely with our sister agencies and there are many examples of this in terms of you know point of entry.

Uhm, as Susan mentioned, we have the SPOA, the Single Point of Access Program, which helps providers connect people with severe mental illness to the services that they need. And uhm, SPOA is available to several of the city agencies including the Department of Homeless Services, community-based organizations and the public directly. And you know when someone calls SPOA, there's an assessment in the triage in terms of what services are needed and then those individuals are then linked to those services.

Another great example of the collaboration is the triage desk and this is the collaboration between NYPD and the Health Department. Uhm, and this is a desk in which again similar, there are uhm, referrals that come in from other agencies like the Department of Homeless Services, B-HEARD, Courts Parole in addition to community-based organizations.

Uhm, and then through this triage desk, an assessment is made and then people are assigned to the co-response team or the heat teams which then can then help people get the services that they need.

Another example, uhm, here are the IMT teams. The intensive mobile treatment teams. Again, that we get referrals from the Department of Homeless Services, Corrections, community-based organizations and these teams really are intensive and assigned to individuals to provide the services that they need.

So, those are just some of the examples that we have where we collaborate with our sister agencies and community-based organizations.

CHAIRPERSON LOUIS: Thank you for that Dr. Cunningham. So, let me give an example of what I'm trying to get into when asking about the framework. Let's say I'm on the corner of Flatbush Avenue and I'm having a mental health episode. And a constituent calls and a mobile crisis rep responds. Can you walk me through a warm referral process from there? What happens next from there?

SUSAN HERMAN: Let me try and start by saying that unlike certain systems where there is only one point of entry, right. If you look at the criminal justice system, there is only one way to get in and then you move through a system seriatim, in a very, very specific order. The health care system and the mental health care system is not like that and we

don't want it to be like that. We want multiple doors, multiple entry points, and then coordination as needed. So, if you take the example that you used Chair Louis, a constituent calls about someone else. Is that what you said or about yourself? Either way, you are either calling NYC Well, you are calling 311 if you believe the person is experiencing homelessness. If you call NYC Well, you may get a mobile crisis team to go out and see you. If they determine that it's an emergency, they are going to call 911 and get someone there very quickly, within minutes, otherwise, you may get a mobile crisis team to go out. If the person is experiencing homelessness, a DHS outreach team is going to go out. They too have the capacity to assess what your mental health needs and refer you either to SPOA or to a mobile crisis team or take you to the hospital if you need to go to the hospital.

If at that moment, the emergency is such that people, responders determine that you need to go to the hospital immediately, then our H+H colleagues can speak for what happens. You go to the hospital, you are evaluated. They are absolutely discharging people with plans about how to stay connected to

care. But I would turn to Dr. Barron to speak a little bit about what happens when someone is brought to the hospital.

DR. CHARLES BARRON: Thank you Chair Louis and also Director Herman for an opportunity to talk about the H+H system in here. As Director Herman indicates, there are multiple doors to come into the mental health system for H+H but this particular one where a mobile crisis team is called to assess, or potentially even 911 emergency or our new B-HEARD teams, if they determine someone needs a more acute evaluation or determination service needs, they are brought to the hospital.

In our emergency, psych emergency or city PHEPS comprehensive psychiatric emergency programs, uh, the patient or person is evaluated having very comprehensive mental health as well as physical uh evaluation. Determine the needs of the patient. What level of service they need. If they are really in a very acute state and require intensive uh issues such as hospitalization, then they are hospitalized.

Or they can be connected to a variety of uhm ambulatory care services. They may need intensive outpatient or partial hospitalization program on an

outpatient basis. Or they may need other traditional clinic services or they maybe referred to be connected back to a community-based mental health clinic. And we are capable of making those connections with referrals and warm handoffs between the various things that have been set up for them. But we assure that our people that are brought to us really have the assessment and have the ability now to have additional services on an ongoing basis that need that. And there is a lot of communication between the different factions and agencies that might be involved.

CHAIRPERSON LOUIS: Thank you for that Dr. Barron. I appreciate it. Uhm, so Director Herman, can you share with us, does the community health agency play a role in the coordination of rollback of everything that was shared by Dr. Cunningham and Dr. Barron?

SUSAN HERMAN: Right, so our office, the Office of Community Mental Health, uhm, is not involved in individual cases. What we do is try and look at experiences that individuals have that hundreds of people might experience and try to work with agencies to develop new protocols and new policies that might

make the experience for many people a better experience.

So, let me give you some examples, so you understand the kind of coordination that we do. First of all, you heard about the B-HEARD program. We are working very closely with four agencies that are not used to all four of them working together on a particular project. And trying to make sure that this goes as well and as smoothly as possible. And I have to say they have all been fabulous partners and that's a coordination role that we play.

We also recently have encouraged the development of a program that involves coordination between FDNY, EMS and DOHMH. Because there are many, many people who call 911. There are about 300 people who call 911 for a mental health crisis, three or more times a month. There is something that's happening with those people that if we can possibly intervene to get them connected to help them stay connected to care in between these crisis, we might be able to avert the next crisis.

So, we look at something like that and say, let's try an initiative where we can reach out to those people, offer them more services, help them stay

connected to care to try and avert the next crisis. We also have been conducting screenings in 100 family shelters and trying to determine what sort of mental health needs people in these shelters have.

Once you screen someone and you understand that they have a particular need, the next task obviously is to connect them to the appropriate care. Our role is to make that DHS can connect people either to the appropriate community-based organizations working with the Health Department or at H+H to make sure that people who are identified, are getting the care they need.

We also as you heard uhm recently, we have developed an expedited referral process between DOE, the Department of Education and schools in the 33 communities hardest hit by COVID. We're going district by district, so far we're in five. But what this means is okay, if DOE and school principals or social workers or teachers or parents identify a particular need, we want to make sure that their connection to a child and adolescent clinic is as smooth and as fast as possible. So, those are a number of ways that we are involved in high level

policy development and coordination. Those are just a few examples.

CHAIRPERSON LOUIS: Thank you Dr. Herman and I hope you understand the reason why I'm asking all these questions is so that people can connect the dots.

SUSAN HERMAN: Yes.

CHAIRPERSON LOUIS: Right, alright, so I want to make sure that you understand that.

SUSAN HERMAN: I just want to highlight I think sometimes people are interested in what happens when this particular individual comes in. We talk to each other as agencies, not our office at this point, but the Health Department, H+H, DHS, they are talking about individuals as aggressively as possible within the restrictions of all the confidentiality rules that the state and federal law places on us. They are very significant.

CHAIRPERSON LOUIS: Right. So, Director Herman, in your testimony, you mentioned the DHS street engagement teams. We know that subways, subway stations and surrounding streets are often where serious mental illness is the most visible to the average New Yorker. There is a lot of stigma in here

associated with serious mental illness resulting from a few incidents that we've all seen in the press, that's occurred in the subway either through the pandemic and even before then.

I just wanted to know if you could share with us or maybe one of your colleagues, what does subway outreach and coordination look like for individuals suffering from serious mental illness?

I would say this also reflects our multiagency approach to an issue. Uhm, first of all, it needs to be said that there are now again, an additional 250 NYPD officers devoted to the subway system, which takes it to 3,000 officers in the subway highest in 25 years. We haven't had this many NYPD cops in the subway for 25 years.

Secondly, there are hundreds of DHS outreach workers in the subways dedicated to the subways every day and they provide mental health support, medical assessment and they can transport people to a shelter if necessary and identify if someone needs to go to the hospital. We also have the new B-HEARD program is able to respond in the subway. And I would also say that MTA is thinking about this in a multiagency way as well. They recently asked our office to

develop a training for their employees on how they should respond when someone shows signs of mental health crisis.

Uhm, we developed a training for them. That training has begun with their supervisors and I believe they are going to be rolling it out to other employees relatively soon. So, we're all working on this.

CHAIRPERSON LOUIS: Is the NYPD trained to provide those services? Are they coordinating with mental health providers and organizations?

SUSAN HERMAN: The NYPD through its CIT training is better trained then ever in how to respond to someone who is exhibiting signs of mental health crisis. That's a joint training between the NYPD and the Department of Health and that training continues. It was paused during the pandemic because it's in person training but its now about to be up again. But you know, I think my latest count, I think we had 60 to 70 percent of all officers in precincts have been trained in CIT. Something in that range.

CHAIRPERSON LOUIS: And what can the city do to make New Yorkers feel safer on the subways, let alone the care that is available for individuals suffering

from serious mental illness? What is the city doing about making New Yorkers feel safer?

SUSAN HERMAN: We again, as all of us as agencies, separately and together, we reiterate that if you see someone in the subway who you believe is homeless, who is having a mental health crisis, please call 311 and we will get someone there as soon as possible. You can talk to the MTA uhm, supervisors in that's station who also now have had training and they know who to call and how do you feel safe? You feel safe because you know that there are more officers there than have been there in 25 years. You know that it's a relatively very small fraction of people who have mental illness who present public safety problems. Mental illness can be scary sometimes for people to look at but it's a relatively small percentage of people who are violent. And how you can help again, I'm going to keep pitching this, is distribute this in your districts and help people know what to do when they see someone who they believe is suffering from a mental health problem.

CHAIRPERSON LOUIS: Besides the distribution of the literature that you're sharing with us and I'm

more than happy to share that with my constituents. What else is your office or what can the city do to reduce stigma in here surrounding mental illness?

SUSAN HERMAN: Reducing stigma is really a — again, it's a multiagency approach. All of us need to be talking about mental health more than we do. And I would actually like to ask uhm, Dr. Rebecca Linn Walton who is nodding, if you would like to talk a little bit about the efforts to reduce stigma. There is public education campaigns that all of us run. The Health Department has public education campaigns. We have public education campaigns. H+H is doing a tremendous amount to encourage people to seek treatment. Dr. Linn Walton, would you like to speak to that?

DR. REBECCA LINN WALTON: Thank you so much, and thanks for having me today. I think you know there is a lot of different ways we can reduce stigma and it has to happen at a lot of different levels. So, there is public education but there is also how we talk to people when they come into our office. How we talk to people when we go out into the community and work with people but even more importantly, it's

having representation in our ranks of people who have had this lived experience.

I know that I share mine regularly as an effort to destigmatize things and to help my colleagues feel ready to come out and share that as well because that's what I use every day in my work with New Yorkers, with my staff, with program design. H+H has done a tremendous amount of work and I know the Health Department as well to bring peers into the normal ways of doing business. A decade ago, there were special programs for it but it wasn't spread throughout the system and we're really trying to bring people with lived experience so that we can greet community members who are in crisis with eye contact. With care, with compassion so that we really understand what's going on and then so that we can turn around and do additional staff trainings as well. So, that folks in the medical community and elsewhere can also understand. You know, as Susan mentioned earlier, it can look scary to someone who hasn't worked with this population when someone is in crisis but when you are used to dealing with us on a regular basis, you are able to connect with that

person in that moment and that can make the difference.

CHAIRPERSON LOUIS: Thank you Dr. Linn Walton. I do want to share and I thank you for sharing what you just brought up. I think all of your agencies have a lot of funding and for some, it may not be enough, right? But if we're saying we're doing public education campaigns, I haven't seen it. Maybe on T.V., maybe but I think the interagency response to public education campaigns needs to be at different platforms and in different ways. And if you all have line items, you should consider building some type of strategy to expand the public education campaign, so that we all can understand that that means. So, I hope you all can work on that together.

Uhm, I'm going to ask a question before I go to my colleagues. I wanted to know, this is either for you Director Herman or any of your colleagues. How does the Mayor's Office of Community Health differ from Thrive?

SUSAN HERMAN: So, the Mayor's Office of Community Mental Health builds on the foundation of ThriveNYC and the Mayor's Office of ThriveNYC. ThriveNYC began as an initiative to both enhance some

existing programs and create new innovative ones that filled gaps in care. And as it became a mayoral office, it became clear that we were not only asked to and needed to oversee programs in many city agencies but we also needed to take on an interagency policy coordination role.

And so, with the Executive Order, we have now uhm, enshrined and I will read to you exactly what the Executive Order says. We are convening the Mental Health Counsel. It makes it formal. The Executive Order says, we will issue an annual report on needs in the city and our uhm, and our strategy to approach it.

Hold on one second, I'm sorry. I just want to get it absolutely right. I will send to you the exact language of the Executive Order. My apologies but the difference is, it is formalizing a role not only overseeing these funded programs but promoting interagency coordination. We have, the Mental Health Counsel was created by Executive Oder. It is now making it clear that this office of community mental health convenes it on a regular basis. That we issue a report. That we are coordinating policy. We are coordinating with substance use policies and programs

in the city to make sure that the work on mental health and substance use is connected. So, it's formalizing it and saying, this is uhm, this is a necessary part of city government to have a mayoral office that is making sure that we're filling gaps in innovative ways. Promoting those programs so that they reach their potential. Moving to an incubator model, so that our portfolio is dynamic and engaging and convening with other agencies.

CHAIRPERSON LOUIS: Alright, thank you. So, this will be my last question so that we can hear from my colleagues. Your office reports Black, Latino, Hispanic and Asian American and Pacific Islander New Yorkers are less likely to connected to mental health care than White New Yorkers. What is the new office for the Mayor's Office of community health plan to address these gaps in service?

SUSAN HERMAN: I think promoting mental health equity has been at the core of our work from the very beginning and we are focusing with laser like focus on the needs of the Black and Brown communities in New York by one, making sure that we are locating services in communities of great need that are historically underserved. 70 percent of our services

are in underserved communities. We make sure that our outreach, our providers, our work, is as creative as possible so that we are reaching people who might otherwise not be reached.

So, we know for instance that more and more people are calling NYC WELL and we have a recent outside evaluation of NYC WELL. One of the findings was that 20 percent of the people who call or connect with NYC WELL, would not have called any other place. Another high percentage of people said, had they not had NYC WELL to call, they might have called 911.

NYC WELL can be you know reached by any New Yorker. Text, phone call, chat, anyway you want to, you can reach NYC WELL. So, we know that we are reaching New Yorkers who might not otherwise be connected to care.

We also know by the interviews that we've done with people that we serve, the crime victims, the seniors in senior centers, the people who we talk to in libraries when we do workshops there, that we are reaching people in places and in ways that are innovative. And again, reaching people that might not otherwise be reached. And as Dr. Linn Walton said, we are increasingly working to make sure that

we have a wider, better, stronger pipeline of people going into these professions so that they not only can serve more people but they reflect our New Yorkers.

CHAIRPERSON LOUIS: Thank you Director Herman. I will now ask Committee Counsel to call on my colleagues for questions for the administration. Thank you.

COMMITTEE COUNSEL: Thank you very much Chair Louis. And I just want to remind everybody that if any of the Council Members have questions, please use the Zoom raise hand function and all members of the public, we'll turn to you next after this panel.

And I see that Council Member Dinowitz has his hand up. So, Council Member Dinowitz, you can begin when you're ready.

SERGEANT AT ARMS: Time starts now.

COUNCIL MEMBER DINOWITZ: Thank you. Uhm, as we know most people with mental health needs develop them at a young age, while they are in school. What coordination is done between all the agencies and the Department of Education to ensure that the needs of our children, the needs of people as they are developing these mental health needs are met?

SUSAN HERMAN: Well, this is — because this is an all government effort and we are taking an aggressive multiagency approach, we have four to five, the mental health resources within our city schools greatly over the last seven years. We've added clinics, we've added social workers, we've added school and created school response clinicians who are there for emergencies and crisis and then can stay with a student or a group of students until they can connect with more ongoing care. And we have created an expedited referral process between the Department of Education and H+H, so that students with acute need, who cannot be served well by or completely by the school itself, can be connected to either an H+H child and adolescent clinic or referred to a local community-based clinic for care.

And conversation between DOE and H=H and the Department of Health as well. When needed, they are also calling children's mobile crisis teams if they need someone to connect them and to work with them immediately.

COUNCIL MEMBER DINOWITZ: And so, that sounds like you are doing more to address — in the recent years I guess, to address acute crisis. Is there any

move to make universal screening for mental health needs throughout?

SUSAN HERMAN: Yes, of course. I'm sorry. I'm sorry. Yes, in terms of the care people need but as you know, I believe uh, we are starting universal SEL screening, Social and Emotional Learning screening of all public school students starting this fall. And they will be moving it out in cohorts but they'll be identifying students who could use some extra attention and that doesn't mean they are in acute need. It might mean that they just need some extra attention in the classroom or they could benefit from a group discussion. Or maybe they should be referred for a more sophisticated assessment.

But DOE has done an enormous amount to instill SEL practices at the Pre K stage, all the way through 12th grade and I would refer you to my DOE colleagues for more detail. But there is a tremendous amount of prevention work and early intervention work and then how to address acute needs when they arise.

COUNCIL MEMBER DINOWITZ: So, so, it sounds like it's in the right direction. Having taught in our schools, I can tell you that the resources weren't there. They maybe there now but with the plans, you

said these plans, universal screening is starting now.

SUSAN HERMAN: Universal screening is starting this yeah.

COUNCIL MEMBER DINOWITZ: Yeah, are the resources going to be attached to that or is it a mandate, another mandate that is unable to be fulfilled by the schools because that is often, unfortunately, my experience, you know you have mandates and ideas that are great. But it's impossible for teachers and social workers, guidance counselors and principals to meet those mandates. Is our resources and is funding attached to these mandates?

SUSAN HERMAN: Well, it was very clear that if we were going to screen all students, we wanted to have resources in place to help people who were identified. And that's why the Department of Education is in the process of hiring 500 new social workers that will be placed in schools throughout the city. That's why some of our other programs have shifted to more of a direct service emphasis but we are prepared to not only screen but to then help students who are identified for any level of extra attention.

COUNCIL MEMBER DINOWITZ: Very happy to hear that.

SUSAN HERMAN: A massive effort.

COUNCIL MEMBER DINOWITZ: Yeah, there is a lot of cases in the schools and you believe that 500 social workers is enough to engage in that universal screening for mental health needs?

SUSAN HERMAN: These are 500 social workers that have been hired on top of the additional school-based clinics that have been created in schools on top of the social workers that are already there. There is huge influx of resources. Schools will not be able to handle the entire need. They will be able to handle a lot of it. Both, they will handle the screening. They will handle a tremendous amount of the need.

SERGEANT AT ARMS: Time expired.

SUSAN HERMAN: But they are also prepared to refer out if they need assistance. And they've been trained in how to do that.

COUNCIL MEMBER DINOWITZ: Actually, so I don't overtime, I just want to take an extra minute to first say, I look forward to working with you on making sure that all the resources are there for the

universal screens and make sure that these programs are implemented. Probably the last question I had if I may, is just as students exit high school, particularly students with disabilities, you know have transition coordinators and special education teachers. Is any particular work being done with outside of DOE to make sure that they are transitioned out of the school setting. That they can continue with mental health services or are able to avail themselves of those services. Is specific effort being made again to children in transition, particularly those with IEP's?

SUSAN HERMAN: I know the work is underway. I'm going to refer you to our Department of Education to get more detail about that.

COUNCIL MEMBER DINOWITZ: Okay.

COMMITTEE COUNSEL: Thank you very much Council Member Dinowitz.

COUNCIL MEMBER DINOWITZ: Thank you.

COMMITTEE COUNSEL: And again, a reminder to Council Members that you can use the Zoom raise hand function if you have any questions. Uhm, Chair Louis, I'll now turn back to you for either more questions or for closing remarks.

CHAIRPERSON LOUIS: A few more questions. Uhm, I wanted to know if the Community Office of Mental Health has an Advisory Board? And if so if you could include the CBO's and community providers that encompass that work.

SUSAN HERMAN: So, we have worked with an advisory group with the B-HEARD project and that's about 20, 25 people. We have worked with the Crisis Prevention and Response Taskforce, which is about 80 people that consists of elected officials, city government officials, academics, providers, peers, advocates, uhm, social service providers. We have convened them periodically.

We have worked with faith leaders on particular projects and we would, going forward we would certainly consider. We're relatively you know a new formalized office now. We would certainly consider having an advisory group.

CHAIRPERSON LOUIS: Perfect and you mentioned B-HEARD communities thrive. Can you give us a total headcount of B-HEARD?

SUSAN HERMAN: I'm not sure what you're asking for. Who is — the headcount for the response teams?

CHAIRPERSON LOUIS: Yeah, what is the total number of social workers hired for B-HEARD?

SUSAN HERMAN: I'll have to get you that.

CHAIRPERSON LOUIS: Okay, do you know the total numbers of EMT trained for mental health calls on the B-HEARD?

SUSAN HERMAN: Well, we train them in teams of EMT's and paramedics and we can get you the exact numbers.

CHAIRPERSON LOUIS: Okay, what is the current staffing of the Office of Community Mental Health?

SUSAN HERMAN: We have about 22 people here in the office.

CHAIRPERSON LOUIS: Do you plan to expand in the future?

SUSAN HERMAN: We have no plans right now to expand. Our office is relatively small. Our programmatic budget as you know, is entirely within agencies. It's not within this office. So, the millions that people talk about are all within agencies and then, the vast majority of that money is filtered to the vendors, the community-based organizations that they partner with and contract with to deliver services.

So, I have attached to our testimony, our 200 community-based partners. So, when you think of the work of this office, when you think of the work that we're building on, you should be thinking of 13 city agencies and 200 community-based organizations. That's who implements the work.

CHAIRPERSON LOUIS: Alright, so if the Office of Community Mental Health is overseeing the coordination of mental health programs, uhm, how is it determined which programs are being listed in the $281 million budget at OMB?

SUSAN HERMAN: I'm sorry, if the office if coordinating, what was the last part? I didn't hear it correctly.

CHAIRPERSON LOUIS: I will say it again. I'm so sorry. If the Office of Community Mental Health is overseeing the coordination of mental health programs, uhm, how is it determined which programs are listed in the $281 million budget that OMB shared?

SUSAN HERMAN: So, the — our portfolio is a dynamic portfolio. We identify innovation, usually agencies are coming to us and OMB and talking about a particular way. We either identify a gap in service

or an agency identified a gap in service. We work with an agency. We're going to be moving towards a request for proposal format, so that agencies can suggest the kind of innovation that they'd like to move forward with. And then we work with those agencies to get proof of concept and maximize the reach and the impact of those programs.

So, we work with OMB and the agencies to determine, is this an innovative model that we believe is worth trying? Let's work with them for a few years and see what the potential is for the program.

CHAIRPERSON LOUIS: So, there is currently no budget for OCMH?

SUSAN HERMAN: There is a budget for our office, which is very small. You know, it's on the website. And then each of the programs has their own budget. We put them together because Council asked to see all of the programs that we oversee and we created that programmatic budget. Our office is a very small part of that. We also have a small research part of our budget.

CHAIRPERSON LOUIS: So, can OCMH budgetary items also be tagged for OCMH rather than only be tagged

for specific agencies if the program runs out? Like, is there anyway to tag that in the budget, so we get a better understanding of it?

SUSAN HERMAN: So, you have all of the programs that we oversee are in our budget. That's what we send to Council. Its been on our website for two and a half years and four times a year we update it with every budget plan. And it shows you what programs we're overseeing.

CHAIRPERSON LOUIS: Right, we've seen that. It hasn't been as clear but we've seen it. Okay, uhm, uhm, Committee Counsel Sara, is there any other hands up, I'm sorry.

COMMITTEE COUNSEL: I'm not seeing any hands at this time, so if you have any closing remarks, you can deliver them now.

CHAIRPERSON LOUIS: Alright, I just want to say thank you so much to everyone that came today. Thank you so much Director Herman for being here and I hope that the agencies can continue to work together but create a better strategy for implementation for safer and warmer referral processes for people that are experiencing serious mental illness. As your agency stated, this is not going away, so we need to do a

better job with implementation and making sure that there is better success rates. So, thank you so much.

COMMITTEE COUNSEL: Thank you very much Chair Louis and thank you to this entire panel. We will now turn to the public testimony. I just want to remind everybody that all public testimony will be limited to three minutes. After I call your name, please wait a brief moment for the Sergeant at Arms to announce that you may begin before starting your testimony. And our first panel from the public will be Ravi Reddi, Yu-Kang Chen, Natalie Reyes, and Jayette Lansbury.

So, let's give everyone a minute and Ravi, as soon as you are ready and the host unmutes you, you can begin.

SERGEANT AT ARMS: Starting time.

RAVI REDDI: Hi everyone. So, I want to thank the Committee Chair Louis and the Council Members of the Mental Health Committee for holding this hearing and giving the Asian American Federation the opportunity to testify on this important subject.

I'm Ravi Reddi and I am the Associate Director for Advocacy and Policy at the Asian American

Federation. AAF represents the collective voice of more than 70 member nonprofits serving 1.3 million Asian New Yorkers. And with the pandemic recovery well underway, this conversation on city agencies and the mental health of our communities couldn't come at a better time.

In particular, rising anti-Asian hate, the most recent wave spurred on by the pandemic, has had citywide mental health implications. In NYC, there were more than 2,100 incidents collected by AAF and our allies from March 2020 to June 2021. Only a tiny fraction of which were reported to NYPD. These bias incidents are significantly underreported, as nearly 70 percent of Asian New Yorkers are immigrants and systemic factors like high poverty, high LEP and lack of immigration status deter reporting and reinforce continued systemic inadequacies.

And our most vulnerable, our seniors, continue to be isolated, either because of the threat of the Delta variant or because of continuing anti-Asian hate. Many seniors don't have smart phones or computers to get on Zoom or even open an email account must less engage in telehealth initiatives or contact city agencies offering help via phone or web

service. And for the seniors who do have technology, many either don't have quality in-language support to learn how to use it or successfully engage with government services. Nonetheless, our senior-serving member agencies are working beyond capacity to create processes to make sure our seniors are getting services they need as efficiently and safely as possible.

Since allocations have been made, we intend to use funding from the city to fund our Hoping and Safe Campaign and help almost 30 grassroots nonprofits provide support services, our most vulnerable community members have been demanding like safety ambassador programs, as requested by our seniors, and multilingual victim support services, including mental health support and an assistance fund to help with assault-related expenses.

Now, I have a lot more to get through but I'm just going to race through to my recommendations. Now, a lot of our mental health agencies are reporting that there have been significant upticks in intense calls related suicidal ideation and cases require hospitalization, but are constrained, capacity-wise, by unstable fee-for-service provisions

because of underfunding and inconsistent staffing, when community members are referred back from ERs. And inadequate case management and administrative support, which is leading to staff burnout across the board.

The current system also makes it prohibitively difficult for uninsured, underinsured, and undocumented individuals with severe mental illnesses to receive the help that they need while also overburdening the very Asian organizations that provide dependable, culturally-competent care.

So, here are a few recommendations. We need increased, consistent investment in Asian mental health organizations to build staff capacity and expertise to address the increased needs —

SERGEANT AT ARMS: Time.

RAVI REDDI: Of clients with severe mental illnesses, as well as implement preventive measures where possible. I have three more recommendations; can I race through those? Great thank you. And then uh investment to create a well-coordinated network of mental health support for vulnerable Asian immigrants that prioritizes collaboration between formal service systems, as we've heard from the administration and

Asian nonprofits that have the language capacity and the cultural competency to advise on and treat clients with severe mental illnesses. Our community members are coming to us first and the city needs to respect and understand that while we need our reinforcement and support from existing agencies.

Thirdly, we need to address systemic issues informing hospital systems allowing clients to be released before they are stable enough, leading to relapse and decompensation among clients and constant burden on Asian nonprofits to provide care for patients who were released prematurely. And finally, improve on programs like NYC Care to ensure mental health access for those with the greatest barriers to care, like uninsured, underinsured, and undocumented individuals.

I want to thank you for giving us the opportunity to testify before you today. This is urgent work, but there are solutions and there are organizations already doing this amazing work, we just need your support. On behalf of the Asian American Federation and our allies who will be speaking here today, thank you and we look forward to working with all of you to

address this crisis and the mental health toll it's taking on our community. Thanks.

COMMITTEE COUNSEL: Thank you very much for your testimony and we'll next turn to Yu-Kang Chen. You can begin when ready.

SERGEANT AT ARMS: Time starts now.

YU-KANG CHEN: Good morning, my name is Yu-Kang Chen. I am the Clinical Psychologist at Hamilton Madison House. We are a nonprofit settlement house located in the Lower East Side. We are also one of the largest outpatient behavioral health providers for Asian Americans on the East coast.

Currently, we operate five satellite mental health clinics, a Personalized Recovery Oriented Services program, a dual diagnosis substance abuse program, and a Supportive Housing program for individuals with severe mental health issues in two locations, Manhattan and Queens. Our staff are all bilingual and we provide services for the Chinese, Korean, Japanese, Cambodian, and Vietnamese community. The large majority of patients we serve are first generation of immigrants of low-income status and many are receiving therapy for the first time. For Asian Americans, access to behavioral

health care is already challenged by a variety of factors, from lower utilization rates because of cultural stigma to a lack of funding for culturally and linguistically competent providers and agencies.

As the COVID-19 pandemic continues and hate crime targeting Asians increases, we have seen a rise of referrals with symptoms of anxiety, depression and other severe mental illness. Hamilton Madison House has been providing telehealth and in-person services to our approximately 600-700 active clients, as well as new referrals, living throughout New York City. We increased our number weekly contacts with the clients, asking clinicians to conduct brief check-ins and provide resources that may meet their concrete needs.

What has really leapt out for us this past year is the number of deaths, suicide attempts, and violent crimes occurring in our patient population, an important indicator of their mental health status. As a general mental health outpatient clinic, in a regular year we have very few of these incidents across all of our programs. They are considered the anomaly for us as generally when they occur it means

a patient's mental illness has gotten more serious and the patient needs a higher level of care.

In the few years before COVID we only experienced one to two of these significant incidents in our patient population per year. From July 2020 to June 2021, however, we tracked 11 of these incidents, including three patient deaths, six suicide attempts, and two violent crimes perpetrated by patients, one of them a homicide. Many of the incidents could be easily connected to the pandemic impact.

I will jump to the recommendations since I am running out of time. So, we would like to make the following recommendations. Increase capacity and funding for supportive services such as case management and benefits counseling to engage some of the Asian American community members who might have strong mental health stigma in treatment —

SERGEANT AT ARMS: Time.

YU-KANG CHEN: To prevent a delay in treatment or relapse. Increase funding and support to organizations to maintain adequate staffing to respond to the increasing mental health needs of the community. Increase access to mental health services by funding organizations that have the ability to

linguistically train and educate providers in different languages. Support organizations and coalitions to further develop partnerships and programming to distribute mental health resources and services for the Asian American community.

Thank you for your time. Thank you.

COMMITTEE COUNSEL: Thank you so much for your testimony and just a reminder to everybody that you can submit your full testimony at testimony@council.nyc.gov and we will read the entirety of it. Our next panelist will be Natalie Reyes and you can begin as soon as you are ready.

SERGEANT AT ARMS: Starting time.

NATALIE REYES: Good morning Chair Louis and members of the Committee on Mental Health, Disabilities and Addiction. My name is Natalie Reyes, I am the Deputy Director at Midtown Community Court. A project site of the Center for Court Innovation and I'm honored to be here.

Before discussing in depth the innovative programming, the Centers Midtown Community Court is implementing to intercept individuals with serious mental health conditions before they intersect with the justice system. We must first bring attention t

the mental health crisis in city jails. Recent reports point to escalating violence which already reached a five year high in 2020. The jails now suffer from growing suicides and self-harm incidents and a widely acknowledged environment of chaos, danger and dehumanization impacting both those detained and correction officers alike. With more than half of incarcerated New Yorkers flagging for a mental health concern, it is more pertinent now than ever before that Council support the centers work upstream to provide treatment and off ramps for folks before they suffer an extended jail stay while battling mental illness.

Homelessness, mental illness, and substance use are public health issues, not criminal justice issues. Crisis response should be imbedded within a holistic integrated healthcare and public health system with high quality accessible and equitable services. Over the past year, Midtown Community Court launched two pilot programs to address the intersection of these issues and criminal justice involvement. Community first is a holistic response that is a collaboration with the Time Square Alliance, Breaking Ground and Fountain House. It

works to link individuals to social and wellness services by employing teams of community navigators who are boots on the ground in Time Square. They are people who use their lived experience to connect with unsheltered individuals, build a trusting relationship with them and over time because of that relationship become a support system for them.

Their consistent presence and engagement allows the community navigators to gain credibility for local businesses, community organizations and other Time Square entities. Which results in creating opportunities for supportive services and access to those who need it.

One example is one of the team encountered men who was living outside of the American Airlines Theater. It was because of meaningful trust building with this individual that this person was able to get connected to housing through Breaking Ground and was able to go from sleeping in Time Square to employed in Time Square by the Alliance within a few months.

Since the end of January, our team has meaningfully engaged over 250 individuals. The second, Midtown Community Court launched a rapid engagement program with Fountain House to meet people

where they are at the precincts level and connect them with a defense attorney, eligibility checks for prearraignment, diversion options such as Project Reset or Hope and provide support to individuals to make their court date and help advocate for a more favorable disposition.

In conclusion, together these two initiatives serve as a way to prioritize peoples varied needs, address those needs and divert Midtown Community members away from the criminal justice system. We believe that working with community-based organizations and city agencies —

SERGEANT AT ARMS: Time.

NATALIE REYES: Like DOHMH and HRA is the way to effectively rebuild New York following this unprecedented global pandemic. As an example, Midtown recently connected to DOHMH on the engagement [INAUDIBLE 1:28:15] and Time Square to ensure that we are collaborating as one team to address our communities needs.

Thank you all. I am happy to answer any questions you may have.

COMMITTEE COUNSEL: Thank you so much. Our next panelist will be Jayette Lansbury followed by

Kimberly Blair, if they are planning on giving any testimony but we can begin with Jayette. Thank you very much.

SERGEANT AT ARMS: Time starts now.

JAYETTE LANSBURY: Hello, thank you for having me today. My name is Jayette Lansbury and I happen to be the Chair Criminal Justice for the National Alliance of Mental Illness, as well as a support group facilitator for them and a family peer advocate.

The reason why I am here today is because of the crisis. One of the reasons is because of the crisis on Rikers Island. I've been hearing from the families about the lack of medications and mental health care for their loved ones. And jails should not be a death sentence and it shouldn't be where they have to be abused and neglected just because they are on Rikers Island.

Also, mental illness alone with other brain disorders should not be a jail sentence. It should not be criminalized. We need to really have more of what we call alternatives and to be able to really look to see if there is trauma or something else going on. It is not necessary or a reason to incarcerate a person with mental illness.

My son's own experience on Rikers Island was enough to make any family or a person really be fearful of the system. But from the other families as well that I work with, they shouldn't have to be experiencing this and their loved ones shouldn't have to be experiencing torture or grief, or a death sentence just because they have a mental illness and they are incarcerated.

I do thank you guys for doing CIT but I think the New York City Corrections Department needs to be also trained in mental health first aid as well as crisis intervention and trauma awareness. The same thing with the NYPD, they need trauma awareness besides CIT and mental health first aid training. I know every police officer is not available for that but those that can and have the compassion for it should be trained.

Also, families, families are tired are being told they are just the families and not being listened to. We need to listen to the families as well. They know their loved ones best and a lot of times they are the best advocates for their loved one. When we talk about family, we think outside the box. Also, case managers, close friends, because not everybody has a

close blood family member that they can relay back to.

And also, I would like to see that book, how to help someone with a mental illness more distributed. So, I'm not going to keep you on time.

SERGEANT AT ARMS: Time.

JAYETTE LANSBURY: I will submit a written testimony via email. Thank you.

COMMITTEE COUNSEL: Thank you so much for your testimony and we'll now turn to Kimberly Blair to begin her testimony.

SERGEANT AT ARMS: Time starts now.

KIMBERLY BLAIR: Thanks Sara. Thank you Chair Louis and members of the Committee. My name is Kimberly Blair and I am here testifying today as the Manager of Public Policy and Advocacy for NAMI NYC. One of the largest affiliates of the National Alliance on Mental Illness. I also come to you as a peer with lived experience and a supportive family member. We would like the Mayor's Office of Community Mental Health to prioritize community relations because as of right now, it is lacking a sufficient relationship with our communities in New York City.

With the creation of this new office, we must step beyond the bureaucracy with other city agencies and focus instead on coordination with the community. This includes action such as the formation of an advisory group consisting of peers living with serious mental illness. Who are directly impacted and often wronged by the current lack of true crisis response system, lack of good quality supportive housing and lack of funding that should go towards more accessible community run respite centers.

Because the current city run support and connection centers seem to only be accessible by referral or if a police officer brings you in. You know and we don't even have enough of these in all five boroughs. There is currently a lack of providers as well in general. Those that take insurance or posses the cultural competency or linguistic abilities to understand BIPOC needs and immigrant community members needs.

Agencies need to address these issues through community reinvestment and by bringing peer advisory groups to table before the rollout of any mental health programs. Not afterwards to justify programs initiated by the city. Regarding crisis response,

crisis do not occur 16 hours out of the day. They happen 24/7 and the triage response must be better in the City's B-HEARD program. There is no reason community members should be calling my organizations helpline which does not operate as a crisis line. For alternatives to calling the city led mobile crisis teams because they are still using 911 to field crisis calls.

911 is tied to the police, the community needs, agencies to roll out an effective 988 number because the community does not feel comfortable using 911 for help and NAMI NYC as an organization and as a steering committee member of CCIT NYC, has countlessly relayed to you the benefits of funding our CCIT NYC proposal. Which would train and incorporate mental health peers at every level of the mental health crisis response system alongside trained EMT's. We strongly urge response teams such as the B-HEARD model to consider our proposal and bring cahoots to NYC. And we hope you consider our testimony and see our organization as a resource to you.

SERGEANT AT ARMS: Time.

KIMBERLY BLAIR: As the city continues to develop its prevention and response programs. Thank you.

COMMITTEE COUNSEL: Thank you so much for your testimony and thank you to this entire panel. I want to remind Council Members that if any of them have any questions, you can use the Zoom raise hand function.

We will now turn to our next panel, which will include Mackenzie Arnold, Beth Haroules, P. Jenny Marashi, Caitlin Becker, Craig Hughes and Kathryn Fazio. Mackenzie Arnold, we can begin with you as soon as you are ready.

SERGEANT AT ARMS: Time starts now.

MACKENZIE ARNOLD: Great and thanks everyone for having us here to testify today. My name is Mackenzie Arnold, and I am a Legal Fellow at New York Lawyers for the Public Interest where I work with the Disability and Health Justice programs.

Today, I've come here to discuss the Council's recent actions regarding mental health crisis response and, the B-HEARD program. And my hope is that in a few minutes I can outline a few actional steps that this Committee can take.

So, I'll begin with at thank you. Thank you to everyone here for taking community crisis response so seriously along with the demands of our community and thank you to the City Council for allocating $112 million to finally make mental health crisis response system a reality. But I've come here today to discuss our major concerns about what is going to be done with that money. Because as Public Advocate Williams noted at the start of today's hearing and as we heard just a minute ago from NAMI, the city's current plans embodied by the B-HEARD program misses the vast majority of the potential of a community crisis response system. And that's not simply to say that B-HEARD is being rolled out slowly or that its logistically difficult. We understand that building a program is hard. We recognize that. It's to say that B-HEARD program creates a system much closer to traditional policing than the City Council undoubtedly set out to create. And as Dr. Herman said earlier today, I think she put it well. The city wants to try something innovative. Something that's worth it and our fear is that this program is not that. As we'll detail in our written testimony, the B-HEARD program in its uniquely narrow scope

exclusion of peers and failure to partner with community organizations is a non-starter for community crisis response. It's inconsistent with comparable successful programs adopted in almost every other city that we've reviewed. It's contrary to evidence showing that mental health response produces markedly better outcomes for clients and it's feasible and safe. Our large scale, far beyond the 20 percent or even the measly goal of 50 percent that the program has set our for the future and it sets the city on a path that's more difficult and unproven and lacking community supports than is necessary and that's really our plea today. Not to push the city to some novel or unproven territory. But to ask it to simply act like every other city that has developed comparable programs.

We recognize that this is hard but other successful programs have not been this limited or this exclusive of community partners and where the city has concerns, look to the evidence and look to groups like NAMI and NYLPI and CCIT NYC for support. The city isn't alone in this endeavor.

As Chair Louis comments and questions pointed out I think earlier in the call, 22 staff simply can't

manage this program and when we look other cities like Eugene Oregon with cahoots or the City of Oakland with their new Macro program, they've been actively partnering with community members to help them figure out staffing, to figure out recruitment, to manage training and all the other things that are a huge burden on the city and are necessary for a program like this to succeed. We're here to help.

SERGEANT AT ARMS: Time.

MACKENZIE ARNOLD: And if we really care about this issue, it's necessary that we help. And I really hope that after today's hearing that we take this seriously and I want to be here to help join in that endeavor. Thanks everyone.

COMMITTEE COUNSEL: Thank you very much. We will next turn to Beth Haroules and Beth, you can begin as soon as you are ready.

SERGEANT AT ARMS: Starting time.

BETH HAROULES: Thank you. My name is Beth Haroules, I'm a Senior Staff Attorney at the New York Civil Liberties Union. We are the New York State affiliate from the NYCLU. We also coalitions partners with CPR and with CCIT NYC. We hope today the Council will begin a period of robust and

frequent monitoring of the City's Response as a whole to the plight of New Yorkers who live with mental health challenges. New York City's public mental health services are quite simply dysfunctional. From policies to procedures to programs to facilities and the system's negative impact on Black and Brown communities is long standing and pernicious. What I heard this morning is simply troubling. The NYPD remains deeply entrenched and in control of New York City's mental health crisis response model. And even if an individual is connected to mental health services, the mental health care that is currently delivered, especially for people reliant on the public mental health system is routinely second-rate, dismissive of choice or convenience, difficult to obtain in many neighborhoods and rarely linguistically competent, culturally competent, gender competent, or, in any way, person-centered.

The Mayor's Office of Community Mental Health and I emphasize the community in their title, has an opportunity to develop a truly comprehensive mental health system. However, the new interagency Council is composed entirely of city employees. Policy and planning originates in a top down fashion entirely

with city employees who are not likely to have any meaningful connection to impacted neighborhoods and the people most in need. It's completely unacceptable. A squandered opportunity to meaningfully include peers, community members, and subject experts in a policy-making role. The absence of these critical stakeholders is particularly troubling given that the mandate of the Council under the incentive order is to reduce the disparity between neighborhoods and reduce the total number of mental health emergencies by addressing mental health needs before they become crises.

We have more substantial testimony but I would suggest that you may also closely examine the following issues: There is a failure of transparency and public reporting by B-HEARD program. Four months into the program, all that has been posted is data from the first month of operation. The NYPD has taken very public issue with the accuracy of that data. The latest news on their website dates from June 2021. B-HEARD has established some sort of advisory board. It has met once. It may only meet four times a year. Many of the operations we heard are supposed to be secrecy.

With respect to the NYPD's ICAT training program, for the past five years, the city has a crisis intervention training program. It was not an optional program but it was suspended without public notice at some point during the pandemic. We heard Susan Herman indicate the CIT program seems to be continuing or will be up and running soon but in June, Chief Shea at the NYPD indicated the NYPD will be training all 35,000 —

SERGEANT AT ARMS: Time.

BETH HAROULES: Of it's officers in a new de-escalation program. There is no forward facing information of this ICAT training program. It was developed by the Police Executive Research Forum and their perspective is NYPD has [INAUDIBLE 1:42:11]. This is inappropriate law. Law enforcement should not be permitted to move forward [INAUDIBLE 1:42:23].

Finally, you had— you did ask questions about the street homeless initiatives. We have watched with great concern the rollout. We urge the committee to exercise oversight authority to understand the abolishment of the mayor's office and the Council in an appropriate oversight of recent homeless initiatives which include making mental health

removal decisions on the street on an at month basis. This cannot be tolerated. We urge you to look more critically and deeper at these issues.

Thank you for the opportunity today to testify here and we stand willing to work with you in any way that's appropriate.

COMMITTEE COUNSEL: Thank you so much for your testimony. And we will next turn to P. Jenny Marashi and you can begin as soon as you are ready.

SERGEANT AT ARMS: Time starts now.

P.JENNY MARASHI: Hi, my name is P. Jenny Marashi and I am here on behalf of Correct Crisis Intervention Today New York City. It's the largest coalition of mental health advocates and organizations working to transform how New York City responds to the over 150,000 mental health calls that are now being responded to by the NYPD.

CCIT believes that it can answer the question presented by this committee regarding the coordination of agencies to address serious mental illness. And it is to hire peers or people with lived experience. And remove the NYPD and policing corrections from the mental health response. That's

the short answer. Hopefully in the next two minutes, I will drive the solution home.

First off, you are all a great group Council people in these unprecedented times and you have taken some powerful action allocating $112 million to the crisis response issue. So, thank you. This $112 million will empower whoever these resources go to. Back to the city agencies and the NYPD or to the communities whose poverty and lack of health care is driving mental health issues.

We at CCIT want to make sure that $112 million goes towards a pure led point one, community point two, response. I want to illustrate the points not with facts and figures but with two short anecdotes. Anecdote one, when my successful and beautiful family member stop sleeping and eating and convinced everyone around her of her delusions, including social workers and her other successful friends. The two people who immediately recognized that she was in fact having a mental health crisis and could delineate her delusions from reality or a friend or cousin in law who were themselves diagnosed with bipolar.

And that made sense of our lives looking back because when my dad died of a heart attack when I was 24, the only person who walked me through my grief was my cousin whose dad had also died. I'm sure you can think of moments of crisis in your own life and when you were heard and seen. It was likely by someone you believed knew where you were coming from. It was a mutual scene. Now, the peers at CCIT advocates would be professionally trained peers having undergone a proven 500 hours of training.

Anecdote two, last September while home schooling my kids and also keeping up with my civil rights legal practice, which incidentally involved watching hundreds of hours of body worn camera footage of NYPD officers responding to 911 mental health calls were the officers and the callers and the family members were all in a complete state of disconnect. I had an important steering committee from CIT.—

SERGEANT AT ARMS: Time.

P.JENNY MARASHI: While we were on the call I was pandemic burnt out and in disagreement with some members about how to handle a CCIT position. The peer colleagues on the call, as they have repeatedly done in communication breakdowns, recognized my

hardship, figured out how to communicate and resolved the issue and got us all coordinated and in action again. Not only will hiring peers to manage and implement crisis response empower the communities that according to your own committee report for today are plagued by the worse of the social determinants of mental health, but it will actually be useful to the city doctors, social workers and lawyers like myself who have only ever had clients and rarely colleagues that are homeless or openly diagnosed with mental health issues.

This across class and crisis coordination is the only way out. We all have our own anecdotes from when things worked and they were likely when we were all seen and heard. Thank you.

COMMITTEE COUNSEL: Thank you very much for your testimony and we'll next turn to Caitlin Becker and you can begin as soon as you are ready.

SERGEANT AT ARMS: Time starts now.

CAITLIN BECKER: Good afternoon Chair Louis and Committee Members. My name is Caitlin Becker and I am the Managing Director of Social Work at the Bronx Defenders. I want to thank you for your dedication

to this important issue and for convening today's hearing.

At the Bronx Defenders, we represent individuals navigating complex mental health needs who are charged in the criminal legal system, the immigration system and the so-called Child Welfare system or as we prefer to call it, the Family Regulation System.

In my role, I manage nearly 40 social workers and advocates who work closely with attorney's to provide holistic defense services to individuals facing the loss of their children, their liberty and their housing because of symptoms of serious mental illness.

Rather than coordinate to support our clients and their families, we often see city agencies working together to prosecute and punish those who are in serious distress. We share our colleagues and the advocates community concerns about the continued involvement of NYPD and the city's response to people experiencing mental health crisis.

We also share our colleagues critiques of the B-HEARD program, which we will address further in our written testimony. We agree with our colleagues who have so powerfully described that the response to

this crisis must not be guided by social workers or the police but by those individuals and families most directly impacted by serious mental illness.

Parents who seek treatment for symptoms of mental illness through the providers referenced in this hearing are met with a call to ACS and a child protective investigation. We regularly represent parents who psychiatric diagnosis alone is the reason their children are removed from their care and placed in the foster system. Removal rates for parents with a psychiatric disability have been found to be as high as 70 to 80 percent. We urge this committee to examine how ACS treats parents and children with severe mental illness and how city agencies contribute to their prosecution rather than their care.

In the criminal legal system and especially right now, given the crisis at Rikers Island, that Public Advocate Williams and other colleagues referenced at the outset of this hearing. People with complex mental health needs are falling through the cracks. While the Get Well and Get Out Act known as Local Law 190 requires correctional health services to share critical information with defense teams to support

our advocacy, we have found that this process is broken. Our written testimony details recommendations to reform this law. While this effort has the potential to support decarceration efforts and keep individuals with serious mental illness out of the criminal legal system more permanently, it is failing to do so now.

We urge this committee to provide increased oversight to ensure that all city agencies are coordinating care that stabilizes individuals and families rather than relying on prosecution —

SERGEANT AT ARMS: Time.

CAITLIN BECKER: I would be glad to answer any questions you may have today or at any time following today's hearing. Thank you very much.

COMMITTEE COUNSEL: Thank you so much for your testimony. We will next hear from Craig Hughes and you can begin as soon as you are ready.

SERGEANT AT ARMS: Time starts now.

CRAIG HUGHES: Thank you and thank you Chair Louis for holding this hearing. My name is Craig Hughes, I am a Social Worker with the Safety Net Project at the Urban Justice Center.

Today, I am going to be focusing on two major themes. One is street homelessness and the second is supportive housing. We are submitting written testimony, so I wont go line by line. I will just give you a brief summary but I would be remiss in a discussion where there is so much mention of trauma informed care and that sort of rhetoric that we need to start thinking about the city as a producer of mass trauma. That city policies produce mass trauma.

Our agency has been inundated with calls over the past few months from people being transferred from safe hotels to dangerous congregate facilities by the Department of Homeless Services in a process that can only be described as an institution of mass trauma. Primarily harming poor people of color.

Wit that said, the number one recommendation we would like to put to the Committee is that there needs to be the change from the broken windows model of social services to a model of social services that actually serves people. Under the de Blasio Administration, we've seen that the punitive broken windows model has gone from policing to the Department of Homeless Services from the CompStat model to the home stat model where our clients on the

street are treated as evidence of disorder that needs to be removed, tallied, counted, and swept increasingly. Now there are dozens of sweeps a day. FOILS have shown that in April the city signed a $1 million agreement with Health + Hospitals for ten nurses. And since then, as part of the Midtown Clearings effort and since then, 95A removals, which are removals by mental health professionals with the homeless services teams have doubled.

In the Fall of 2020, there were 13 95A removals. Through July of 2021, there were 30. That kind of clearance effort, that kind of institution of broken windows to target our clients is dangerous and it doesn't help anyone get housing. We need to make sure that people can get housing directly from the street. The supportive housing lobbyists have an incredible amount of power over who gets into supportive housing and who doesn't and we know for a fact that people on the streets do not get into supportive housing directly from the street. People from the street can possibly get in the shelter and then after a year or two, may get into supportive housing but there is virtually no intervention from city or state government to make sure that supportive

housing landlords aren't rampantly discriminating against applicants for supportive housing, which they are.

And there needs to be intervention to make sure that supportive housing landlords, trade groups and providers, do not have an ordinant amount of power over city policy, which they currently do so that we have a housing first model, where everyone on the street can get housing. That supportive housing that needs it and not who a landlord or provider decides —

SERGEANT AT ARMS: Time.

CRAIG HUGHES: Just a couple more things. Decides it is who they believe is the best. Rather, there should be a housing first model and not a landlord first model.

DSS needs to seize from weaponizing supportive housing eligibility. What that means is that the city is increasingly moving toward turning eligibility for supportive housing into a way to prevent people who are eligible from accessing other rental supports and New York City recently saw this with the attempt by the Department of Social Services to preclude people who are deemed eligible for supportive housing. Not who have an apartment but

just eligible from accessing over 3,800 Section 8 vouchers. With HUD intervention, the city backed down on that but they continue that approach in other areas.

Finally, just two other pieces. New York City must intervene to make sure that supportive housing landlords don't lock out or otherwise evict tenants. All tenants must be provided a safe and habitable living conditions. And this is my final point, we very often see that the supportive housing landlords will weaponize housing court and bring supportive housing tenants into housing court unnecessarily for things that can be resolved without doing that. And the city should be holding supportive housing landlords accountable to standards that prioritize maintaining individuals in their housing at all times. And not just the functioning of the housing court as a weapon against poor people, primarily poor people of color.

If we don't abandon the broken windows approach to social services, if we don't actually hold landlords accountable, we are only going to continue seeing the crisis that pervades the city right now in terms of mental health and stability and people who

just simply cannot get out of homelessness and find themselves in desperation all the time. Thank you.

COMMITTEE COUNSEL: Thank you so much. And our next and final panelist will be Kathryn Fazio and if we've inadvertently missed anyone, please use the Zoom raise hand function. Kathryn, you can begin as soon as you are ready.

SERGEANT AT ARMS: Starting time.

KATHRYN FAZIO: My name is Kathryn Fazio; I am a poet. I represented the USA at the Fifth World Congress of Poets. When I got the Silla Gold Crown World Peace Literature Prize. I am a peer advocate. I have lived experience. I have seen the nurses, psych nurses displaced. I don't want them displaced. They were definitely trained to help coordinated care and pathways to community services.

I've noticed in my neighborhood, which is Winsor Terrace that the Methodist have removed beds. We need beds because that's the start. If you want a start, you need to have someone there to be able to help in crisis. So, we need those beds back again. So, I'm representing that and asking for that to be looked at.

I also am a small business advocate. I believe that there are people that cannot — they get lost in the system and the only way that they do is they band together and they use the subways and graffiti. They harm uhm, the storefronts and that's their own code. I believe that these graffiti should be whitewashed and it should me light masks. It should definitely be removed from the subways. It doesn't matter if it's on a light or a wall. Get it together, it's just trying to harm Brooklyn New York or any place with mental health.

I believe that the arts can be used as positive outcomes to health care and peer support must be looked at. The Fountain House model must be looked at and funded. I believe that uhm, I am concerned about uh, the funding for the community services. The person organization I work with is Street Into Action and I'm a network specialist and a job developer. I would like to offer any assistance I can to be part of this conversation. If you want to ask me any questions you can.

I was hospitalized in South Beach as well as being a peer. I saw that was only an extension of the jail system. Uhm, we need help together. We

need help together. One blood, I'm sorry, the blind only helped when Helen Keller met Roosevelt, that's when meat and potato job opportunities and pathways really happened with newspaper stands etc..

The mental health community has not really gotten their word out or organized together and so, I even wonder why the Department of Social Services, I'm not sure if they were represented here. I only know that resources are so different. It's like animal farm. For what someone with mental health that has to negotiate as far as resources.

SERGEANT AT ARMS: Time.

KATHRYN FAZIO: Okay, that's it. I am saying, thank you very much.

COMMITTEE COUNSEL: Thank you so much and thank you to this entire panel. I'm just going to wait a moment to see if we inadvertently missed anyone and please use the Zoom raise hand function if you have not testified or hoping to.

Okay, seeing no hands, I will turn to Chair Louis for closing remarks and to gavel out the hearing.

CHAIRPERSON LOUIS: Thank you so much. I want to thank everyone who came out today. Ravi, Jayette, Kimberly, you came. Natalie, Mackenzie, Beth, P.

Jenny, Craig and Kathryn for sharing your testimony, recommendations, thoughts and the concerns on the ways the city can further tackle the mental health crisis effecting New Yorkers today and thank you to those that waited and those incarcerated on Rikers.

We definitely live in a world that is so much more connected than any other time than before. Yet it may feel at times that we've never been further apart due to the COVID-19 pandemic. And while the topic of self-care and personal and physical health has dominated public discourse these past months, it is high time the city look at mental health the same way.

I believe that it's critical that the city provide safer, more effective and most importantly quality and equitable access to mental health services and there is no better time for the city to get that done than now.

I want to thank Director Herman, Dr. Cunningham, Dr. Barron, Dr. Linn Walton, Deputy Commissioner Kavanagh, First Deputy Commissioner Dr. Torian Easterling for participating today. I also want to thank Public Advocate Williams for joining us. My colleagues that participated today, as well as my

staff Legislative Director Kristia Winter, Legislative Liaison Alex Tymkiv and our Counsel Committee Staff. Uhm, uhm, sorry, Sara Liss who is our Senior Counsel, Legislative Policy Analyst Cristy Dwyer and Financial Analyst Lauren Hunt for making today's hearing possible. This meeting is now adjourned. [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 October 15, 2021