# Exhibit H

CITY COUNCIL
CITY OF NEW YORK

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TRANSCRIPT OF THE MINUTES

Of the

COMMITTEE ON MENTAL HEALTH, DISABILITIES, AND ADDICTION

Jointly with the

COMMITTEE ON HOSPITALS

Jointly with the

COMMITTEE ON PUBLIC SAFETY

Jointly with the

COMMITTEE ON FIRE AND EMERGENCY MANAGEMENT

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Monday, February 6, 2023
Start: 10:18 a.m.
Recess: 5:00 p.m.

HELD AT: COUNCIL CHAMBERS, CITY HALL

B E F O R E: Linda Lee, Chairperson
Mercedes Narcisse, Chairperson
Kamillah Hanks, Chairperson
Joann Ariola, Chairperson

COUNCIL MEMBERS:

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Shahana K. Hanif
Vickie Paladino
Nantasha M. Williams
Kalman Yeger
Public Advocate Jumaane Williams

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

Jason Hansman
Deputy Director
Mental Health Initiatives, Crisis Response, and Community Capacity
Mayor's Office of Community Mental Health

Omar Fattal, MD
Systems Chief for Behavioral Health
Co-Deputy Chief Medical Officer
New York City Health and Hospitals

Michael Fields
Chief of Emergency Medical Services
New York City Fire Department

Theresa Tobin
Chief of Interagency Operations
New York City Police Department

Juanita Holmes
Chief of Training
New York City Police Department

Michael Clarke
Director of the Legislative Affairs Unit
New York City Police Department

Jamie Neckles
Assistant Commissioner
Bureau of Mental Health
New York City Health Department

Karim Walker
Outreach and an Organizing Specialist
Safety Net Project, Urban Justice Center

Graham Nyaasi
Advocacy Specialist at Community Access
Steering Committee Member of
Correct Crisis, Intervention Today NYC.

Danny Kim speaking for Eric Vassell
Justice Committee

Ellen Trawick
Mother of Kawaski Trawick

Christine Henson
Mother of Andrew Henson

Oren Barzilay
FDNY EMS, President of Local 2507

Selena Trowell
Vocal New York Homeless Union

Beth Haroules
New York Civil Liberties Union

Siya Hegde
Housing Policy Counsel
Bronx Defenders

Elena Landriscina
Staff Attorney
Legal Aid Society

Anthony Feliciano
Vice President for Community Mobilization
Housing Works

Rabbi Joshua Stanton
Tirdof: NY Jewish Clergy for Justice

Craig Hughes
Social Worker
Bronx office of Mobilization For Justice

Antonine Pierre
Brooklyn Movement Center

Toni Smith
New York State Director
Drug Policy Alliance

Danielle Regis
Supervising Attorney
Mental Health Representation Team
Criminal Defense Practice
Brooklyn Defender Services

Dr. Samuel Jackson
Psychiatrist
New York Doctors Coalition

Dr. Michael Zingman
Psychiatry at Bellevue Hospital
Secretary Treasurer
Committee of Interns and Residents

Dr. Ashley Brittain
Resident physician of Emergency medicine
Regional Delicate
Committee of Interns and Residents

Luke Sikinyi
Director of Public Policy
New York Association of
Psychiatric Rehabilitation Services

Chaplain Dr. Victoria Phillips (Dr. V)
Mental Health Project
Urban Justice Center

Dr. Betty Kolod
Primary Care Physician
New York Doctors Coalition

Jessica Fear
Senior Vice President for Behavioral
Health
VNS Health

Fiodhna O'Grady
Samaritans of New York

Casey Starr
Co-Executive Director
Samaritans of New York

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Supervising Attorney
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Senior Vice President, Behavioral Health
VNS Health

Fiodhna O'Grady
Samaritans of New York

Casey Starr
Co-Executive Director
Samaritans of New York

Helen "Skip" Skipper
Justice Peer Initiative

Sarah Blanco
Clinical Director
Midtown Community Court Midtown
Center for Justice Innovation

Nadia Swanson
Licensed Clinical Social Worker
Director of Technical Assistance and
Advocacy
Ali Forney Center

Christina Sparrock
A Founder of Person Centered Intervention
Training
Mental Health Response Pilot

Lena Allen
Policy Analyst
Fountain House

Nadia Chait
Senior Director of Policy and Advocacy
The Center for Alternative Sentencing and
Employment Services

Alexandra Nyman
CEO
Break Free Foundation

Ruth Lowenkron
Director, Disability Justice Program
New York Lawyers for the Public Interest

Jason Bowen
Peer Advocate
Community Access Crisis Respite

Richard
Homeless person

Dr. Jeremy Kidd
President
New York County Psychiatric Society

Sandra Gresl
Co-Chair, Social Welfare Law Committee
New York City Bar Association

Deborah Berkman
Supervising Attorney
Shelter Advocacy Initiative
New York Legal Assistance Group

Lauren Galloway
Advocacy Coordinator
Coalition for Homeless Youth

Carolyn Strudwick
Associate Vice President
Street Work Project
Safe Horizon

Dr. Erick Eiting
President
New York County Medical Society

SERGEANT AT ARMS: Good morning and welcome to today's New York City Council hearing for the Committees on Hospitals, Mental Health, Public Safety and Fire and Emergency Management at this time please silence all electronic devices. Chairs we are ready to begin.

CHAIRPERSON LEE: Okay. Good morning everyone. My name is Councilmember Linda Lee, Chair of the Committee on Mental Health, Disabilities, and Addiction. I'd like to thank all my colleagues, Councilmembers Mercedes Nasrcisse, Chair the Committee on Hospitals, Councilmember Joanne Ariola who's with us virtually, Chair of the Committee on Fire and Emergency Management, and Councilmember Camilla Hanks Chair the Committee on Public Safety for being here at today's joint hearing on oversight for mental health and voluntary removals, and Mayor Adams recently announced plan. And I also want to thank all of the folks who are here from the Admin who are here to testify.

This may be a long hearing, so I want to thank all of you, potentially-- I want to thank all of you ahead of time for your patience. And just as a reminder, you know, just to keep it respectful and

cordial in the chambers and if there's any issues, please let us know or any of the staff know as well.

So thank you so much. As I mentioned, representatives from OCMH, Health and Hospitals, FDNY, NYPD, and DOHMH for being here to provide testimony and answer the Committee's questions.

And we will also be hearing two bills Proposed Intro 273 A sponsored by Chair Narcisse, which would require police officers to receive training related to recognizing and interacting with individuals with autism spectrum disorder, and Intro 706 sponsored by Councilmember Shaun Abreu, which would require the Office of Community Mental Health to create an online services portal and guide on available mental health services in this city.

So at this time, I'd like to acknowledge our colleagues who are here with us today. So I'm just going to stand up so I could see everyone. We have Councilmember Cabán, Councilmember Barron, Councilmember Hanif, Councilmember Bottcher. Our Public Advocate has joined us Jumaane Williams. We have Councilmember Rita Joseph, of course, our Chair, fellow Chairs, and we have Councilmember De La Rosa, Majority Leader Keith Powers. We have Councilmember

Vicki Paladino, Councilmember Holden, Councilmember Carr. So thank you all for joining us today and for being with us.

And it's also great to see my fellow social service colleagues, former colleagues in the audience as well who will be testifying today.

To begin the term Serious Mental Illness or SMI as defined by DSM as a mental health disorder that substantially interferes with or limits one or more major life activities. All mental health conditions have the potential to interfere with someone's quality of life, so it's important to note that in many instances, using quote/unquote "serious" to refer to a mental health condition can vary depending on the context. Generally, SMI refers to disorders such as schizophrenia and subsets of major depression and bipolar disorder.

In New York City, nearly one in every 25 adults is living with a diagnosed SMI, and according to the most recent statistics, although white New Yorkers have a higher percentage of SMI diagnoses, black New Yorkers actually have higher hospitalization rates. Adding to this suffering is the fact that according to OCMH, the highest poverty neighborhoods have over

twice as many psychiatric hospitalizations per capita compared to the lowest poverty neighborhoods.

We are not here to dispute the seriousness of this issue or does to dispute that we are in a psychiatric and homelessness crisis which deserves recognition as well as our immediate support and action, but we are here today to talk specifically about the Mayor's recently announced directive to city agencies, which provides updated guidance on how to carry out involuntary removals of individuals with SMI in our communities. The directive interprets the state's mental health hygiene law standard for involuntary removal, which provides that law enforcement, peace officers, or mobile outreach teams may remove any person who appears to be mentally ill, and is conducting themselves in a manner which is likely to result in serious harm to the person or others. The law explicitly states that "likely to result in serious harm" means a substantial risk of physical harm to other persons as manifested by homicidal or other violent behavior by which others are placed in reasonable fear of serious physical harm. However, both the State Office of Mental Health and the Administration have released guidance

that interprets this standard as also applying to those who appear mentally ill and display an inability to meet basic living needs such as lack of food, clothing, or shelter. In other words, this standard permits unhoused individuals in our communities to be removed even when they have not committed an observable or overtly dangerous act.

I respect the Administration's dedication to the psychiatric care crisis in our city, but I would be remiss not to mention that there are many valid concerns that come with this standard. We do not want New Yorkers being removed from our communities merely because they are homeless or unhoused, only to be cycled out of hospitals and back onto the streets without adequate care or housing. We do not want New Yorkers with disabilities and substance abuse problems to be unfairly targeted due to inadequate training by those carrying out this directive, and we do not want black and brown New Yorkers to experience the brunt of the trauma that may occur if this directive is not carried out equitably.

The goal of today's hearing is not just to gather more information on the Mayor's directive, and how it will be implemented, but also to receive feedback

from community based groups, nonprofits, public defender organizations, medical and mental health professionals, and other advocates on how this plan will directly impact our communities and to hear any recommendations for improving oversight of this plan going forward.

In closing, I'd like to thank the Administration and the dedicated advocates and community members here today that are here to testify. I would also like to thank my colleagues and staff as well as the Committee staff, Committee Counsel, Sarah Sucher, and Senior Legislative Policy Analyst, Christy Dwyer, for their work on this hearing, who both have extensive knowledge and experience in this area.

I will now turn the mic to my colleague Chair Narcisse of the Hospitals-- Oh, I'm sorry, Chair Ariola. Just kidding. To give her opening statement.

CHAIRPERSON ARIOLA: Thank you Chair Lee. Good morning to everyone joining us here. My name is Joanne Ariola, and I'm the Chair to the Fire and Emergency Management Committee. I'd first like to thank my colleagues, Chairs Camilla Hanks, Linda Lee and Mercedes Narcisse, for holding today's hearing.

In the interest of time, I will keep my opening brief, because the Committees have a lot to examine and discuss in relation to the Mayor's recent plan on mental health involuntary removals.

As we all know, New York City Emergency Medical Services personnel, provide critical emergency care and work endless hours helping ensure the well-being of New Yorkers. Their responsibilities ranged from responding to cardiac arrests, fires, automotive accidents, as well as numerous other incidences. EMS first responders are often the frontline of responding to 911 calls and are tasked with providing immediate care, which includes the responsibility of caring for individuals with emotional disturbances or other serious health illnesses.

The Committee wants to examine what steps the fire department has taken, and plans to take moving forward to ensure that EMS personnel is receiving the necessary training to handle the individuals with serious mental health illness. Specifically, has the Department provided professional training on properly identifying if someone is under duress, de-escalation and self defense tactics if personnel are under attack, and are personnel provided with adequate

equipment to handle cases involving individuals identified with mental health issues?

I have concern over assaults that have taken place on EMS personnel, and how these incidents of workplace violence have increased over the years. Ultimately, we are here to support these first responders provide the proper care for their in the individuals who have serious mental health, illness, and work to avoid further increase of assaults against EMS workers by ensuring the safety of these vital public servants.

Again, thank you all for being here today regarding this very important issue, and hopefully, at the conclusion of today's hearing, we will all have a better understanding of how the city plans to address and support New Yorkers with Serious Mental Illness, as well as providing the necessary tools and training and safety equipment needed for our first responders.

I'd also like to thank our committee's legal staff, led by Josh Kingsley, and our Chief Analyst, William Hongash.

And now I'd like to turn the mic over to Chair Lee.

CHAIRPERSON LEE: Thank you so much. Chair Ariola. Now I'd like to turn over to Chair Narcisse of the Hospitals Committee to give her opening statement.

CHAIRPERSON NARCISSE: Good morning, and I want to say thank you to my colleague, Linda Lee, Hanks, and Ariola, for being part of this needed process to see how we are functioning in as a city when it comes to mental health.

Good morning, everyone. I'm Councilmember nurses Chair of the Committee on Hospitals. Thank you for joining us for this very important hearing to discuss Mayor Adam's recently announced plan regarding mental health involuntary removals.

As many of you know, mental health has been one of the most overlooked and neglected issues in our healthcare and justice system. According to the National Institute of Mental Health, 1 in every 25 New Yorkers suffer from a diagnosed Serious Mental Illness known as SMI. That is over 3.38 million New Yorkers that might be suffering from schizophrenia, severe depression, bipolar disorder. Just last year, over 131,000 mental health crisis calls were made to 911. This equates to roughly 500 calls per day.

NYPD are usually the first to arrive from the response team, who often lack proper training in interacting with individual with SMI or developmental disabilities which could further escalate the situation, jeopardizing the lives of the officers, the individual suffering from the crisis, and the people involved. It should not be this way.

So, today, I am proud to announce my Intro 273 A, which could require police officers to receive training related to recognizing and interacting with individuals with autism spectrum disorder so they could be better equipped when encountering someone suffering from a crisis. As you know, the mental health crisis is a multifaceted issue that has been brewing over decades of policy misshapes and has only been exacerbated by the pandemic. According to OCMH 2023 Annual Report, one of the greatest challenges facing the provision of mental health services is the current workforce shortage.

The CEO of Mental Health Association of New York State, Glenn Lippmann, said in an interview that COVID-19 has amplified the shortage tenfold, as some mental health programs are seeing 30 to 40% vacancy rates. Additionally, many of the cities er are

overwhelmed by the influx of individuals suffering from mental health crises. Psychiatric staff is overworked, understaffed, and underpaid. We need to create better incentives and working conditions for our healthcare workers who care and nurture us back to health.

Additionally, the city has a severe shortage of psychiatry beds. We know that. For a population of about 8.47 million New Yorkers. The city only has 2225 functioning psychiatric beds. According to a Wall Street Journal report, during the peak of the pandemic, about 14,000 individuals suffering from mental health issues were prematurely discharged without any proper follow up. The current rise in mentally distress people could be attributed to the untimely discharges as there was an 8% increase in 911 calls related to mental health crisis between 2021 and 2022.

This is a clear need for investment in our mental health landscape with a focus on black and brown communities who are often neglected and giving the short end of the stick. If you look at the statistic in 2017 SMI prevalence among white New Yorkers was seven times higher than among black New Yorkers, and

yet, black New Yorkers had a higher rate of mental health related hospitalization than any other ethnic groups. In fact, according to the Mayor's Office of Community Mental Health, the highest priority neighborhoods, which as we know, tend to house black and brown communities, have over twice as many psychiatric hospitalization per capita as the lowest priority new neighborhoods in New York City. This fact paints a clear of the systematic inequalities that are prevalent in our healthcare system.

Since this hearing is about involuntary removal, I would be remiss if I did not remind my fellow city and the state legislature and administrators to be mindful of the broad nature of voluntary removal directives and guidelines and how they can impact certain communities.

Surely, a lot of work needs to be done around a credible mental health axis in New York City, but I want to give credit where it is do believe it or not. Thank you, Governor Hochul and Mayor Adams for bringing in much needed funding in efforts to fix our mental health care system by restoring psychiatric beds lost during the pandemic, creating loan repayment plans for psychiatric doctors and nurses

and a funding program to help New Yorkers suffering from mental illnesses. And most importantly, I want to say thank you to my city agencies, H&H, DOHMH, OCMH, and NYPD, FDNY, EMS and all the advocates present. As you are the people working on the ground and making things to keep all New Yorkers safe, I look forward to hearing all of your testimonies.

I want to conclude by thanking my staff as well as committee policy analysts Manoh Butt, and Masaf Saya Joseph, my Chief Of Staff, for their work on this hearing. Now I will pass it on turn it over to Chair Hanks, Chair of Public Safety. Thank you.

CHAIRPERSON HANKS: Thank you so much. Chair Narcisse. Good morning. My name is Kamillah Hanks. I am the Councilmember and Chair on the Committee on Public Safety, and I am very happy to be joined by my colleagues. I'd like to thank Chairs Lee, Narcisse, and Ariola for joining this Public Safety Committee and convening this important hearing on involuntary mental health removals and Mayor Adams's recently announced mental health plan. I'd also like to thank the panel that all came here today to testify.

As my colleagues have all stated, there are many outstanding questions regarding how these plans will

be implemented, what role NYPD will play in these efforts, and how the Administration will limit any adverse consequences to some of our most vulnerable New Yorkers.

So the goal of this hearing is to learn how the Administration will implement a fair, compassionate, and practical plan for and for providing the care and support needed by those with severe mental illness, while at the same time protecting the public from those who may inflict harm to themselves or to others. We also want to avoid criminalization and provide and provide meaningful access to treatment and to the long term support that we know is desperately needed.

Moreover, we want to learn how the Administration intends to evaluate the success of their plan and examine the impact that Mayor Adams's plan will have on public safety for all New Yorkers, and we hope to hear more from the NYPD and how they will record data and maintain transparency regarding these efforts. Furthermore, we want to understand how NYPD intends to train its officers to successfully navigate engagements with people experiencing a mental health crisis.

Additionally, the Public Safety Committee will be hearing Introduction 273, sponsored by my colleague Councilmember Narcisse, which will ensure that all new NYPD officers are provided with the necessary training for engaging within individuals with autism and on the spectrum. This important legislation for which I am a proud co-sponsor seeks to provide officers with the skills necessary to promote effective communication between officers and with those with autism, in hopes to minimizing risks for officers and civilians alike. I look forward to hearing the Administration's testimony and the valuable perspectives brought by the members of the public and experts who dedicated their lives to providing care and service to those with mental health issues.

I also like to thank our Committee Counsel Josh Kingsley, and my staff, Chief of Staff Marcy Bishop and my Senior Counsel Mr. Paul Casalli, thank you.

CHAIRPERSON LEE: Yes. Thank you, Chair. Thanks. And now I would like to first recognize additional Councilmembers we've been joined by. We have Councilmember Gutiérrez, Councilmember Brannan,

Councilmember Abreu, Councilmember Feliz, and also online we have-- on Zoom we have Councilmember Moya

And so now I'd like to turn it over to Councilmember Abreu, if you'd like to say a few words about your bill.

COUNCILMEMBER ABREU: Good morning, and thank you, Chairs. I want to speak very briefly about my bill Intro 706, our Mental Health One-Stop Shop legislation.

We've learned so much in recent years about the importance of supporting mental health. Access to services is critical, but sadly, I hear from constituents who are facing barriers to care due to lack of information, and lack of options when it comes to paying for care. Our bill would centralize all available free city-sponsored options into both a digital and print format resource guide, broken down by population and type of service. It would also require outreach on the portal while also putting in place important security measures to ensure public trust that their information is safe and confidential. Mental health services are critically important and I'm hopeful this legislation will ensure that all city resources are centralized in one

place for maximum benefit to those in need. Thank you and I look forward to hearing from the Administration.

Thank you again Chairs.

CHAIRPERSON LEE: Thank you, Councilmember. And now I'd like to turn it over to our Public Advocate, Jumaane Williams, to make a statement.

PUBLIC ADVOCATE WILLIAMS: Thank you so much. As I mentioned, my name is Jumaane Williams, Public Advocate of the city of New York.

I want to thank all the Chairs and the members of committee for holding this important hearing. In any given year, one in five New Yorkers experiences psychiatric illness, and hundreds of thousands of those are not connected to care or support. Those who are not receiving treatment or services for their psychiatric disabilities are more likely to be low income people or of color.

In addition to a shortage of inpatient psychiatric beds, our city is also experiencing an affordable housing crisis forcing more and more people into the shelter system in the streets, making people experiencing homelessness and or symptoms of psychiatric disability even more visible. In

response to a rising crime rates in the subway, including two tragic and high profile incidents where people who were experiencing symptoms of psychiatric disabilities pushed commuters in front of trains, Mayor Adams announced in November of last year that NYPD and FDNY will be allowed to involuntarily take people perceived as being unable to take care of themselves to hospitals. Many perceived this to mean that they will be removed regardless of whether they pose any threat of harm to themselves or others. It also seemed that this was simply an announcement of a tactic, much less a full entire plan.

First, we have to make sure we're clear that mental health is not a crime, and most people who are experiencing mental illness will not commit crimes. Until that announcement, people experiencing mental health crisis could be involuntarily detained only if they were deemed to be an immediate risk to themselves or others. Now it was assumed, based on that announcement, that those perceived to be mentally ill and unable to care for their basic needs, can be detained and forced into hospitals, even if they pose no risk of harm to themselves or to

others. If this is the case, it would not only be dangerous but also a waste of resources.

It's important to point out there is no evidence that court-ordered involuntary treatment in hospitals is more effective than community-based treatment. In fact, Martial Simon, the man who fairly pushed Michelle Alyssa Go in front of a train while experiencing the symptoms of schizophrenia, had been hospitalized at least 20 times and reportedly was upset that hospitals were discharging him before he believed he was well enough to live on his own.

Involuntary hospitalizations also have a broad negative impact on many areas of a person's life often leading to the loss of access to basic rights and services including employment, parenting, education, housing, professional licenses, or even the potential right to drive.

Involving police as the primary people to respond or having them present without being called when responding to a person a mental health crisis can be extremely dangerous and has had some historic deadly results. The number of NYPD officers who have received crisis intervention training has dropped over the last two years to the point where two thirds

of active duty officers remain untrained, and the NYPD has no way to ensure that those officers who have been trained are the ones responding to 911 calls reporting mental health crisis.

To name only one tragic story in 2019, two police officers were dispatched to the home of Kawaski Trawick, a 32 year old black man experiencing a mental health crisis. Within two minutes the officers escalated the encounter to the point that one of the officers fired four shots, killing Mr. Trawick, who did not have a gun. The officer who fired the shots had attended crisis intervention training just days prior.

Mayor Adams says that the City has a moral obligation to help those who have acute psychiatric disabilities and I agree. However, merely holding a person in hospital before releasing them into the same environment does not have help anyone, and in fact may make people distrustful and less likely to seek behavioral services.

Just a few weeks before that announcement, my office released a report saying how we were doing on mental health and what we could be doing better. I

did not receive any response from the administration. All of our reports do go to the Administration.

If the City truly wants to fulfill its moral obligation to New Yorkers with psychiatric disabilities, it must invest in a continuum of care that everyone needs. I will also mention that on December 1st, my office sent a letter to the Administration to get questions answered about many of the things that not only my office but many New Yorkers and reporters were asking to see if we can flesh out if there was a fuller plan here. As of today, we still have not received any responses. The continuum of care has to include affordable and supportive housing, affordable community-based health services, accessible education, non-police response to mental health crisis, and employment, should find mental health support and services, not weapons.

I want to be clear that most communities that can access this continuum of care are generally white and wealthier. Most who cannot a generally poorer, black, and brown, and unfortunately, receive a response of police, forced hospitalizations, and arrests.

So we want to make sure that we can provide a continuum of care that's actually needed that may include hospitalizations, but it needs to be clear what that plan is. And my hope is that with this hearing today, perhaps we can get many of the questions answered that many of us have and including mine and hopefully my letter can be responded to shortly. Thank you so much.

CHAIRPERSON LEE: Thank you so much. And I'll turn it over to Sarah Sucher to administer the oath.

COUNSEL SUCHER: Will you please raise your right hand?

Do you affirm to tell the truth nothing but the truth before this committee and to respond honestly to Councilmember questions?

ALL: I do.

COUNSEL SUCHER: You may begin when ready.

DEPUTY DIRECTOR HANSMAN: Good morning, Chairperson Hanks, Chairperson Lee, Chairperson Ariola, and Chairperson Narcisse and members of the Committees on Public Safety, Mental Health, Disabilities, and Addiction, Fire and Emergency Management, and Hospitals. My name is Jason Hansman, and I am the Deputy Director of Mental Health

Initiatives, Crisis Response, and Community Capacity at the Mayor's Office of Community Mental Health or OCMH. I'm joined this morning by my colleagues Dr. Omar Fattal for tall Systems Chief for Behavioral Health, and Co-Deputy Chief Medical Officer at New York City Health and Hospitals, Chief Michael Fields, Chief of Emergency Medical Services at the Fire Department, Chief Theresa Tobin, Chief of Interagency Operations, Chief Juanita Holmes, Chief of Training, and Michael Clarke, Director of the Legislative Affairs Unit, all from the Police Department, Jamie Neckles is Assistant Commissioner of the Bureau of Mental Health at the Health Department.

OCMH coordinates and develop citywide policies and strategies to facilitate critical mental health care so that every New Yorker in every neighborhood has the support that they need.

In November of 2022, Mayor Adams announced a plan to create a culture of engagement for New Yorkers with untreated Serious Mental Illness. It is clear that we have a responsibility as a city to lead with compassion and care, and that there is more that we can do to help New Yorkers experiencing a mental health crisis, especially when their mental illness

is so severe that they lack the ability to recognize and care for their own needs. The plan that Mayor Adams announced is an important step to delivering essential care to our most vulnerable fellow New Yorkers.

Our office had a significant role in crafting the Administration's mental health involuntary removal policy, and has an ongoing role and coordination across these agencies. I'm happy to testify before you today to discuss Mayor Adams's recently announced plan, including his policy regarding involuntary removals.

New York state Mental Hygiene Law allows for individuals to be removed from the community to a hospital for evaluation by a medical and psychiatric professional who can assess the need for admission and treatment. The policy the Mayor announced in November draws on two of the Mental Hygiene Law's provisions that grant this authority: section 958 and Section 941. Section 941 authorizes a police or peace officer to remove an individual who appears to be mentally ill and is conducting themselves in a manner likely to result in serious harm to self or others from the community to a hospital to receive a

psychiatric evaluation. Similarly, Section 958 authorizes designated clinicians or mobile crisis outreach teams, which can include a licensed psychologist registered professional nurses, and certain social workers to direct the same kind of removal for evaluation at a hospital.

Importantly, the Section 941 and 958 only authorize removal to a hospital where a physician then conducts an evaluation to determine if the individual should be hospitalized. They do not allow for designated clinicians, or police officers, or peace officers to order the involuntary hospital admission of any individual. In February of 2022, the New York State Office of Mental Health, OMH, issued interpretive guidance stating that both Sections 941 and Section 958 authorize the removal of an individual who appears to be mentally ill, and displays an inability to meet basic living needs, even when no recent dangerous act has been observed. Their guidance was intended to help clinicians and other community providers make thoughtful, clinically appropriate determinations relating to involuntary removals, while at the same time respecting an

individual's due process and civil rights. The City concurs with OMH on their interpretation.

Before this plan, these removals were done without a coordinated approach across agencies. First responders and clinicians often followed their own protocols that we're usually unknown to one another. With the Mayor's new policy, everyone is working off the same playbook, and ensuring our most vulnerable New Yorkers have an opportunity to be connected to life saving and life changing care.

As the Mayor said in November, job one is as follows: New York State law allows us to intervene when it appears that mental illness is preventing an individual from meeting their basic human needs. We must make this universally understood by outreach workers, hospital personnel, and police officers.

To that end, the Mayor's New DOHMH, FDNY, EMS, and NYPD directive does two things: Number one, it creates an expedited step-by-step process for involuntary transportation for individuals in crisis. And number two, it states explicitly that in concurrence with OMH, it is appropriate to use this process when individuals appear to be mentally ill and unable to meet their basic needs.

Second, the Mayor also announced enhanced training for outreach workers. This training led by the New York City Health Department in consultation with OMH emphasizes the need for basic needs interventions, and includes engagement strategies to try before resorting to a removal as voluntary transportation is always a goal. Training is already underway.

Third, the Mayor announced establishing specialized intervention teams. He announced a special cadre of clinicians and officers to ensure safe transport of those in need of hospitalization. These specialized teams will have the training, the expertise, and the sensitivity to handle these complex cases.

Fourth, the Mayor announced creating a new support line staffed by clinicians from Health and Hospitals to provide support and advice to police officers in real time as they consider potential response to individuals with mental health needs. This support line became operational last week.

Fifth, the Mayor announced that the city's legislative agenda includes working with state partners to amend the law to make clear that serious

harm includes the harm that comes from an inability to meet basic needs because of mental illness. This would codify court precedent to make this principle widely understood across the state. Additional legislative needs he announced were requiring hospital evaluators to consider all relevant factors such as treatment history and recent behavior, not just how a person presents in the moment, allowing a broader range of mental health professionals to perform hospital evaluations and serve on mobile crisis teams, and requiring Kendra's Law or AOT eligibility screening in hospitals to help our most vulnerable New Yorkers stay engaged in treatment.

Importantly, the Mayor's plan does not call for sweeps of people living with mental illness in public spaces. It does not expand the powers of City personnel to transport individuals for hospital evaluation. It does not increase the reliance on police to address untreated Serious Mental Illness. It does not allow for 958-designated clinicians or police officers to involuntarily admit individuals to the hospital, and it does not represent the sole answer to fix our public mental health system.

The City will be releasing our Behavioral Health Agenda in early 2023 That covers Serious Mental Illness, youth and family mental health, and preventing overdoses

To ensure that we are doing all that we can for our fellow New Yorkers, this work requires an interagency approach to maximize connections to mental health services. All of this work begins with high quality training. For 958-designated clinicians, DOHMH conducts a two-day virtual Section 958 training. Trainings include a variety of experts in mental health crisis intervention and risk assessment. At the end of this training, DOHMH confirms the trainees credentials, licensure and employment on an approved mobile crisis outreach team, and issues a DOHMH identification with photo and letter signed by Executive Deputy Commissioner of the Division of Mental Hygiene, designating a person as authorized to direct a 958 removal. These credentials expire every two years and can be renewed by recertifying licensure and employment.

DOHMH also conducted refresher training in November focused on clinicians doing outreach on the subway and streets to ensure that clinicians doing

958 removals understood the guidance from OMH. This included composite vignettes from real situations involving people experiencing street and subway homelessness.

This refresher training content will be folded into the regular ongoing 958 designation training curriculum for all eligible clinicians working in mobile outreach teams for housed, unsheltered, and unsheltered individuals. The NYPD trains officers on how to interact with people suffering from a mental health crisis starting at the academy. There, the NYPD has designated modules that provide officers with the skills that they need to make determinations on whether an individual needs to be removed to a hospital pursuant to Mental Hygiene Law Section 941. This training is reinforced throughout an officer's career, through command level training videos, and training at the Academy including during training whenever an officer is promoted to sergeant, lieutenant and captain.

Additionally, the NYPD is working to provide all officers with a four-day crisis intervention training, which provides an officer with more in depth skills when responding to a mental health call.

When the Mayor announced this directive, the NYPD added new training that builds upon and reinforces the training officers already receive. This training developed in consultation with OCMH and DOHMH ensures that officers understand the guidance from OMH.

To help reinforce this training, NYPD is also producing a training video that all officers much must watch. Moving forward, the OMH guidance will be incorporated into existing training.

The training for all outreach workers, hospital personnel, and police officers emphasize the importance of using best efforts to encourage the individual to be transported to the hospital voluntarily. To that end, when a 958-designated clinician believes that an individual may be evaluated at a hospital, their first responsibility is to use their clinical skills, where safe and appropriate, to work collaboratively with the individual to secure their voluntary agreement to be taken to the hospital for further evaluation. In the less common cases where an involuntary removal is necessary, the clinician will call for NYPD to assist with this process. In all of these cases, NYPD's

role is to aid the individual in getting to the care that they need.

Working with the clinician, EMS and NYPD will effectuate a transport to the hospital. In the case of a Section 958 removal, the decision to remove is solely the clinician's. NYPD and FDNY follow the clinician's lead.

In the case of a 941 removal, once again NYPD's role is to aid an individual and getting to the care that they need. When officers determine that an individual is suffering from mental illness and is engaged in behavior that is likely to cause harm to themselves or others, consistent with Section 941, they will work with EMS to bring the individual to the hospital where a physician can do a comprehensive evaluation. To provide additional support to officers in the field, Health and Hospitals is providing a dedicated support line for NYPD officers as they encounter potential 941 situations. This support line is staffed 24/7 by behavioral health clinicians from Health and Hospitals Virtual Express Care Service, who can answer questions and advise officers as they determine whether circumstances

truly call for the last resort of an involuntary removal.

Critically Health and Hospital staff also provide NYPD officers with information on other appropriate community and social service resources to consider for those individuals who do not meet the criteria for involuntary removal, or who might otherwise be better served in the community. Importantly, if individuals feature location is predictable, and they appear at no risk of imminent harm, Health and Hospitals might advise sending out a clinician the next day.

To reiterate, the 958-designated clinician and the police officer or peace officer in the case of 941 removals can only have the individual taken to the hospital for evaluation. They cannot have the individual involuntarily admitted. That is at the sole discretion of the physician at the hospital.

Once an individual arrives at the hospital, the 958-designated clinician or police officer, assist them in registering and provides information about the reason for the removal to the hospital staff. At that point, the role of the 958-designated clinician, NYPD, and EMS is complete. Ideally, the hospital

will then obtain additional relevant information on the individual by contacting family members, community providers, and outreach teams, and at that point, conduct a thorough psychiatric evaluation. If necessary, they will admit the patient following Mental Hygiene Law admission criteria. And if not, they will be discharged with a discharge plan that includes follow up care and community resources.

All of this work is about ensuring that New Yorkers and psychiatric crisis get the highest level of care that the city can provide. This is a truly health-driven approach, and one that is grounded and trying to connect everyone with the care that they deserve. I thank your committee's for your attention on this important topic, and we're happy to answer any questions that you might have.

CHAIRPERSON LEE: Okay, great, thank you. So I'm just going to dive right into the questions, and I'll try to keep it brief because I know my colleagues and I are going to tag-team.

So thank you so much, again, for being here. So I'm going to focus largely most of my questions to DOHMH as well as OCMH. So if you guys-- but feel

free, you know if anyone wants to jump in to go ahead.

So what is DOHMH's opinion for the Mayor's proposed expansion of the legal definition of "likely to result in serious harm"? How do you guys-- what's your interpretation of that? I'll hand that Jamie to respond to.

ASSISTANT COMMISSIONER NECKLES: Red is on. Interesting.

I'm actually-- I don't have a legal position on that. I'm sorry to decline your question, but I'm not prepared to take a legal position here on that proposed legislation.

CHAIRPERSON LEE: Okay.

ASSISTANT COMMISSIONER NECKLES: No. No opinion. I can't comment on the proposed legislation.

CHAIRPERSON LEE: Okay, if you could let us know or get back to us, that'd be great, because a lot of the new policies seem to be around this new definition of what it means to "likely result in serious harm." So I think that'd be great to get a better understanding of that.

ASSISTANT COMMISSIONER NECKLES: Will do.

CHAIRPERSON LEE: Okay. So in an ideal world, in your informed opinion, as medical and healthcare experts, what would be the best way to approach individuals with SMI who are homeless. Is B-HEARD the ideal model? What about the other co-response teams? If you could speak a little bit to that as well.

DEPUTY DIRECTOR HANSMAN: Yeah, I'll start on that. And I think, you know, for-- for folks who are both homeless and have an SMI, it's going to really depend on-- on the situation, right? I think-- we do have homeless outreach teams through Department of Homeless Services that are skilled in working with folks who are both homeless and have SMI. If someone is --in certainly in a-- in a mental health crisis, B-HEARD within the pilot areas could also be an option, as could mobile crisis teams that are dispatched through NYC-WELL. So we have a wide range of options for folks who are who are homeless, who are seriously mentally ill, and might need connection to support, and much of that actually does start with our DHS homeless outreach teams that are on the ground serving street homeless New Yorkers every day.

CHAIRPERSON LEE: Okay, and I've-- I've asked this before in other-- because I just know from being on the nonprofit social sector side, how not, you know, a lot of times the issues are that city agencies don't always coordinate or communicate with each other. And I know there's a lot of different outreach teams out there. Some are state, with AOT and others, and then others are through the City. DOHMH has one, EMS, DHS, DOH, and there's ICT, IMT, B-HEARD.

So how are you all coordinating the outreach teams in terms of who has what, and who responds to what situation? How are you guys communicating with each other?

DEPUTY DIRECTOR HANSMAN: Yeah, I'll get that sorted and see if Jamie wants to add anything on the DOHMH-specific teams. But many-- much of it relies on, you know, how an individual might come to-- come to the attention of the city. So you know, certainly if someone is in a mental health crisis, and they call NYC-WELL, they are likely to get a mobile crisis team. If they're street homeless, they might get a homeless outreach team. And I think within the confines of-- certainly within the confines of the

law and being able to share information, that information is shared, I think across agencies, right?, especially when there are multiple touchpoints for singular individuals across different teams.

And I think there's a-- there's certainly a difference between kind of our, our mobile teams that are kind of doing outreach, so our DHS teams, even our mobile crisis teams, our B-HEARD teams, kind of our longer-term treatment teams like our ACT Teams, our Assertive Community Treatment Teams, and our Intensive Mobile Treatment Teams, or IMT teams, which provide kind of that longer-term treatment. But within-- I think within the confines of law, all of them are trying to work together to-- to serve those individuals. And we are constantly I think, talking about how to improve that system and make sure that the right individuals are getting the right touchpoint at the right time.

CHAIRPERSON LEE: So what does that handoff look like though? So for example, if someone comes in and originally is on the short-term team, let's just say for treatment, crisis treatment, and then it turns

out that they need longer term care. So how does that handoff happen? And what does that look like?

DEPUTY DIRECTOR HANSMAN: Yeah, I'll actually hand that to Jamie, and maybe give an example of moving from a mobile crisis team to maybe like an ACT Team, how that would work out.

ASSISTANT COMMISSIONER NECKLES: Yeah. So crisis intervention services are, you know, they're providing de-escalation in the moment, sometimes transporting to the hospital for a higher level of care, as we've talked about, but most often connecting to ongoing community based treatment. That is their main mission. And the most sort of successful outcome that we can see for a mobile crisis intervention team is connection to ongoing care. So that looks different for you know, different people in different situations. And they'll usually make an appointment, and help the person get to the appointment if needed, and confirm that connection to care before closing out a case. So-- so a crisis intervention steam, you know, main, you know, focus, is that that linkage to community-based care.

CHAIRPERSON LEE: Okay. And actually, you brought up a good point, Mr. Hansman, which is a perfect segue to my next question about the 911 operators.

And just out of curiosity, if I could just take a poll of the room, how many of you are familiar with 988? Okay, good. Well, I'm probably speaking to the choir here.

But I think a lot of folks are not aware of 988 and-- and when to call 988 versus 911. And then, when people call 911, I think the issue becomes that oftentimes, it's up to the operators who answer the calls to navigate which mental health type of crisis to direct the calls to.

So just out of curiosity, what does-- what guidance does DOHMH or H&H provide to operators on how to navigate the mental health crisis calls?

ASSISTANT COMMISSIONER NECKLES: Sure. So 988 is a three-digit number to connect to a local crisis hotline. In New York City, that local crisis hotline is NYC-WELL, so you can either dial 1-888-NYC-WELL, or 988. You get to the same place, the same cadre of trained crisis counselors, who will do risk assessment and connect the person to, you know, maybe

on the phone, telephonic risk assessment, or connection to a mobile crisis team, dispatch the most appropriate team citywide, so that the caller doesn't have to be expert, the caller doesn't have to remember all these different three and four, you know, letter acronyms. The caller doesn't have to decide, is this right or wrong. The counselor will use his or her skills to, to gather information and make the next step. Often, you know, these are referrals to in-person Crisis Response Teams. sometimes it's a handoff to 911 if there is an emergency and-- and a need for an ambulance response, for example. So that-- the burden is not on-- on the on the general public, right? We have trained counselors who can help make these decisions.

CHAIRPERSON LEE: Okay.

DEPUTY DIRECTOR HANSMAN: And as-- just real quick, as for the difference between, for instance, 911 or 988 or NYC-WELL, we advise people call 911 when there is an immediate emergency, when a person is in immediate risk of hurting themselves or others, or is in imminent danger because of a health condition or other situation. Anything beyond that is appropriate for NYC-WELL, and then to that point

that Jamie made, they can make that determination on the call if it does need to get escalated to 911.

I'll make one other point just about 988, and about, you know, where you're calling from and what your area code might be. It is true that if you call from a New York City Area code 988, you're going to get NYC-WELL, what if you call from outside of New York City, you're likely to get the-- the mental health hotline for that city that you're that you're calling from in your area code.

CHAIRPERSON LEE: Okay. So moving on to the 958 trainings: Has the agency designed delivered and updated the 958 trainings for the participating agencies? And if yes, what agencies have received the training? What does the training consist of? And if not, when do you anticipate the training to get up and running?

DEPUTY DIRECTOR HANSMAN: So yes, trainings for 958 have been updated at DOHMH, and that NYPD. So both of those trainings are already underway at this moment.

CHAIRPERSON LEE: Okay. And also has the agency began conducting the 958 trainings for clinicians who will be part of the outreach teams?

DEPUTY DIRECTOR HANSMAN: Yes, there was-- there was an updated training in November of 2022 for the clinicians.

CHAIRPERSON LEE: Okay. So in terms of-- I know, the Public Advocate mentioned continuum of care, and that like that language speaks to my heart, because coming from the nonprofit CBO side of things, I just want to give a shout out to anyone here who is providing services in the community, on the ground, because you all are doing amazing work and are our key to community services. And I just want to make a note also that that doesn't even capture the culturally-competent language barrier folks that have LEPs that are not even anywhere in the system.

And so I think that's a continuous issue that we need to address because we have so many languages that we speak in the city. And so how do we increase the caseworkers and the folks that speak all these diverse languages? So I just wanted to put that out there. But, you know, we all know that peer services, CBO nonprofit services, even if they're not, quote/unquote, "clinical" by definition, that-- those are all services that statistically are evidence-based to prove someone's success in care.

So how are you coordinating with the CBOs? Because I know that there was a nonprofit resiliency committee at one point that partnered with agencies, but are you actively engaging a task force that have CBO partners that are included to really inform a lot of this care, because I think oftentimes, where I got frustrated was that someone would be in an inpatient and not get referred out properly.

And so how do we better utilize our nonprofit sector, you know, organizations and-- and handoff those services, and if you could, you know, provide a list not necessarily today, but of groups that you do partner with, because I personally would love to see who it is that you're working with in the community. But if you could speak a little bit more to the partnership there.

DEPUTY DIRECTOR HANSMAN: Yeah, I think what I would say just to-- to Jamie's previous point about, I think the role of our crisis services, and even in hospitals, it is about getting to that next level of treatment and services and to community providers. That is a critical part of all of our-- all of our crisis workers-- all of our interactions with individuals is to get them to-- to community

providers. And this policy itself was driven, at least in part by conversations with-- with community providers, as well, especially our providers who are working with this population, day in and day out, which we continue to hear from about, you know, individuals that are experiencing a Serious Mental Illness and-- and can't get connected to care. So I think we're continuing that work. And we will-- we'll get back to you about providing a list of-- of community providers.

And I'm not sure if, Jamie, you want to add anything or Omar.

ASSISTANT COMMISSIONER NECKLES: I can add to that. Sure. So at DOHMH we-- we develop and deliver the training that leads to designating qualified physicians or mental health professionals to direct 958 removals. Most of the clinicians that we're training are working on community-- within CBO-- CBOs that are in contract with the city and/or licensed by the State Office of Mental Health.

So the vast majority of clinicians who are doing this work are based in CBOs based within the communities that they're serving. I'm also happy to say that we added dedicated peer lines, roles. They

are specialist roles to our mobile crisis teams a couple of years ago. So all those teams have peer perspectives folded into their crisis response work. And of course, NYC-WELL has an option to talk to two peers as well, and about 20% of people who call in to NYC-WELL opt to speak to a peer specialist. And so I think we've done-- you know, we have a long way to go but we've gone a long way already in terms of making peer services and peer perspectives and greater language diversity available through all of our crisis response services.

CHAIRPERSON LEE: Okay, thank you. So I'll yield the rest of my time and ask questions later. Follow up if I have any, but I wanted to hand it off to Councilmember Narcisse, if you have any questions.

CHAIRPERSON NARCISSE: Before I get to the question, I want to make sure that we address the Intro 273 will require the training for the NYPD. At the end of the day it's to make sure the officers are safe, and the person that the provided care is safe as well, is to train them how to interact with someone with autism, and recognizing it, and getting skilled to deal with that.

It will require our police force to undergo this training and could possibly save lives, right? Traditional tactics and approaches that would work for neurotypical people may not work for people with autism.

As a nurse for over three decades, I'm sure that I have done with so many individuals, that you will think that the person is okay by their appearance, but the person is really dealing. It's not only for autism, but mostly I want to focus on autism, because so many times things could have been prevented.

So I hope all my colleagues will join as a matter of fact signing and supporting this piece of legislation. And most importantly, I did not do it by myself. I have to thank some terrific folks, community partners, who helped get this legislation to this point, ADAPT community network, Brooklyn Conservatory of Music, My Time Inc, YAI, and Michael from the NYPD Legislative Team that helped us to get through this great journey, to make sure that we address those vulnerable folks in our community.

And of course, thanks to my dynamic Colleague of Staten Island, Councilwoman Hanks, and her legislative team. That was very-- that worked

closely with my team, Chief of Staff Sai Yee. Thank you.

And, um, I have a couple of quick questions by listening.

Has anyone been taking into custody under this initiative that we're talking about right now?

DEPUTY DIRECTOR HANSMAN: I'll note that, you know, 958 and 941, the longstanding law that has been used and is used by mobile crisis teams, by mobile crisis outreach teams, and NYPD.

CHAIRPERSON NARCISSE: Okay, since it was announced, I'm talking about going back to November after the Mayor made the announcement, did anybody been...?

DEPUTY DIRECTOR HANSMAN: There have certainly been-- been individuals who have been involuntary removed under 941 and 958 since the announcement.

CHAIRPERSON NARCISSE: Have all NYPD officers and FDNY EMS been trained to recognize the behaviors that could initiate involuntary removal? If so, how long was the training, and what did it include?

DEPUTY DIRECTOR HANSMAN: So training has begun at NYPD and I'll hand it to my NYPD colleagues to give some further details.

CHAIRPERSON NARCISSE: Good morning.

CHIEF HOLMES: Good morning, everyone. Good morning Chair. So yes, training has begun at NYPD. There are several trainees that's been conducted. Since this initiative was-- was brought to our attention to directive by the Mayor in November, as a result of such there was a telephonic communication put forward that this was up and coming. There was also the creation of a training. This training was dear to my heart, especially the language surrounding it, the individuals delivering it, and more importantly, the comprehension of the men and women, the end users.

And as a result of such we had a roll-call training. Naturally the primary goal, voluntary compliance, voluntary compliance. I can't say that enough. I don't use the term removal. The term that I like is voluntary and involuntary transports, and I thought it just had a more softer connotation. We have learning outcomes, understanding effective crisis communication, to assist with those voluntary transports, recognizing the legal authorities and department policy involving involuntary transports, and naturally understanding the Mental Hygiene Law

958 and 941, recognizing situations that may necessitate the involuntary transport of an individual who is mental-- is mentally ill and a danger to themselves or others or not capable of self care. And a lot of those factors we're surrounded about around what is mental health crisis? What does that look like? And naturally, sometimes its behavior, speech, and just the-- the thought contents.

CHAIRPERSON NARCISSE: So how long was the training?

CHIEF HOLMES: The training is given at roll call. That particular training is about 25 minutes of training, lecture, both discussion and interactive.

In addition to that, there's a video to assure compliance. So roll call training is about 88%. That's now cease and desist because the video was uploaded. And the video now is at 60% of the agency, but know that 88% of the agency operational has been trained in that training, 60% of the same individuals that received the roll call training. The video ensures compliance that everyone had it-- has it, so it allows us to collect that data.

CHAIRPERSON NARCISSE: There is a special unit that you have to respond, right?

CHIEF HOLMES: It's not-- it's all.

CHAIRPERSON NARCISSE: Or is it all officers? So how many officers that you have?

CHIEF HOLMES: So currently -- I'll get the number -- the department's about 33,000. So all-- everyone's going to be trained in it.

CHAIRPERSON NARCISSE: How many have been trained to date?

CHIEF HOLMES: How many have been trained?

CHAIRPERSON NARCISSE: To date.

CHIEF HOLMES: Operational?

CHAIRPERSON NARCISSE: Mm-hmm.

CHIEF HOLMES: I do have the numbers one second.

Okay, so on patrol, we have 16,436, and over 8000. Transit has completed 91% of all transit officers, 89% of housing officers-- and forgive me 87% of all patrol officers. I apologize. 14,461 out of the 16,436 have been trained.

CHAIRPERSON NARCISSE: Thank you.

CHIEF HOLMES: You're welcome.

CHAIRPERSON NARCISSE: Reports show that one out of five New Yorkers have symptoms of mental health

disorder. With rates so high why are NYPD CIT training figures lagging behind?

CHIEF HOLMES: Right. So the CIT training now is currently at 17,000-plus, but we've had some retirements and resignations. So it's 13,000-plus, but that's in-service training. So there is a large amount of people trained in it. And I apologize it started in 2015. Every recruit attends CIT training. So all of our recruits that have graduated since 2015 has that training as well, in addition to the 13,000-plus.

CHAIRPERSON NARCISSE: With many facilities reporting that their psych beds at full capacity, especially in New York, in Manhattan, right? How do we anticipate being able to accommodate the flux of patients into the system.

DEPUTY DIRECTOR HANSMAN: I'll hand it over to Dr. Fattal to talk a little bit more about the-- about the hospital bed situation in New York.

DR. FATTAL: Good morning. So we-- I can speak for H&H. Obviously, we are the largest provider of behavioral services in New York, including inpatient beds, but we're not the only providers. So there are other providers as well. We have about 1000-- a

little bit more than 1000 beds that are open right now. And we have plans to reopen up to 200 beds by the end of 2023. And to know that since that announcement in November, we have not seen an increase in emergency room visits to our ERs.

DEPUTY DIRECTOR HANSMAN: I'll also note that the Governor did make an announcement to push hospitals to reopen the beds that have been closed since 2020. Throughout, I think the remainder of this year and next year, to kind of help with that situation of hospital bed availability.

CHAIRPERSON NARCISSE: I got that understanding. That's why I say thank you to her and the Mayor as well for putting-- pushing forward. We know it is not at the capacity we would like to see it.

The standard for detention appeared to be a very broad and potentially open our city up to Civil Rights lawsuits. Has the Corporation Council or other city attorney issued an opinion to this plan to you.

DEPUTY DIRECTOR HANSMAN: They have reviewed the policy, yes.

CHAIRPERSON NARCISSE: They did? Okay.

If this percentage of New Yorkers suffered from mental illness, why can't we get 100% training, coming back to you, to CIT.

CHIEF HOLMES: Well CIT is four-day training. So naturally it's very challenging when members of the service still have to do what we do. And it's a smaller class. And we're aiming for that. Naturally, that's a primary goal. But it's 30 individuals to a class, it's co-training. So we're relying on licensed medical clinicians, as far as community partners, but with that it's a more intimate training, right? We want them to have a clearer understanding of what this really is when it comes to crisis.

CHAIRPERSON NARCISSE: All right. So we're looking forward for the 100%. Do they anticipate-- do you anticipate, right?, not our side, you-- do you anticipate that this initiative will cause an increase in patients?

CHIEF HOLMES: Will it cause an increase in patients? Absolutely. You say that-- what? Can you hear me? Oh. I thought it was you.

CHAIRPERSON NARCISSE: That's all right.

DEPUTY DIRECTOR HANSMAN: Yeah. So here's what I-- here's what I-- I'll hand it over to Dr. Fattal in a moment. But what I might say is-- you know, this-- this initiative, and this-- this new plan of looking at involuntary removals is very new, right? So it was announced in November of 2022. And we are still looking at-- we're still looking at data. And what I might also add is that removals in and of themselves are not necessarily the measure of success that we're-- that we're using. We are looking at really-- we're looking at all manner of engagement and ensuring that you know, our partners, both at you know, DOHMH, and Health and Hospitals, at NYPD, and FDNY are having this culture of engagement, not just on the removals themselves, but on engaging folks in in treatment, in long-term treatment.

I'll let Dr. Fattal talk about what-- what they've been seeing on the-- on the H&H side. But I did want to make that note about-- it's not necessarily entirely about increasing the number of involuntary removals, but about the engagement of folks who are experiencing a mental health crisis, or Serious Mental Illness, and have that, you know, that-- that potential for danger to self or others.

DR. FATTAL: Yeah. I agree 100%. And since November, we have not seen an increase in the number of patients coming to our emergency room. But we do have plans to reopen up to 200 beds in the coming year by end of 2023. And that's because of this initiative and other initiatives that are being rolled out by the City and the State. So we want to be prepared in case there is an increase in demand. And we are keeping a very close eye on this. And we're very committed to meeting the need if it does go up.

CHAIRPERSON NARCISSE: My last question: They say out there in newspapers that folks are getting into the hospital, but they are discharged too fast before they get stabilized. What do you think, coming from the H&H?

DR. FATTAL: Yeah, I mean, it's hard to comment because every-- you know, we have thousands of discharges to the ER, so it's very hard to comment on a specific case. Every one is different. But when it comes to this initiative, we take it very seriously, because it takes sometimes hours and days, sometimes weeks to actually plan a removal. So we-- once we get the removal to our facility, we take that

very seriously. We make sure that we do a thorough psychiatric evaluation and assessment. But also, more importantly, we make sure that we connect that patient with community resources and a follow up plan before we discharge them.

So I think the key is not the timing, it could be quick or delayed. But the idea is we want to make sure when we discharge people that they have a discharge plan, and that they're connected with outpatient services and community resources that they need to stay in treatment.

CHAIRPERSON NARCISSE: What-- I said it was my last, but something just popped in my head. The discharge planning: Do you actually communicate, making sure that the folks understand their discharge planning before they leave the hospital?

DR. FATTAL: You mean the patients?

CHAIRPERSON NARCISSE: The patients.

DR. FATTAL: Definitely. We start discharge planning on day one. And that's something that we you know, work with the patients, but also with families or their support systems. Most of our patients have a caseworker or other people in their lives who are involved in their treatment. So we

make sure that we include them as well in the planning of the discharge itself. So this is not a one-way communication. This is something that we work on collaboratively with the patient and whoever they have in their lives.

CHAIRPERSON NARCISSE: I'm going to leave it as that. But the communication have to be clearly, both for the patient and person that is discharging the individuals. Thank you.

DR. FATTAL: Sure. You're welcome.

CHAIRPERSON LEE: Sorry. I just want to recognize we've been joined by Councilmembers Stevens, Ayala, Riley, and Councilmember Brooks-Powers. And with that, I'll hand it off to Councilmember Hanks. Chair Hanks, I'm sorry.

CHAIRPERSON HANKS: That's okay. Thank you, Chair Lee. I appreciate it.

Thank you. I kind of want to, you know, put my questions more towards giving a little background to how we got here. And then, as my colleagues, I think, one of the most important pieces is going to be the recognition of someone who is mentally ill, and what is the training for officers?

So my first question is, how many 911 Mental Health calls were-- were there between 2021 and 2019? And do you see any trends of calling increasing during COVID?

DEPUTY DIRECTOR HANSMAN: I'll hand it over to NYPD.

CHIEF TOBIN: Good morning Chair. In 2020-- in 2019, where you first referenced, there were 171,490 calls. In 2020, there were 161,268 calls. So there was a reduction of 911 calls during COVID in 2020. In 2021, there were 166,487, and in 2020, to 176,311.

CHAIRPERSON HANKS: Thank you. So how many of these 911 health calls resulted in emergency dispatch, and how many calls were referred to other resources like NYC-WELL or other community-based services?

CHIEF TOBIN: So all mental health calls result in an emergency dispatch. The only exception to this as the B-HEARD pilot presence where NYPD will not dispatch alongside FDNY EMS, unless there is violence, there is a weapon, or imminent risk of harm to self or others.

CHAIRPERSON HANKS: Okay. So of the calls to the police civilian encounters, how often are people

designated, quote/unquote, "emotionally disturbed" and what implications does that carry?

CHIEF TOBIN: Could you repeat that?

CHAIRPERSON HANKS: So of the calls to police and civilian encounters, how many people are designated as emotionally disturbed persons? Because I think you touched on it a little bit when you said there was a weapon, I mean, because we want to make that distinction.

CHIEF TOBIN: So in 2022, of the 7,170,174 calls to 911 176,311, which was 2.5%, were mental health calls.

CHAIRPERSON HANKS: Okay.

CHIEF TOBIN: The NYPD continues to respond along FDNY EMS to mental health calls and to assist in transporting to the hospital for mental health evaluation if necessary.

CHAIRPERSON HANKS: Okay. So of these calls in these civilian police encounters, how often does it lead to an individual being arrested and for what charges?

CHIEF TOBIN: Sure, in 2022, approximately 1% of all mental health calls resulted in an arrest. Most of the arrests were resulting from EDP calls, or for

charges such as assault 3 -- which does not include assaults on police officers or EMS -- criminal contempt, violating an order of protection, and menacing. Many of the calls that we go to are actually domestic incidents when we must arrest the individual due to the violation of an order of protection, or if an arrest must be made to prevent further violence and to ensure the safety of all members.

CHAIRPERSON HANKS: So when we've talked about the, you know, how you testify that officers are trained, and for people suffering mental health crisis, and you have these dedicated modules. Is there a differentiation in that training where there's a difference between mentally disturbed person who needs to be, as you say, transported, and someone who was transported or and or arrested, and how does that training differentiate?

CHIEF HOLMES: So the training that was put in place as a result of the Mayor's directive encompasses "not capable of self care," right? So that's something different. It's always been there. I think it's something that we weren't really, really focused on when it came to 9.41.

But with that being said, that training is really designed to remind them of that particular aspect when you're transporting. But when you speak about arrests -- and that's why the percentage is so low, 1 percent, when it comes to this -- when you're speaking about arrests, when it comes to the community of mental health crisis, nine times out of 10 there's no arrest as a result of the officer being assaulted. It's a protective community, it's a person in crisis. And it kind of, for lack of a better term, it comes with the territory, meaning comes with the job. So if the officer is injured as a result of that particular encounter, then it's what we call a line-of-duty injury. It's not an arrest, but, you know, made because of that, if that makes sense.

CHAIRPERSON HANKS: Thank you very much. So the other question I have is in regard to when you're in- - when NYPD officers are in this engagement, do we have any guidance on whether officers are engaging with the person who's being removed for hospitalization, or whether they're resisting arrest? Is there a difference? Because if they're...?

CHIEF HOLMES: So-- so it's not-- it really isn't a difference, you know, as far as I'm concerned, you know, officers are trained in de-escalation, active listening. Naturally, if they have-- if it comes to someone's safety, you may need to take some sort of immediate action. There is non-lethal devices that they're trained in. The one thing about the New York City Police Department, largest city agency, allows for quick response 24/7. But we're equipped and trained, and not just for the individual that's in crisis, but also for all the partners that are responding to the scene that don't have these-- that particular type of equipment.

DIRECTOR CLARKE: And I think that's part of the training as well to--

CHAIRPERSON HANKS: It's like a laser shot on-- on the training component--

CHIEF HOLMES: Yes it is. That's part of the training.

CHAIRPERSON HANKS: --and how to make those differentiations.

CHIEF HOLMES: Yes.

DIRECTOR CLARKE: Right. And I think just to build on what Chief Holmes was saying. It's part of

the training is-- I think your question earlier was, you're responding to a person with a gun, you're responding to a past crime, responding to a person in a mental health crisis. All three trainings are different on how to handle that situation, right? And when you're responding to mental health crisis, you're trained specifically for that, and part of that is understanding that people may be struggling, maybe violent, may act out towards you, and how to handle that, with de-escalation, with compassion, working with everything we can to get a voluntary transmission, transported back to the hospital, in order to de-escalate that situation.

CHAIRPERSON HANKS: Thank you. What is the current status of the CIT training and the future plans for the training program going forward? But I'm sorry, first I wanted to ask how many officers have completed this crisis intervention team training between 2022 and like 2016. The training was first implemented in 2015. We currently have 17,000 plus, which resulted in 3000, with some resigning or retiring, so currently, it's about 13,400 that are trained in that particular training. That's in service. So I relate in service to people that are

already NYPD officers. We bring them back for additional training.

CHAIRPERSON HANKS: Okay.

CHIEF HOLMES: But we still have the graduates, since 2015, up until current that have received that training. That's not-- that number is not encompassed in that. And I apologize for not having the exact number of graduates, but I can get that to you.

CHAIRPERSON HANKS: So does the department anticipate reaching a point where all officers have received the training? And if so, do we have like a timeline on what that looks like?

CHIEF HOLMES: So that is the primary goal. I don't have a timeline, being it is so small in nature, the classes are consisting of 30 members, usually on a 4-day particular training, but that is the primary goal, that everyone's trained in that. We also have training-- roll call training. So that's given every three to four months on de-escalation, active listening. You know, it's not the whole, comprised crisis intervention training, but it's key components of that training that's given on a regular to all members of service.

CHAIRPERSON HANKS: Thank you.

CHIEF HOLMES: You're welcome.

CHAIRPERSON HANKS: So, okay, so we asked those questions as far as the training is concerned.

So does the department plan to update the patrol guide on these trainings? And if so, in what way will procedures change?

DIRECTOR CLARKE: Yeah, so we did is initially we put out a message to all the officers, alerting them to the standard, that is the new standard. We are in the process of updating our patrol guide procedure, and we anticipate that coming out in the coming weeks.

CHAIRPERSON HANKS: Okay, thank you. That's all for right now. I'll pass it back to Chair Lee. Thank you so much. Thank you.

CHAIRPERSON LEE: To Chair Ariola. Sorry. Before I begin, I just want to recognize we've been joined by Councilmember Brewer as well. So Chair Ariola, please take it away with your questions.

CHAIRPERSON ARIOLA: Thank you Chairs. My questions are for Fire Department EMS. How many EMS personnel have received training in de-escalation and/or self defense in other-- and any other

specialized training for responding to calls for people in crisis?

CHIEF FIELDS: So of the 4300 EMTs and paramedics, 99% have received the 12-hour course on de-escalation and self defense, 28% have received the second module of the same training, and there's a total of five modules.

CHAIRPERSON ARIOLA: You anticipated my question. Thank you.

Mayor Adams's directive says the MPs must transport the individual to the closest appropriate hospital. What does "appropriate hospital" mean? And are certain hospital facilities designated as such?

CHIEF FIELDS: Yes. So we deal with CCC categories. That's in respect to mental health. So if a hospital has mental health capabilities and they're not on diversion, that will be the appropriate hospital.

CHAIRPERSON ARIOLA: Is there a collaboration between FDNY and NYPD in creating operational guidelines regarding mental health calls, and-- and removals?

CHIEF FIELDS: Currently we're in the process of updating the protocols. So we don't have anything that's current that I'm aware of. But we are working to develop the program. We anticipate that March, the second week of March, we should have everything finalized.

CHAIRPERSON ARIOLA: But there is a collaboration, or at least contact, even though it's not finalized in written form, you do work collaboratively when 911 calls go out.

CHIEF FIELDS: Oh 100%. Definitely. So that's pretty much-- we work collaboratively with NYPD on daily operations, especially when dealing with mental health crisis on a daily basis.

CHAIRPERSON ARIOLA: Okay, and how often do voluntary hospital units respond to an EDP incident? Would you have that data?

CHIEF FIELDS: No, I don't have that data but the voluntaries are 30% of the 911 system, so they do respond to the priority 7 psychological mental crisis calls.

CHAIRPERSON ARIOLA: Okay. And when you are in the middle of a hospital transport of an emotionally disturbed person, does the police officer accompany

you to the to the hospital every time? Do they accompany the ambulance?

CHIEF FIELDS: Every time? I'm trying not to live in the world of definitives. Should they? Yes, they should. But I can't attest to every time.

CHAIRPERSON ARIOLA: What happens when you-- when you arrive at a scene with a with an EDP, and you're faced with an EDP that has a weapon, and PD is-- is en route. How does the EMS handle at that point?

CHIEF FIELDS: Our EMS members are taught to retreat. So they should retreat to a safe distance, and get an ETA for NYPD as well as supervision to that location.

CHAIRPERSON ARIOLA: Okay, I appreciate your answers, Chief Fields. And that's it for me. Thanks so much, everyone.

CHAIRPERSON LEE: Thank you so much.

CHAIRPERSON ARIOLA: For now.

CHAIRPERSON LEE: Yes. For now. I think all of us have more questions, but I'm going to hand it off to our colleagues also for questions. So first we have Councilmember Barron, followed by Councilmember Cabán, and then Powers. So-- How many minutes? Two

minutes. So if you guys could limit it to two minutes each with some wiggle room.

COUNCILMEMBER BARRON: Thank you very much and I find these hearings incredible, how you can come before us and not even have a list of the community organizations that you're funding. This is a serious here, and "I'll get back to you," and then have the police department fumble on voluntarily/involuntary. I think that was incredible. "I don't support the involuntary thing." "They voluntarily got--" and those who do go and voluntarily, come on now you know that kind of flip flop and double talk I find incredible.

Also the Mayor's definition-- he wants to redefine, you know, what is considered serious-- "likely to result in serious harm." That has to be redefined. What does that redefinition going to mean?

And on a very serious note, I don't think a police officer who hasn't been psychiatrically evaluated themselves should be in the streets with a nine millimeter Glock, a laser, and a baton, dealing with people who are mentally challenged or having some difficulties.

I think you need to put something-- or do you have something in your program to evaluate each and every police officer on their mental state? Because I've been around them. I've been around them and when they get this little herd mentality, they go crazy. And they very dangerous. So I think this is a dangerous proposition.

A few more things and don't finished.

For my colleagues, stop complimenting the governor so much on what she's given to mental health and the Mayor. We haven't even gone through the budgets yet. And already, 27.5 million for 1000 beds? Beds that they took away during the pandemic and gave it there, and shut down the mental health beds. I was in the State Assembly. And I saw what they did with mental health in the State Assembly. So when someone comes before us-- [Bell rings] Just a few more seconds and I'll be finished. When someone comes before us with a $227 billion budget, and you compliment her for 27.5 million and 1000 more beds, when we need 10 times as much as that, is an insult to our intelligence.

So I think we should be stronger on those who have planned to fund this program.

And then finally, you know, in my dealing with this issue over the years: Peter Funches, years ago, murdered by police, mentally challenged. Eleanor Bumpers, in the Bronx. Her eviction notice was a shotgun blast. And they said, "Well, it was done rapidly." So the first blast blew her hand off that they claimed she had a knife. So why the second one that blew a hole in her chest and killed her. Deborah Danner, also killed. Saheed Vassell killed. I can go on the rest of this hearing, talking about all the people that were killed by police.

So I think that this is a dangerous proposition that you're presenting here. If we don't do something about getting peer intervention more than you, I'm fearful that there'll be more death as it-- as opposed to a solution to this problem.

And finally, poverty and mental illness is connected. So if the Mayor really wants to deal with mental illness, deal with poverty, deal with homelessness, deal with the real issues, the root causes to mental illness. We're not born this way. Conditions drive people to make the decisions, and their state of mind is to conditions, and for us to have $102.7 billion budget in the city and a $227

billion budget in the state, it is unconscionable and unacceptable that we allow poverty to exist the way it is.

So I just think your proposal is dangerous. And I think that you should be more prepared when you come before us to address the issues. Thank you.

[APPLAUSE]

CHAIRPERSON LEE: Thank you, Councilmember.

Okay, so just as a reminder, you guys actually were ahead of me. Instead of clapping, we usually do this in the chambers. And so thank you. You know, you did-- you guys are good.

So thank you so much, Councilmember Barron, next we-- oh, before we move on, sorry. I just wanted to recognize we've been joined by Councilmembers Mealy, Yeger, and Rivera.

[To others:] Oh, yes, I do. Okay, sorry.

And so next we have Councilmember Cabán followed by Councilmember Powers.

And I know two minutes is not a long time, but we have a long list of folks who are testifying today, so please stick to it as much as possible, thank you.

COUNCILMEMBER CABÁN: Thank you Chairs. So I just want to start by commenting on, or addressing

some of what was testified to today. And-- and also just a blanket statement that, you know, when-- when there is a mental health crisis occurring, the life-threatening emergency is the wrong response, and we have to keep that at the forefront.

And we're sending street response because other systems have failed. And I know, I certainly am, and there are lots of folks here committed to this, we're not going to continue to watch people die on the responder side, but we have to address the upstream, where the investments need to happen.

And to put like a real emphasis on it, that treatment response needs to be a medical response, not a police response, a medical response. And it-- and I have had the privilege of traveling to different cities to see how they address their mental health crisis on the ground. And what I have learned from those places, including from their police chiefs, I must say, that it needs to be big enough to be effective, which means more funding, which means you cannot cut the DHS budget that-- that's happening. You cannot cut DHS which is in the proposed budget. You cannot cut B-HEARD and all these other things while the NYPD budget stays

intact. So it has to be big enough to be effective. It has to be nimble enough to be effective. And it has to be separate from the police.

But I do want to address your testimony. There was-- there was an emphasis by you all that, you know, it's a physician at the hospital making the termination?

Well, I had the opportunity to speak to a street outreach mental health professional that works with the City that does co-response work, and told me that the thresholds are different. That the thresholds for them on the street when they're making an assessment is not the same threshold that the doctor in the emergency room is using.

And so what happens is, is that somebody is agitated, they are upset, they are involuntarily brought to a hospital, they don't meet the hospital threshold, they are left where they're at, and oftentimes, obviously, we know the intersection of our homeless population and folks that are struggling with mental health issues. That is a real gap and a real problem that is not being accounted for.

In addition to that, you testified important-- quote, "importantly, that the Mayor's plan does not

call for sweeps of people living with mental illness from public places." But again, the intersection between our homeless population and the mental health population is such that you cannot ignore the fact that he does direct sweeps of homeless encampments. That includes sweeps of people experiencing mental health issues.

And I would just like a few more seconds to address the testimony. You know, for-- for agency, testimony that says that they will not be relying increasingly on police to undress this, three quarters of the testimony given here today was focused on trying to convince us that the police had the tools to do this job. That tells a very different story. And we know that police make up 20% of the city's entire workforce. That is a problem.

I say all this to say that we have to make sure that we are building out a continuum of care that we have the right workers responding to this, and it is not reflected by the line items in the budget. I am deeply, deeply concerned about the plan that's being presented.

And I will ask one question, can you share data on how many mental health involuntary removals the

NYPD does per year, the locations of where people are removed from, and what hospitals they get taken to, the amount of hours that NYPD officers spend on average on each involuntary removal, and demographic data of those involuntarily detained?

DEPUTY DIRECTOR HANSMAN: So-- so what I'll say about the data on involuntary removal is that it's very fragmented and very dependent on the type of removal.

So while we have for a long time tracked certain types of removals for certain types of teams, in other places that data is just now being built out because of this initiative. And we're working across agencies to identify the data to collect to ensure that we're using our best effort to implement this plan in the most responsible way. This will include looking at how successfully we engage people in getting connected to all kinds of treatment across the continuum of care, to include involuntary hospital transports for the purposes of evaluation.

The plan under the Mayor's directive has only been announced for a bit over two months, and we've learned as we've been planning and rolling out that limited data for this was previously tracked. This

means we're building much of this from the ground up on the-- in respects for data.

COUNCILMEMBER CABÁN: Well, let me amend my question, then: Can you commit to-- that those-- those data points that I just mentioned. Can you commit to giving them to this council?

DEPUTY DIRECTOR HANSMAN: What I would say is that those are very similar to the data points that we are looking to collect for--

COUNCILMEMBER CABÁN: Right. And when you-- but you're not answering my question. I just want-- when you-- when you collect them, can you commit to giving them to this Council? That's my question. It's a yes or no.

DEPUTY DIRECTOR HANSMAN: I believe we will. We will answer the Council's questions on the data as we collect it. Yes.

COUNCILMEMBER CABÁN: Thank you.

CHAIRPERSON LEE: Okay. And if we have time later, we'll try to do a second round questions for members as well.

Okay, so next we have Councilmember Powers followed by Councilmember Hanif.

COUNCILMEMBER POWERS: Thank you. I know you don't have data for-- I just wanted to follow up with a question from my colleague. Do you have data on the last two months since the announcement was made, or whatever the timeline is, of how many-- how many folks have been-- have been-- with the new law changes and the new policy, just how many folks have been taken into custody because of that?

DEPUTY DIRECTOR HANSMAN: We have some data, but not all data.

COUNCILMEMBER POWERS: Can you share that with us real quick?

DEPUTY DIRECTOR HANSMAN: So I can say that the data that we have is very longstanding for our mobile crisis teams. So I'll hand it to Jamie just to give a bit of an overview. So these would be specifically for 9.58.

COUNCILMEMBER POWERS: Just-- if you can just give us the numbers. I don't need a narrative just to know what the exact numbers are.

ASSISTANT COMMISSIONER NECKLES: So the Health Department monitors mobile crisis teams. Mobile crisis is both a generic and a brand name, if you will, so it's used differently in different

scenarios. But there are 24 mobile crisis teams operating across our city, that have been operating for decades.

COUNCILMEMBER POWERS: Just-- I had a question and we only have two minutes-- I have 50 seconds now. So I just asked a question, what the number is. Can you just give us the data points on how many people have been--

ASSISTANT COMMISSIONER NECKLES: I'm trying to give you some context, because it's a very small snippet of a larger system.

So in December, there were 42 removals conducted by these mobile crisis teams. They are not just serving homeless people. In fact, they are mostly serving people who are housed, not people who are homeless or on the subway. So there's-- this is Mental Hygiene Law that could apply to, you know, anybody in New York State.

COUNCILMEMBER POWERS: I understood. Thank you for that. Look, this is obviously one of the most complicated issues, I think, facing our city and our state right now, is how to help individuals who have mental health-- serious mental health needs, and who are also potentially presenting a public safety

threat to New Yorkers. And I don't think it's nearly as simple as some people are presenting, and I also think that how to get people effective care, and make sure that people are not being a threat to New Yorkers-- I know I've had this in my district plenty of times, is really kind of essential. And I don't take-- I don't envy anybody who has got to try to figure that out. But that's why we're here.

So I just had a couple questions. And I'm sorry to take more time, but I just-- I'll just do questions, just to clarify the policies that are in place, because I get this question all the time from-- we encounter this all the time in my district. Number one is: Is the policy around -- I know what the state law allows, it says individuals from meeting their basic human needs, I believe, is the definition -- how does that differ then from individuals who might be-- Because there might be some individuals who have-- there's a public safety issue, but perhaps they are meeting some of their basic human needs. And there's a question about exactly in a gray area question. So I want to understand the sort of human-needs policy versus the public safety aspect of that.

And the second part I have is where you talk about involuntary transfer, but then when they-- and I've seen this happen in my district and I've had this question, so I'm just asking it a plain, fact-of-the-matter way, not in any agenda way -- but which is when they get to a hospital and then they're asked to take a voluntary transfer, I think, to services if I'm correct? So isn't it sort of-- like I'm trying to understand the involuntary versus voluntary parts of that, which is to say, somebody might take-- you might take them into custody, because you believe they can't meet their basic human needs, then get to the hospital and they are asked to volunteer-- I think-- I believe they'll voluntarily sign something saying that they'll accept treatment.

There's again, there's like one analysis saying, maybe they can meet their needs, and the second one saying, but they're in a mental health state where they can actually voluntarily sign their rights away. And I think that's, to me a big question about how that policy works.

DEPUTY DIRECTOR HANSMAN: So-- so let me talk about the-- what the-- the actual 958/941 Mental Hygiene Law says. And that is around that appearance

of mental illness, and conducting themselves in a manner likely to result in harm to self or others. So that's our public safety -- to put in your terms -- kind of standard. Within that "serious harm to self", OMH issued guidance around that inability to meet basic needs. So that's how-- it's not really a gray area. It's more of just on top of that-- that serious harm to self, which will include inability to make-- meet basic needs, and that serious harm to others in the community, which is more of that potential public safety standard.

What I'll say about the removals themselves and-- and heard it earlier also about there being two different-- two different standards between the removals. I think, Councilmember Cabán mentioned this. The different standards between the removal and what happens in the hospital, I might ask Dr. Fattal to talk a little bit more about that. But I think that is-- that is by design, because that removal is just to get that evaluation, right?, and to understand a little bit more about what that individual is experiencing and what kind of treatment and support that individual needs. But I'll hand it over to Dr. Fattal to talk a little more.

DR. FATTAL: Yeah. Just to clarify, I think this is a continuum. So the-- the removal, which happens in the community, and at that point, obviously, whenever we can do it voluntarily, then we do it voluntarily. But if the person is not agreeing to it, then it becomes involuntary. The same thing happens when someone presents with emergency room, we always try to-- if someone meets the criteria for admission to do it again, voluntarily. So at every moment, we go back to the idea of trying to do it voluntarily. But if they refuse, then we have to follow the Mental Hygiene Law. And I'm going to go back to an earlier comment that the standard for-- that was issued by OMH in February of 2022 is the same. It's the exact same criteria for involuntarily removing someone, or involuntarily admitting someone to the hospital. It's the same concept, which is danger to self or others, and under danger to self, inability to care for basic needs is a form of danger to self. So we're following the same standard.

COUNCILMEMBER POWERS: Just one last follow up question: On the 41 individuals in December who were removed, how many-- and I understand that's a wide

range of people, or a range of people -- how many were then admitted into-- to get medical help?

ASSISTANT COMMISSIONER NECKLES: I don't have that. I don't have that information available.

COUNCILMEMBER POWERS: Okay, if you can get us information, that would be helpful. Thank you.

CHAIRPERSON LEE: Okay. Next we have Chair-- Oh, sorry. Councilmember Hanif, as well as Councilmember Ayala after that, and then Bottcher.

COUNCILMEMBER HANIF: Great. Thank you so much. I agree with them, some of my colleagues who've shared that this directive is dangerous. It is regressive and-- and violent. We cannot police our way out of the city's homelessness and mental health crises. There are successful voluntary mental health programs that work, and we should be engaging in and expanding those critical services, including recovery based mental health programs, respite centers, peer supports, clubhouses, and much, much more.

My colleague, Councilmember Cabán pointed to other cities that have developed these kinds of programs. We should be looking to them, modeling, and actually be doing them even more successfully in our city.

And we know that coercive mental health treatment has not proven to have better effects than voluntary treatment, and is it disproportionate-- the involuntary treatment is disproportionately applied to black, Latinx immigrants, LGBTQI folks, and other communities of color, who are often over diagnosed and underserved.

So I'd like some-- a summary of some of the data and I know you haven't been successfully able to share data with us. But I'd like to know what happens to individuals who are taken to hospitals by the NYPD on involuntary removals, how long they spend in the hospital, if they are physically or chemically restrained, what other kinds of care they receive, and if they are successfully connected to services when they are discharged?

What is the discharge plan for folks who have been involuntarily placed in-- in the hospital setting?

DEPUTY DIRECTOR HANSMAN: So I'll hand it to Dr. Fattal to talk about what happens in Health and Hospital, hospital settings for folks who are brought there in a crisis. What I might say is that, you know, this-- this policy is not the starting point

for engagement, right? Starting points for engagement, include, you know, our teams that DOHMH, our teams at DHS that are working with-- with folks on the street every-- every single day, those are really our starting points for engagement, to get people into, you know, this critical care that can get them that long term treatment. This is really meant for a very, very small subset of folks where-- where that engagement might not have been--

COUNCILMEMBER HANIF: Respectfully, I understand. But I'd just like to know, how many have been taken to the hospital on an involuntary basis. And what those folks' discharge plan has looked like, what services they were offered, what has happened after their hospitalization, and how long they've been hospitalized?

DEPUTY DIRECTOR HANSMAN: Understood. I'll hand it to Dr. Fattal.

DR. FATTAL: Yeah. Just to clarify, H&H is only one provider. So not every removal comes to us. I just want to make sure to put that in context, that-- and also, it's-- the plan varies between different people. So I'm going to give you a general idea of

what we do for someone, right? It's very hard to break it down exactly.

COUNCILMEMBER HANIF: Great.

DR. FATTAL: But it all starts with receiving the information. So we're part of this initiative. And, you know, a key component of this initiative is collaboration and coordination. And it starts at the point of receiving heads up that someone, again, as Jason mentioned, this is a very, very select group of people, to get heads up that someone is coming to our one of our facilities, to get the information, make sure that we have it.

And then once we have someone come in, we do comprehensive psychiatric evaluation, but also a medical evaluation. A lot of people who have been living out on the streets have some medical issues that have been ignored as well. So we make sure that we address both the mental health needs and the psychiatric needs. And also get additional information to put the person in context history, we outreach the 24/7 command center that has information about people, and can connect us with the outreach teams that have been working with them so we can get the full picture.

Then once we've done a very thorough assessment that could include keeping someone for observation for up to three days in the emergency room, if you're not sure immediately. Then we answer the biggest question, which is: Does someone need to be admitted or not, right? And not every single person who was brought to us ends up being admitted, but some end up being admitted either voluntarily or involuntarily. And then once you're admitted, the main goal of the admission is stabilization. This is a you know, an inpatient unit, so you don't want keep someone there for too long. But then we have to make sure that they have a discharge plan, which we've talked briefly about before. But a discharge plan includes making sure someone has follow up appointments and follow up care, so that they're able to--

COUNCILMEMBER HANIF: How does the follow up work?

DR. FATTAL: It depends on each person. So usually it's an appointment. It could be, depending on the level of care, could be in an outpatient clinic, could be in a post program, it could be in a partial program, it depends on what the person needs. But more importantly, we make sure that they have

wraparound services, which could include case management, and depending on the person it could be a caseworker, or it could be as intensive as critical time intervention team working with them for up to nine months.

COUNCILMEMBER HANIF: Got it. I hope you understand that I'm not just trying to like probe you all and trick you into asking these questions, but it is really important for us as Councilmembers who have constituents who may be involuntarily and coercively moved to a hospital setting, that there is a plan, that this is not just a revolving-door strategy, a short-term strategy, that they in fact-- once they receive these wraparound services during the three day-- three day period where you all are evaluating them, plus deciding whether they're admitted to the hospital, or whether they can come back at a later time, that there should be a long term strategy. That they're not just coming back into the ER for services and then getting sent back to the streets. So it would be really-- it's really urgent that you provide us with more transparent data, even if that data set isn't available yet. It doesn't-- I don't think it needs to be public. But we deserve to know

how exactly all of these agencies are administering this-- this directive.

CHAIRPERSON LEE: Thank you. Okay, so next, we're going to move on to Councilmember Ayala and then Councilmember Bottcher.

COUNCILMEMBER AYALA: Thank you, Madam Chair. I just want to start by saying that there's a-- I'm really disappointed, and I don't-- in everything that I'm hearing today, but you know, our mental health system is a sham. It is completely broken, completely broken, and not recognizing that as part of this conversation, I think is a disservice.

The fact that the commissioner is not here is also insulting. Commissioner Vasan, I have a lot of respect for him, but he should have been here. I don't-- I can't think of a conversation more important than the one than we're having here today, and he should have been here.

I want to just, you know, highlight a couple of points that I have been, you know, sitting here kind of contemplating on. First of all, the term "community based care" has been brought up as part of this conversation continuously. When was the last time that anybody, you know, check the data to see

what the number of mental health providers were per community, you know, based on the on the number of hospitalization rates? Because in my community, I will tell you that it may take you up to a year to get an appointment in a community-based organization because we cannot attract or retain staff, because we don't pay them enough, because the Medicaid reimbursement rate is laughable, because we're losing people to the private sector every single day.

And so people are going. These people that are involuntarily being, you know, taken to the emergency room have been to the emergency room many times before that. That's not the problem. They've been there. They've been there on their own. They've been there with their family members. They're held for three days, and then they're released out into the community with no supervision, with no aftercare, with no follow up, expected to make decisions that they are unable to make sometimes on their own.

So while I agree with the Administration's position on, you know, it'd be inhumane to allow people to walk the streets when they are in that state, I blame the system, because the system is putting them out there.

So you're not rectifying anything by picking them up and taking them back to the hospital that they already came out of, right?

And I will, you know, I also, I want to highlight two cases, because they really bother me because I think that they're really connected to this. One was the case of Eric Davita. Eric Davita walked into a hospital in my district, and he was-- he took himself to the emergency room under duress. He knew that he needed care. Nobody needed to pick them up. His family didn't take him. He took himself. And while he was there, under whatever manic phase he was under, he got into an altercation with a security guard, and instead of treating him they arrested him, sent him to Rikers where he then committed suicide.

Explain that to me. Explain that to me. Because I need to understand. I don't I don't get it. I don't know who is on the receiving end, who's-- who is making these decisions, but our system is broken and that is why we fought so hard last year to create the Office of Mental Health, because we wanted to ensure that all of these gaps in services that somebody was looking at them and creating real policy to create meaningful change.

I'll share one last thought and I'm sorry, Madam Chair. But my brother -- and I bring them up all the time, you know, he has bipolar disorder. He was in a in manic -- in a manic state, a really bad manic state, and was released from a hospital. Even after I, the Deputy Speaker of the City Council, begged, begged them to keep him on a psychiatric hold, because he had been manic for days, hadn't been eating, hadn't been sleeping. He was on, you know, social media for days on end rambling. And I knew, I knew that he was at threat of being, you know, having himself beat up outside on the street, or being a danger to somebody else.

They released him against my recommendation. They didn't listen to anything that I had to say. They released him. He took himself took himself to Bellevue. Went AWOL three times. Again, he's in a manic state. The last time they brought him in, they left him in a room by himself with a-- with a doctor, he punched her in the face. And now where is he? He's in Rikers Island facing three years. And he'll do his time. Because, you know why? We don't even have court mental health court. The fact that he was under-- under mental health distress wasn't even a

part of the conversation. It became an assault like any other assault. What a disservice, not only to him -- and I bring him up, because he is the rule, not the exception. This is what we're seeing. And I am-- you know, I'm very passionate about this, because, you know, I've been very fortunate to be given a platform where I can speak to things I actually know about, because these are my life experiences, my lived experiences. I go through this every single day.

And nobody has ever picked up the phone and said, You know what, Councilmember? We would like to hear a little bit more about what those-- those gaps and services are because you've lived it. I don't know when was the last time any of you took one of your siblings or anybody in your family to the emergency room. I will be fascinated to find out.

[APPLAUSE]

CHAIRPERSON LEE: Thank you. Thank you, Deputy Speaker for sharing.

And next we will go to Councilmember Bottcher, and then Majority Whip Brooks-Powers.

COUNCILMEMBER BOTTCHER: Hi. So the Mayor's announcement in November, as I understand it,

essentially expanded the criteria for transporting someone to the emergency room involuntarily.

Prior to November, the guidance that was given was for someone who appears to be mentally ill, and is conducting themselves in a manner which is likely to result in serious harm to themselves or others.

Now, the criteria has been expanded to also include those who appear mentally ill and-- and who display an inability to meet basic human needs, like the need for food, clothing, or shelter.

Dr. Fattal, you had said that there's been no increase in emergency room visits at H&H. How is it possible that there's been no increase when that universe has been expanded so much? It wouldn't need to be such a big universe, if we were providing actual community-based services like clubhouses and other services on the ground. But it is a big universe. How has there been no increase?

And you don't have the numbers today of how many people have been transported on the whole? When do you think we'll be able to get those numbers? Also, another question: You said you had a goal of expanding site bed capacity by 200 by the end of the year? Do you also have hard number goals for other

steps in the continuum of care, like medical respite beds? And what are those number goals?

And also, third question: These involuntary transports are done by the NYPD. Are there involuntary transports to the ER done by civilian entities as well?

DR. FATTAL: Yeah. I'm going to try to answer but I'm definitely going to defer to my colleagues at DOH and OCMH to also answer some of these questions. Again, H&H is has only one provider. We're one player in the mental health field in New York.

As far as the numbers. I think-- I hear exactly your question. I think the issue is in the context. I said we didn't have an increase. We see thousands, and I can get back to you with exact numbers, but Bellevue alone sees 12,000 people a year in our CPEP.

So the universe of people who are homeless-- and again, this initiative is very, very narrow. We're not going and, you know, doing this everywhere. This is a very, very, very small denominator of people that we're talking about who are homeless and have severe mental illness, and are being targeted by this intervention. So the whole number is very small -- the denominator, not everyone's being removed --

compared to the volume of people that we see in our ERs, it's very small in that context. I feel like that's the-- what I was trying to say that the volume has not increased.

As far as other than beds, we definitely have different programs and initiatives that we're working on and have been working on planning. But I also would defer to Jamie to talk more-- we had said that there's a plan that's going to be announced. And, you know, I don't know how much you can share today, but there's definitely a very robust plan that's being worked on that will address a lot of what you mentioned. Not to mention the plan that the governor just announced a few days ago that includes also a lot of additional supportive housing and other housing-related items.

And the third question about--

COUNCILMEMBER BOTTCHER: Civilian.

DR. FATTAL: Yeah. I also defer to Jason and Jamie for that one, because they have that answer.

DEPUTY DIRECTOR HANSMAN: Yeah. Just for-- for transports, just to be-- to be clear, the transports-- the actual transports themselves are being done by FDNY EMS with the support of NYPD, and those are just

for the involuntary transports. So-- and Chief Fields can talk more about that. On the-- on the numbers, I think, over the over the coming months, we should have more numbers to share about what actually is happening on the ground and how that relates into what's happening inside of the hospitals. It's, as I mentioned, I think, incredibly complex and fragmented, these numbers, and then how the kind of the outcome, if you will of the hospital system, how it's all related to the actual removals themselves. I'll also just make another note, and I'll see if Jamie or Chief Fields wants to add anything in, just about the standard: That the Mayor didn't expand the criteria, right? So that was-- it was interpretive guidance out of OMH in February of 2022 that really clarified the statute for both 941 and 958 removals to include this interpretation along the basic needs, and in November, the Mayor simply released a comprehensive way that the city will be conducting these-- these removals which did not exist before, and concurred with the state's guidance.

But Jamie or Chief Fields anything to add?

ASSISTANT COMMISSIONER NECKLES: Yeah, I would agree that the standard was not greatly expanded. It

remains very, you know, consistent with Mental Hygiene Law for a long time. And our focus is always on connecting to a lot of the great services that many of the Councilmembers and my fellow presenters have-- have mentioned, crisis alternatives, respite centers, support and connection centers, peer support services on a brief, you know, intervention.

And then the real measure of success is connection to ongoing care, right? Clubhouses are a great resource. Treatment services-- there's a lot of innovative treatment models that are out there and our more comprehensive mental health agenda will include broader metrics focused on the whole population, connections to care, moving into stable housing, right?, improved quality of life, those things that we know that are more robust and long standing in terms of their impact on an individual person and our city at large.

CHAIRPERSON LEE: Okay, great. Thank you. So next, we have Majority Whip Brooks-Powers, followed by Councilmember Holden.

COUNCILMEMBER BROOKS-POWERS: Thank you Chairs.

As you all know, we had a hearing back in December, a joint hearing on subway safety, and at

the time, the Administration didn't provide any-- a clear answer that I'd like to follow up on today. It's very much in line with what Deputy Speaker Ayala was referencing in her remarks.

But individuals with severe mental illness tend to be disoriented, have a typical thoughts such as paranoia, and are generally not in the best position to comply collaboratively with law enforcement.

If law enforcement engages and the individual reacts poorly, would the individual then be arrested and charged with a felony assault on a police officer? Or will they still be taken in for evaluation? When this was asked of the NYPD in our December subway safety hearing, it seemed that no clear guidelines had yet been worked out for how to handle the situation. So I'd like to have an update on that today.

And then as a follow up in terms of the CIT training, how was the crisis intervention training course selected by NYPD as the best option? How does this training course compared to other police precincts? Is it the most rigorous among major city police departments? And in terms of co-response, what is the NYPD's long term approach to co-response?

Does administration have a plan to increase the number of clinicians that serve in the field in response to mental health calls? Thank you.

DIRECTOR CLARKE: So I'll start with the first question. I think, you know, it really comes down to training. And I was at the hearing in December, and I think, when we look at the data, which we didn't have with us, about 1% of mental health crisis calls result in arrest. And as Chief Tobin mentioned earlier, the majority of that is assault three-- or not the majority, the most common is assault, third grade, criminal contempt, which is violating an order of protection, and menacing. So frequently, we're coming into domestic violence situations.

It is infrequent, and it's very uncommon for the felony arrest for assault on a police officer or an EMT. It's not zero, but it's infrequent. And I think it turns to training, on how we train our officers, and part of that is training them to respond to people in a mental crisis.

So even if-- the goal is to get voluntary compliance, but even if we don't, you know, to make sure we're providing a medical transport with EMS,

and bringing them to the hospital for care, and not to criminalize that.

COUNCILMEMBER BROOKS-POWERS: Is there any corrective measures taken in the event that an officer may not have been trained, and someone who's had a mental health crisis ends up in Rikers, where at some point someone is assessing that this person may have had a mental health crisis, so that we're not criminalizing mental illness?

DIRECTOR CLARKE: Yeah. And I think-- so, you know, every case is individual, so I can't speak about why-- why individuals made that choice. But, you know, after that, even in those situations where an arrest happens, we're still bringing them into the hospital for evaluation. The district attorney's office have programs for people suffering from mental health to sort of off-ramp them from the criminal justice system.

If it's inappropriate, there's supervision to try and make sure we're instructing officers on the proper way to handle these situations. But there are off-ramps in the criminal justice system for people suffering from mental health crisis.

COUNCILMEMBER BROOKS-POWERS: But there's a chance that they can be charged with the felony?

DIRECTOR CLARKE: I mean, like I said, it's infrequent. For--

COUNCILMEMBER BROOKS-POWERS: So then that means that they can be. I just need a clear answer.

DIRECTOR CLARKE: It can be, but the goal on the training is not to do that, and it's infrequent.

COUNCILMEMBER BROOKS-POWERS: Let's change the question. Has-- has it happened?

CHIEF HOLMES: So, I can speak to that. I'm Chief Holmes, right? Because I'm a training I've been here 37 years and NYPD and I touched many aspects of the department. So Can that happen? Yes. The primary goal is for that not to happen. I've been in precints myself, where I'm the commanding officer or a sergeant on the desk. Someone brings an individual in that was suffering from a mental health crisis, and sometimes it's quickly resolved that this person needs to go to the hospital, not be arrested, the arrest is voided, things of that nature. And I'm talking long-- I'm talking way back because I've been here a long time. But the training that's in place now, hopefully is addressing that. We're pushing it

out more often. I believe in reoccurring training is essential in getting the message out and making it stick. And like it was testified to today that the leadership training courses encompass that. If you're a new sergeant, new Lieutenant, captain, going through the course, it's-- it's emerged in that-- that training is emerged in those particular forums. But hasn't happened? Obviously, because I've listened to some of the Councilmembers here today. That is not what I think any of us want to see as a result of such. And, you know, if it happens, and we're made aware of it, naturally, officers are made aware of it. And we speak quite often.

It doesn't have to happen in New York, something can happen. And still I feel the need or the agency feels a need: Let's get it out there before our men and women and make sure to try and offset it from happening here in New York.

And with that being said, we're talking about a national model, which is the crisis intervention training, national model initially, I think it was Memphis, Tennessee, in 1988. We adopted it in 2015. But I'm still looking for if there's a better product out there, believe me I'm trying to research and look

for it. And that's-- training is ever-evolving and we're always looking for growth here in the agency.

COUNCILMEMBER BROOKS-POWERS: Sorry. Just a last followup question. I just want to know if the training is required for all offices and how frequently those trainings happen. Because I know oftentimes, you know, I hear from officers also feeling that they're not getting enough training. And so with something as sensitive as this, I'm just interested in understanding what investments are making-- are being put in place to ensure that they are receiving that training.

CHIEF HOLMES: So yes. This training, especially the one that was recently implemented, it's for all officers. I don't care what unit you're in. I don't care if you're in an administrative position, because at any given time -- and we saw that recently -- you can be put in a position where you need to have this particular training.

And training currently, right now the entire agency took an overhaul. So I know I'm writing a succession plan where I want to see training for NYPD in the next two years, if not more current.

So it's-- yes, it is mandated to answer your question for all officers in NYPD.

COUNCILMEMBER BROOKS-POWERS: Thank you. Thank you.

CHIEF HOLMES: You're welcome.

CHAIRPERSON LEE: So next we have Councilmember Holden, followed by our Public Advocate Jumaane Williams.

COUNCILMEMBER HOLDEN: Thank you, Chair. And thank you, Chief Holmes, for-- for that.

You have a wealth of experience in this. Yeah, I was behind at another council. But-- and that's why you're so valuable to NYPD. You have the history and you know some of the problems that we've experienced in the past, but let me-- I was critical of Thrive NYC in the last administration, because we had a lot of, we probably still do, but a lot of acts of random violence. Somebody just punched somebody for no reason. They didn't know the person is just punching somebody.

And we had multiple times like say dozens of times, they were rearrested and then just sent out again, with-- nobody red flagged him. I asked Thrive, "Does anybody red flag these people?" And

they have probably a Serious Mental Illness that needs to be, you know, needs to be handled. A lot of them had schizophrenia, you know, whatever it is, they're just getting rearrested. So-- and I think that's probably still happening to some degree.

When somebody is-- attacks someone else, doesn't know them just punches them for no reason, no apparent reason. And they're, you know, they're-- they're diagnosed. I mean, they're brought to a hospital by a police officer or EMS, does the doctor have access to their records, their arrest records of that individual?

DR. FATTAL: I have to get back to you about that one. I-- yeah, I need to confirm.

COUNCILMEMBER HOLDEN: But see, this is the problem.

DR. FATTAL: Yep.

COUNCILMEMBER HOLDEN: When-- if we don't, then it's-- it's a merry-go-round. It's going to keep happening.

DR. FATTAL: Yeah.

COUNCILMEMBER HOLDEN: And that person might be sent to Rikers and never be diagnosed. When we, you know, we could admit them. And that's-- so we got to

get off this merry-go-round of this kind of, you know, lack of communications.

So if you can get back to me on that, because that's very important, that the officer tells the doctor. I don't know if the officer can hang around, but that's a that's a big issue.

DR. FATTAL: Oh, I'm sorry. I thought you were talking about, if someone is brought to us by someone, we do receive that information. But you're saying if-- sorry, maybe I don't understands.

COUNCILMEMBER HOLDEN: Yeah, no. We just we just see the same-- you know, we read about the newspaper the same individual keeps getting arrested and re=arrested and re-arrested, for the-- for obvious signs that they're unstable.

DR. FATTAL: Yeah.

COUNCILMEMBER HOLDEN: And they're put back on the streets. Why are they-- why are they out on the streets first of all, and why aren't they committed to an institution where they can get better? You know what I mean. So I'm asking you, does the doctor have the records of that individual to-- the arrest records?

DR. FATTAL: So if someone is brought to us by NYPD than we do receive that information when they bring them to us. So we would have access to that information.

COUNCILMEMBER HOLDEN: But the officer hangs around until the doctor comes? How does this work?

DR. FATTAL: Oh, so this is part of the protocol. Maybe Jason can talk more about that. But definitely the chain of custody ends when we take over the patient. So the patient is never left without any-- you know, being under the custody of anyone. So definitely they hang around long enough to make sure that the patient is registered in our emergency room.

And by definition, if you're registered, that means that now you're under our custody, it means that our healthcare professionals--

COUNCILMEMBER HOLDEN: So if they're brought in by EMS, what happens? They have the arrest records if there's no police officer there?

DEPUTY DIRECTOR HANSMAN: You know, they might not. What I what I might go back to is you know what-- what happens in the hospital around talking to service providers, to other collateral contacts, and that might be where some of that gets-- gets

uncovered and gets to the physician who's doing that psychiatric evaluation. I think the-- the intent, and Dr. Fattal can talk a little more about the intent of psychiatric evaluation, is really meant to collect some of that information beyond arrest records, right? We're talking about, you know, you know how they have been in treatment, you know what other folks that they have?

DR. FATTAL: Yeah, I mean, I can talk about this also, as a physician, the physician is only a member of the team. So the team has the nurse has the clerk has transport person. We have EMRs. So obviously, when you do an evaluation, you're not only relying on the information that was given to you personally, you're relying on everything that happened, including the EMS records, including the registration information. So yes, if the information makes it at any point in our system, then we have access to it.

COUNCILMEMBER HOLDEN: Yeah, I just think-- I'm sorry Chair, but I just think that we need a very definitive process. That-- and I think that's the critical thing. Because we all-- we read about it in a newspaper every day. Somebody just punches somebody, and the same person was re-arrested 46

times. Is anybody out there red flagging all these arrests? I mean, that's what we need somebody in oversight looking at this, a doctor or, you know, somebody that that can red flag people. Because that-- in the last administration, I was very critical. All this money from Thrive was going out there. And they said most of it was for training. But that we didn't even see. So that's the-- that's the problem here. And I hope the Administration-- I like what's-- what's happening in this administration. At least they're communicating. But we didn't learn anything in the last eight, you know, eight years, especially in the last four of Thrive NYC. We didn't get that information. There's a lot of money out there, but we didn't see a difference. Thanks.

CHAIRPERSON LEE: Thank you.

CHAIRPERSON NARCISSE: And for my colleagues, as a triage nurse, you come to us first. And when you come, we get the record. And then we give it to the doctor, and then we have a meeting. We have that a lot. The biggest problem we have, believe it or not, is the continuous service with the CBOs in our community, the-- we don't have enough support system.

Because when those guys come to us, we have to refer, get the social worker involved, but by the time we do that, we don't have enough. And that's what happens. You don't have enough beds, you don't have enough support services, you don't have enough support housing. And that's the crisis we're dealing with right now. Unfortunately, been going on for decades.

CHAIRPERSON LEE: Thank you. Okay, next we have our Public Advocate Jumaane Williams, followed by Councilmember De La Rosa.

PUBLIC ADVOCATE WILLIAMS: Thank you so much, Madam Chair. First, again, just reiterating hopefully, the answers to the letters-- to the questions that my office submitted will be answered shortly.

I did want to say this framework in context, I think there's something we have to break down that caused a lot of some of these questions to be moot.

The first one is: we're getting better as a society, but as a society as a whole, and government in particular, has a hard time letting go with police having to be the response to everything that goes on in our city, and in our state in our country. That is one of the primary problems that we have: Police

do not have to be the ones responding to everything. But we haven't committed to that even as we say it. Even if we look at the budget right now, the police department is one of the larger funded. They also have access to unlimited overtime that no one else has access to. If I was asked about the overtime access for H&H for DOHMH and EMS, it would pale in comparison to the NYPD.

Also, NYPD is the only one not facing any cuts so that other agencies are facing cuts on top of not having any access to overtime, and on top of that the recent budget laid out by the governor is giving NYPD additional funding for overtime, while not giving any money to try to restore cuts to the other agencies.

That said that framework is a framework that we have to change not just in words, but in practice. I know it's hard to do. These are hard questions. And these are hard things to put into play. But if we don't do it, we're going to continue seeing the problems over, and over, and over again.

And that leads me to saying why I want to make sure that people are trained, we have to make sure our officers are trained continually training is not going to solve the problem. The question is how when

why and who were using law enforcement to replace? That's the question that we have to ask and who gets the brunt of that. But I did want to just point out hopefully I have-- I'm sorry.

On page four and page six, you mentioned clearly that the orders did not expand any powers. You also said that they cannot create involuntary admittance. I just want to be clear, we're playing with semantics here, because there was a change that the Mayor was trying to make clear, that did expand some things in its clarity.

Also, while they may not be able to involuntary admit, they can involuntary bring people to the hospital, so I want to just be clear about that.

And also on page five it said the clinicians can call for NYPD in person, that they are in the lead. I also want to be clear what we've heard, is that the person with the gun is the lead. So that's one of the reasons the best intentioned officer, I believe what we've learned is the presence of the officer with a gun in uniform can heighten the situation even for the best-intended and best-trained officer.

So I did have a question so I can better understand, because you said clinicians can call for NYPD, which would assume that NYPD is not there.

So I want to understand how it works with these teams, is there a law enforcement person already there? Or are these teams going out, assessing situations for themselves, and then if it's necessary, calling for NYPD.

DEPUTY DIRECTOR HANSMAN: So I'll hand it to Jamie in just a second, but first Public Advocate I do-- I do want to just note that we did receive your letter, we're working on responding to it, and we're going to respond to it very soon.

And the other thing I'll just say is: It's going to depend on when and where this happens. Sometimes PD will be there, other times they won't.

But I'll let Jamie talk a little bit more about the situations where they may or may not be there.

ASSISTANT COMMISSIONER NECKLES: Sure. So, again, there's a lot of different types of teams. There's teams that explicitly focus on crisis intervention, and there's other teams that work with people on an ongoing basis. And sometimes those people may also have a period of crisis, you know, if

they're working with somebody over the years. I'll focus on the specific crisis intervention teams that respond over 16,000 referrals a year via NYC-WELL. General public providers concern family members, anybody can call NYC-WELL, they will connect if a person is in crisis, and they can't get to treatment themselves, or they will dispatch a mobile crisis team that will meet with the person wherever they are, these teams focus on people who are housed, which would actually include shelters, but is mostly people in private residences or supportive housing, et cetera, 16,000 referrals a year. They include peers and clinicians, they de-escalate, connect to ongoing care. Less than 4% of the time, they will assess the person as needing to go to the hospital. The person may go voluntarily, they may, you know, "My brother will drive me. We'll go right now." They may not want to go voluntarily, in which case, that mobile crisis team would call 911, and the police and EMS would respond.

PUBLIC ADVOCATE WILLIAMS: Okay, thank you. I have other questions hopefully the letter will respond to. I did want to also say part of the problem is that when this was announced, it was

announced as a plan, but it was a tactic. And that is a difference. And if we can talk about a full-fledged plan, it would help relieve a lot of the concerns that we have. We all know that there are failures happening now. I do want to lift up Samantha Prius, I believe her name was. She was let out of Queens Hospital. She was nonverbal mute, on autism spectrum, let out in the freezing cold. Her parents-- her family waited for weeks to find them. To Shawn Carter, Michael Lopes, who were getting help on a psychiatric hospital who were brought to Rikers. They're now dead.

And so we do know that they are failures here. And we have to work on getting a continuum of care system that is not reliant on simple law enforcement because it has never worked before, and it harms black and brown communities primarily.

Thank you so much. I appreciate it.

CHAIRPERSON LEE: Thank you so much. So next we have Councilmember De La Rosa followed by Councilmember Paladino.

COUNCILMEMBER DE LA ROSA: Thank you so much. I want to piggyback on some of my colleagues comments. I want to uplift that there is inherent violence in

the interaction between police and people who are suffering from severe mental illness. And those interactions have been, you know, have been plastered all over newspapers for us to see for over a decade. They are the names of New Yorkers that have been murdered by police officers in these interactions. And they are people with families.

And I just want to say that we have been given information that talks to some of the disparities that exist in these practices. Black New Yorkers have been found to have a higher hospitalization rate for mental illness despite lower prevalences of lifetime diagnosis and severe mental illness, as well as-- as well-- We also know that the highest poverty neighborhoods that have over twice as many psychiatric hospitalizations per capita as the lowest poverty neighborhoods in New York City. Those data points point to the targeting of black and brown New Yorkers who are severely mentally ill, as well as the criminalization of poor New Yorkers in those same communities.

So while there has been an emphasis today in the testimony on trainings, trainings alone will not change this bias and the disparity that exists. We

need accountability as well. And I want to say that we have information that since 2017, the CCRB, has recorded close to 2700 allegations that police abused their power when sending someone to the hospital against their will. This is an alarming number, obviously, and complaints about NYPD abuse during involuntary removals and what is-- so we want to know, right?, that this-- this data point is that we want to know what is happening for NYPD officers who in the past have been-- had a CCRB complaint, have abused their power when having interactions with New Yorkers? What is the accountability for those officers in this process of involuntary removal? That's number one.

And then number two, just to ask both of my questions quickly. I do have a question regarding staffing at these agencies, the Office of Community Mental Health, and the office-- and the Department of Health and Mental Hygiene. We know that there is a staffing crisis in New York City. So if training is relying upon, for example, DOHMH to do this training, but we don't have enough staffers to-- to even service our city, how is that happening, and what are

the impacts on actual trainings if those agencies are hollow?

CHIEF HOLMES: So I'll take the first component as far as accountability. First and foremost, there's body worn cameras now, and those cameras, it's mandated and encompassed in the training, that that camera is to be activated upon the first encounter with an individual.

And, you know, full transparency, you're right. We've seen where officers have forced wants someone to the hospital, and they've been disciplined as a result of it. As a matter of fact, I used one of those scenarios in my training, as to "this is not what we want to see."

So you know, some can be training, and then some, yes, you do have where someone has interacted in, you know, inappropriately, and, and been met with discipline.

COUNCILMEMBER DE LA ROSA: So are you red flagging? Since we're talking about red flagging New Yorkers who are walking down the street? Are we red flagging NYPD officers who have a history of brutality.

DIRECTOR CLARKE: So I also want to put a little context in here. You know, we're talking about 2745 complaints. We're responding to 170,000 of these calls a year. So this is, again, of this-- between 2017 I don't have the math in my head right now, but we're talking 600,000 to 800,000 responses to calls a year, and we're talking about 2000 complaints. So I agree with Chief Holmes: When it is improperly done, it should be, it should be investigated by CCRB, and there should be accountability for the officer.

But by and large, we're talking about officers who are handling situations correctly given the vast numbers of calls we respond to, and the low number of complaints comparatively.

COUNCILMEMBER DE LA ROSA: I will say that it's not apples to apples. Just the fact that you have that many complaints points to a problem. And the fact that the CCRB has not always acted independently leads us-- leads me to have concerns over the validity of the of the complaints that have been dismissed.

And so that's not apples to apples, in my opinion, and to have those complaints be at the forefront. Those are still people. Those are not

just numbers of complaints. Those are people that are walking in New York City streets, and as you heard our colleagues say here, there are people with people with families, who are concerned about their well being when an interaction happens, right?, with police officers. They leave their house, they're in a manic state, and there is an interaction. So we need accountability as well as training. Thank you.

CHAIRPERSON LEE: Thank you. Okay, next we have Councilmember Paladino, followed by Councilmember Abreu.

COUNCILMEMBER PALADINO: Good afternoon, everybody and thank you for coming.

I'd like to commend you, Chief Holmes. I'd like to thank the Mayor's Office for taking the steps that you are taking. It's a long time coming. We've seen this mental health crisis put be put on hold for decades now. Let's not remember-- let's remember, when state hospitals were considered inhumane and they were closed. We presently have a lot of vacant properties that can actually be used to serve the mentally ill. The mentally-- the mentally ill, and the mentally challenged, cannot be put in a criminal status. They are mentally ill.

Now when I think of these safe spaces, this is a safe space where they could receive the treatment that they need, whether it be long-term or short-term.

So I think you guys are doing your jobs right now, but we have to go deeper. We've got $227 billion coming down from the state of New York. What are they doing with that? We had Thrive New York, which was a joke, $1.2 billion, and yet we're sitting here talking about this as if it's a new problem. It's misappropriation of funds.

Now let's keep an eye on our governor, and let's see what she plans to do when it filters down here to the city so that we can get a grip on this problem.

Another thing I went on a ride along. I went on a ride along to Friday nights ago with the one on Ninth precinct. And I watched your officers handle two very severely mentally challenged people, one knife wielding, and I watched the EMS come in everything you spoke about here, your training, I saw put to good use. And another person who went crazy in Rite Aid, totally ballistic, throwing things around threatening people. Once again, the offices I was-- I were with, one was a-- on the force for 16

years, the other fresh out of the academy. I couldn't be more proud the way you guys handled this situation. I know there's a crisis once your inputted, and there's no long term solutions. So long term solutions rests in the $227 billion that the state is supposed to be giving this city.

So let's make sure the money is used properly. And the Mayor could go forward in purchasing perhaps Creekmore, which is 300 acres of state-owned land. There are places and-- and things we could do. I work with these people all the time, and I look forward to furthering this and not just talking about it. It's time for action. Thank you very much.

CHAIRPERSON LEE: Thank you. And next we will go with Councilmember Abreu followed by Councilmember Gutiérrez.

COUNCILMEMBER ABREU: Thank you Chair. Considering there is a shortage of mental health staff across all H&H hospitals, how many more mental health professionals need to be hired to meet the demands of AOTs?

DR. FATTAL: Yep, thank you. I'm going to defer to Jamie from DOHMH, who oversee the AOT program.

ASSISTANT COMMISSIONER NECKLES: Sure. Yeah. The Department of Health implements assisted outpatient treatment in New York City.

We have-- I don't-- about 100 staff on my team, clinicians and non-clinicians, you know, lawyers. It's interdisciplinary. I don't have the exact headcount, but certainly, you know, there-- there are vacancies in the program and across our agency, and AOT is no-- no exception to that.

COUNCILMEMBER ABREU: Is it fair to say that you don't have the-- enough staff to meet the demand?

ASSISTANT COMMISSIONER NECKLES: So AOT is a court monitoring program, civil courts, a civil matter. We're not providing care. So everybody on an AOT court order is receiving community-based treatment and care coordination provided by CBOs, hospital-based clinics. And so those, that larger behavioral health workforce is not DOHMH staff or city staff necessarily, there are also shortages within the sort of larger behavioral health workforce that I think we're all aware of.

But everybody on an AOT court order in New York City is in treatment, that is the requirement of the program. So nobody on AOT is without treatment.

COUNCILMEMBER ABREU: Thank you for your question. And because Intro 706 is being heard today, I would like to have perspective by OCMH on that. Is this something that's feasible? Would it be possible to create a virtual interactive map that shows where services are located?

DEPUTY DIRECTOR HANSMAN: So thank you, Councilmember. So we support the goal of providing access to mental health services, which is why we, with our partners at DOHMH launched NYC-WELL. This commitment to access includes ensuring that there are places for New Yorkers to find the resources that they need. And so NYC-WELL, which is New York City's single point of entry for behavioral health services, provides a robust online portal that the public can access now, and it's organized by population, type of service. They can also call and have counselors and peers to help navigate the system and provide crisis counseling via phone, text, and chat.

OCMH also published a how-to help guide to help walk folks through how to get services in the city and direct folks to that comprehensive resource that is NYC-WELL.

So we look forward to talking to you about the bill and how to make it-- and how to get these resources out to folks.

COUNCILMEMBER ABREU: So we-- there's-- there's a path for us to work together on this.

DEPUTY DIRECTOR HANSMAN: Absolutely.

COUNCILMEMBER ABREU: Thank you so much.

CHAIRPERSON LEE: Okay. So actually, we're going next to Councilmember Brewer followed by Councilmember Rivera.

COUNCILMEMBER BREWER: Thank you very much. Just a few questions. In my discussions with all of the mental health groups, at least in Manhattan, it's all about the staffing. So I always hope that agencies don't work in silos. So my question to you is, are you -- sometimes it's hard to fight OMB, I know that -- but are you willing? Are you able are you doing advocating for more funding for the mental health agencies, you'll hear about the clubhouses, there are many other models. That's question number one, because without that support, you can't be successful.

Number two, I wonder if you have any statistics, whatever the overall number of voluntary or

involuntary, of people who are going back to the shelters, are they going back to families? Where are they where are they going after three days, et cetera, because there is very little opportunity for a stable environment in our city. And it's not your fault, but that's the housing problem.

Third, I believe there are 50 -- at least in the Manhattan court, and I know DA Bragg is upset about it -- only 50 People can be handled by the mental health court. Are you-- is it worth it? Do you need more slots there? What are you doing about that?

And then finally, leaving Rikers has been a problem for I don't know, 40 years that I've been doing this. Me and Madam Holmes, or we've been doing this for a long time. 40 years I've been doing this. So is there any change in leaving Rikers? I know there's a lot of talk. Rikers has a lot of people with mental illness. What are we doing as a city -- even though there's a lot of talk -- to make sure that people coming out from Rikers have support. When you leave the state system? I know I had a son who came from the state criminal justice system, mentally ill, they do pay attention, but does-- Rikers talks about it, but those could be recidivism

unless you're paying attention to mental health. So those are my four questions.

DEPUTY DIRECTOR HANSMAN: So I'll take it from the top. If I miss anything, let me know. Just on the funding and staffing, what I'll say about the-- the staffing is staffing is a national issue, right? So we're facing--

COUNCILMEMBER BREWER: I don't live in Iowa. I'm interested just in New York City.

DEPUTY DIRECTOR HANSMAN: I understand. I think we're facing staffing issues across many of our-- many of our programs, and we are I think actively working on many, many strategies to-- to kind of, you know, get out of this staffing crisis that we're in.

So whether that's, you know, collective job fairs, whether that's, you know, enhanced recruiting efforts, we're trying to find the staffing that we need to really fill our vacancies across our teams, and within the Administration.

COUNCILMEMBER BREWER: Definitely for the Administration, but also for the nonprofit community-based organizations that really are an extension of city government. Are you fighting for them to get money too against OMB?

DEPUTY DIRECTOR HANSMAN: I mean, I think we're always looking at ways that we can some work support community providers, to make sure that they can find the staff that they need to hire and have the appropriate level of support.

Just on the statistics, for discharges back to shelter, I'll hand it over to Dr. Fattal to talk about what happens after that three day period.

DR. FATTAL: Yeah, and I just wanted to go back to-- I know I mentioned three days, but I want to clarify the context I used it. It's the-- if someone comes to our emergency room, we can do an evaluation, and we could keep them up to three days in the emergency room for observation, but that's not the overall duration. If they ended up being admitted, then, you know, the admission is definitely a longer stay.

So just want to clarify that because I don't want the impression to be that we only keep people to up to three days.

And as far as what happens to them afterwards, I think that's the data that was asked for before and we can get back to you on that, but we do keep track.

COUNCILMEMBER BREWER: But it is the most important data of this whole conversation. Just so you know.

DR. FATTAL: Yes.

DEPUTY DIRECTOR HANSMAN: Um, the other one around Rikers. So when I might say, you know, there's Correctional Health Services that provides health services at Rikers that does--

COUNCILMEMBER BREWER: I know.

DEPUTY DIRECTOR HANSMAN: Yeah, an amazing job to-- to help folks--

COUNCILMEMBER BREWER: Comme ci, comme ça.

DEPUTY DIRECTOR HANSMAN: Understood. And you know, they're helping folks as they get discharged to get connected into-- into treatment. And I think we're trying to find ways to make that a easier, better process.

COUNCILMEMBER BREWER: But what are you doing to make that easier and better, because people leave? I know, I've been there. They leave, and they just don't necessarily follow appointments, and so on and so forth. So what is the connection there between leaving Rikers and support?

DEPUTY DIRECTOR HANSMAN: So my-- I'm going to have to defer that to Correctional Health Services, and I'll get back to you with what they're-- they're working on.

Similarly with mental health courts, that's within the purview of MOCJ. I'll get back to you on the-- the mental health courts as well.

COUNCILMEMBER BREWER: Thank you very much. I guess what I'm trying to say after 40 years, we still silo, and we cannot-- we've got to stop siloing agencies. That's a huge issue. Thank you.

CHAIRPERSON LEE: Thank you so much. Next, we will go to Councilmember Rivera, followed by Councilmember-- Oh, we actually did that. Go ahead.

COUNCILMEMBER RIVERA: Good afternoon. Thank you for being here. Nice to see you, Chief Holmes.

I want to go over some of the numbers that you mentioned today. It was mentioned that 42 removals were made in December 2022. Is that correct?

DEPUTY DIRECTOR HANSMAN: Um, so that was just for our mobile crisis teams.

COUNCILMEMBER RIVERA: Do you know where those removals were made? I'll defer to Jamie.

ASSISTANT COMMISSIONER NECKLES: Yeah, so mobile crisis teams operate citywide. We would know the location--

COUNCILMEMBER RIVERA: You wouldn't?

ASSISTANT COMMISSIONER NECKLES: We would. We would. I don't-- I couldn't tell you the location of all of them off the top of my head. But yes, we have the location.

COUNCILMEMBER RIVERA: Could you get those-- those neighborhoods for us? I only ask because the highest-poverty neighborhoods have over twice as many psychiatric evaluations per capita as the lowest poverty neighborhoods in New York City. So how the city responds to the these individual areas, I think, is important. So I would love to know that.

ASSISTANT COMMISSIONER NECKLES: When I-- can I just respond to that, because I totally agree. And the training that we do for 958 designation includes a module on anti racism and bias in mental health services. So we completely understand the role.

[crosstalk]

COUNCILMEMBER RIVERA: Let me just say-- I appreciate that. I just want to ask about were those

removals through calls that were made regarding a mental health crisis that was in progress?

ASSISTANT COMMISSIONER NECKLES: So the removals I'm talking about were calls to NYC-WELL, where the-- there was a report either, you know, by the person, or by a loved one, or by a provider, anybody who might know them, explaining that there was a mental health situation that was assessed to be a crisis by the NYC-WELL counselor, and then dispatched to a local CBO operated team, who then went out into their home, did an assessment, and then assessed the-- if the threshold was met for removal.

COUNCILMEMBER RIVERA: So 16,000 referrals were made to NYC-WELL in a year, you mentioned, and all of these go to nonprofit organizations?

ASSISTANT COMMISSIONER NECKLES: No. So there's about 400,000 contacts to NYC-WELL, about 16,000 referrals to mobile crisis teams through NYC-WELL--

COUNCILMEMBER RIVERA: And those go to nonprofits?

ASSISTANT COMMISSIONER NECKLES: They go to a variety of-- it includes nonprofits, as well as hospital based mobile crisis teams. So there's 24 mobile crisis teams. Some of them are operated by

hospitals, including but not limited to Health and Hospitals. Some of them are operated by voluntary hospitals. And then some are operated by community-based organizations in contract with DOHMH.

COUNCILMEMBER RIVERA: And is NYPD ever involved in those?

ASSISTANT COMMISSIONER NECKLES: So, no, the mobile crisis teams are staffed by clinicians and peers. If those-- the clinician on scene assesses the person to meet the criteria for hospital-- or potentially meet the criteria for hospitalization, they would attempt to get the person to the hospital voluntarily. If that's not an option, then they would engage the police and EMS to transport the person involuntarily.

COUNCILMEMBER RIVERA: I just have one more question. Is that okay.

I only ask because you have organizations, and we'll hear from them later today. But VNS was formerly visiting nurse, you know, they've been doing this for decades. And they really must be leveraged and fully funded if you rely on them for that many thousands of calls every single year. And that goes for our community based organizations that approaches

this work in a very, very culturally humble way. So I just want to put that on the record.

And my last question was, it was said that 2.5% of 911 calls are mental health related, with 1% of crisis calls resulting in arrests. And Chief Holmes, you mentioned that some of those arrests eventually are voided. Is that-- is that crossover in the same percentage?

And secondly, why again, is NYPD the best to handle these calls?

CHIEF HOLMES: So I'm not-- when I speak about some of them being voided, I'm speaking from personal experience, my tenure as a commanding officer. I don't know the stats now. I will look into it, now that it has come to my attention.

As far as police being the best to respond. No, I am not going to say I agree to that. What I'm going to say is: Is it necessary for our response sometime? Most of the time we're responding, it's either someone's flagging us down, or someone's calling 911, and it warrants a response based on the circumstances being given: They have a weapon, they're screaming, some sort of circumstances that leads communications to notify us, as well as our--

one of our primary agencies there, EMS to respond to that particular scene. And when we get there, that that deter-- that assessment is made. There's several times that EMS may get there before we get there. And they can give us you know, give further feedback.

But as far as us being the best to respond. If it's something emergency in nature, we took an oath to protect and serve, that's what we do. As far as the Mayor's directive, my interpretation of that is, we don't leave someone in the street. It's inhumane to leave someone in the street that requires some sort of assistance, whether it's reeking of urine and incoherent, or open wounds and not capable of self care. That's my interpretation. Those are some examples used in our training, something to that magnitude.

CHIEF TOBIN: I'd just like to piggyback on that and say that the NYPD's default with responding to mental health calls is always as an aided case, not as a criminal justice matter.

COUNCILMEMBER RIVERA: Always as an aided case?

CHIEF TOBIN: Like it's someone that requires medical or behavioral health attention.

COUNCILMEMBER RIVERA: Right. I just asked because the, you know, if there are resulting arrests, that's what's so concerning, I think, for this body, but I know we're trying to...

COUNCILMEMBER RIVERA: So I just want to point out, I think it was earlier, that there are situations where it's a must arrest. So if we go to a scene, and it's called in as a mental health call, and when we get there it's actually a domestic dispute, and the person has an order of protection, we have to arrest for criminal contempt.

COUNCILMEMBER RIVERA: All right, well I look forward to a breakdown of those arrests and related to the mental health crisis calls.

Thank you, Madam Chairs for the graciousness and the time.

CHAIRPERSON LEE: Thank you so much. And I will actually hand it off to our fellow Chair Camilla Hanks for just a couple more second-round questions really briefly. Thank you.

CHAIRPERSON HANKS: Thank you, Chair Lee. And I thank my colleagues. I mean, this has been very informative. The questions were leading, they were engaging, and I think we learned a lot here.

Second, I would like to thank everyone on this panel, because you know, your expertise, and it's not easy what we're discussing here. So I do want to thank all of you for coming here today and talking about that. To that end, we discussed, you know, training, we discussed that 1% that goes into police custody, that lead to arrest, they may be on Rikers, they are released. Councilmember Holden explained, you know, what is the pipeline to making sure that those individuals if they are rereleased? How do we interact with that?

So all of that is coming under the umbrella of training. And I appreciate, Chief Holmes, your candor is like, "No, this isn't the proper, this is what we have to do as law enforcement that when we're called we have to answer."

So I think I want to end this by saying to a person, regardless of funding, because everybody always wants more funding: What do you think we need to be doing or looking at to make this work better, in your, in your opinion, to a person?

DEPUTY DIRECTOR HANSMAN: Yeah, I think some of the ways that that we-- some of the things that we need to do to make this work better. We've-- we've

heard it today, some of the coordination. That's partially what this plan was meant to address is a coordination between agencies.

But you know, it is-- it's difficult when we have a bunch of we have we have a lot of agencies that are working with individuals and across individuals. So coordination is I think one of the things. I think staffing is another one. We do have that-- that nationwide staffing shortage and that citywide staffing shortage that affects really from-- from the top to the bottom, right? Every-- every part of this response does have a staffing component that does need to-- you know, does need more support. And a lot of a lot of that is outside of the control of the city sometimes, right?, just because of how staffing is done.

So interagency-- more interagency coordination. And I think it's a testament to our interagency coordination that we have, you know, health agencies up here along with our public safety agencies, really trying to do what we can for the support and care of New Yorkers. And staffing, I think across-- across services.

CHAIRPERSON HANKS: Anyone else? Please?

CHIEF HOLMES: So I have to agree. First of all this is-- I think it's a collaborative effort. I know we have a call every Wednesday with the Deputy Mayor Isom Williams, who is very passionate about this subject as well, and the coordination that I see as far as tracking an individual from the beginning to the end, and what services they're receiving. I think it's phenomenal.

But we all know, this is a whole entire ecosystem that-- that requires some adjustment-- adjusting and staffing in order to make it work.

As far as a temporary, quick fix, for lack of a better term. I think that each agency here is focused on doing the best that they can with our client-customer, with that particular community in mind, and best interests in mind. The humanity in this, I think, is amazing. And that's just from the phone calls that I participate in as well as how you feel about this particular subject as well. I know Councilmember Brewer -- , I think she's gone already -- you know, when I think about Rikers, I just think about-- it's something I talk about. Maybe something like I say a Welcome Wagon at the foot of Rikers Island when you're being discharged, that's not

Rikers personnel, but have agencies, different agencies represented. Even something as simple as getting a CDL license? Do you have children? And if so, plugging them in to ACS. You'd be surprised. A lot of people don't even know ACS gives cribs and things of that nature.

People want to eat, you're going to have recidivism, right? Because they have no other option. So I think just trying to plug them into different things, you know, different services and educating about that. And, I think it'd be helpful.

CHAIRPERSON HANKS: Thank you so much. Is that it? Does anybody else have a--

DR. FATTAL: Just very quick, just to-- I agree with Jason, and add that, you know, I've heard, "Is this the best approach? Or is this the best approach?" I think different people need different approaches. I think the key is coordination. Also, because we need all the different approaches. We need all these different agencies to work together, because not everyone is going to be the same. So-- and every situation needs a different response.

CHAIRPERSON HANKS: Thank you so much. And thanks for-- actually, I have one comment about the

mobile unit. I had a situation where there was a person, a good friend of mine, in a mental health crisis, and we called the mobile crisis unit, and they did not respond, and then NYPD had to come in.

And what the CBOs were able to do was highlight the history of this person, so they would not be attacked or treated with, you know, with their civil liberties intact.

So my last thing is, what do you need from CBOs? What kind of capacity building measures do you think you would like to propose to make sure our CBOs and folks are-- are supporting and making sure that maybe that coordination is happening, or there's training on a local level, so the civics the CBOs, are also-- who are really on the ground, understanding who these folks are in individual communities can be helpful. Anything that you would want to...?

DEPUTY DIRECTOR HANSMAN: Yeah. I think we always want to hear from CBOs, and how-- how individual cases play out. So I think for-- in this case, Chair, where you didn't get the mobile crisis team, I think we would want to look into kind of where-- where that broke down, so that we can improve for the next time, or explain why it broke down,

right? And I think same with the CBOs. I think we would, we would want to hear from them on the ground about what they're seeing, so that we can develop, I think, the best process that that we can.

CHAIRPERSON HANKS: Thank you so much. That's the end of my questioning. Thank you, Chair Lee.

COUNCILMEMBER CABÁN: Thank you. I just wanted to continue with some of my commentary and follow up on some of the answers that were given earlier, in addition to some of the additional testimony that I have heard.

You know, I will say that, respectfully, I'm hearing that the-- the threshold for removal is the same in in the field as it is in the hospital. And there's been you've protected a lot of confidence about the approach that's being taken. But I do want to note that there are doctors across the city that are vehemently opposed to this plan. And I'm just just to name a few, for example, like CIR of the SEIU, doctors and residents-- the interns and residents union that say that this is not medical best practice, and think that it is very harmful and dangerous. And so I just want to point out that

there is a very differing opinion across the medical community on this response.

I did also hear about the point is not criminalization. Maybe somebody gets brought into the precinct, and then they're like go, I just want to accurately and clearly define what criminalization is. Criminalization is not the act of an arrest. Criminalization is responding to a social ill with policing, and that very interaction at every single point is a traumatic event, and most often, with somebody experiencing mental health struggles, it is one that escalates rather than de escalates. It is one that further-- furthers decompensate decompensation, rather than making a situation better.

I also want to talk about metrics. It was also mentioned earlier that the goal is to look at how often we are connecting people to care. And that is an important metric, but I think what we need to understand about that is that the infrastructure doesn't exist. That models in other cities, what they have that's different than us is more investment, so there's more places to take people. That the only two options are not a shelter, or a

hospital, or third, Rikers Island, and that actually a real measure of success would be to be responding less.

And so that idea about a Welcome Wagon coming off the island. We need welcome wagons in our neighborhoods, before people get onto Rikers Island. And so my question for you all is, do you agree that the DHS budget, the DOHMH budget, the B-HEARD budget, do you agree that those should not be cut, that they should not be subjected to PEG, and that those budgets should actually increase?

And then my-- my next and last question are, and then I have an additional comment, if you'll bear with me Chairs is-- you know, I have had the opportunity to talk with police chiefs and fire department chiefs in different cities, particularly the Portland Street Response Team, the Denver Stars team, and the things that they have told me unequivocally, is that their police department is not the right workforce to be doing this work, and there is no amount of additional training that can do that. We've heard a lot about additional training.

So my question for-- for the NYPD representative is: Do you agree with that, that the NYPD cannot and

will never be fully equipped to address this crisis, and that what is really needed is an alternative-- a deeper investment and an alternative models so that we have more capacity to respond to more than 2% of eligible calls, for example. Because I believe, based on the last B-HEARD data in that catchment area of all the calls coming in that are eligible, there's only capacity to respond with that team to 2% to 3% of those.

And the last thing, I will add, I promise, thank you, is that, you know, this question about when a mobile crisis team is sent or an alternative is sent. This is not a unique issue and problem. Like yes, the biggest issue has a lot to do with whether there's personnel to get that done. But it's also in dispatch.

I've had the opportunity to stand in the middle of 911 Dispatch, and hear how these calls are, are coming in how they're routed and what gets done. And a big part of the problem that they are experiencing is-- it's not so much as the dispatchers inaccurately coding or putting a call in. They have to by law, they have to rely on the information given to them. And so it really relies on how an officer or how a

community member is describing the person. And if they use certain buzzwords than they are handcuffed. They can't send an alternative team when they want to.

And so is there a plan to make, for example, everyday community members better reporters, so they aren't using stigmatizing language, so that they aren't categorizing behavior that maybe-- might seem like they are dangerous, but mental health clinicians, for example, know that it is not, and that they would be more than happy and more than comfortable to be the people who respond.

So the three questions were: Do you agree that instead of cuts in PEGs, those different social services should be getting more funding in the preliminary budget? Does the NYPD agree that they are not the agency that should be doing a lot of this work, and that somebody else should be doing it, and that we need to invest in that? And third, are there any plans or thoughts around that dispatch problem, which really, really necessitates, I believe, a education for community members who are looking to help their neighbors?

DEPUTY DIRECTOR HANSMAN: I'm going to touch on-- on all three questions, and then I'll hand it to PD to talk about the second one.

I'll say that, you know, I don't have enough information at my fingertips right now to make a determination about whether-- like what the budget should look like. What I will say is we-- we are in from what I understand a budget crisis, and there-- there are going to be adjustments.

And I will note around B-HEARD specifically, because I can talk about the B-HEARD budget, which is one of the budgets that was-- that was cut, and the B-HEARD budget was readjusted based on our expansion, right? So it wasn't-- it was numerically cut in the budget, but it was based on--

COUNCILMEMBER CABÁN: My understanding is that there were like 50 positions that weren't filled. And so that is being touted as a basis for reducing that budget when, again, my argument is that actually we need to be expanding an alternative workforce.

DEPUTY DIRECTOR HANSMAN: Yeah, and we need to we need to fill these lines, and we will fill these lines as we expand to additional areas. So we'll be--

COUNCILMEMBER CABÁN: But we can't tell them because of the PEGs.

DEPUTY DIRECTOR HANSMAN: We still have-- there is still money in the B-HEARD budget to continue to hire, again, both at H&H and at EMS--

COUNCILMEMBER CABÁN: But it's $13 million less than it was last year.

DEPUTY DIRECTOR HANSMAN: Correct. And it's based on the rate of expansion that we see as reasonable and feasible within this fiscal year. So we are going to be expanding into parts of Queens by the end of this fiscal year, and the budget is reflective of that expansion.

So that's what I-- that's what I'll say about the budget. I will also say around-- around B-HEARD, right? B-HEARD is meant to be this alternative response where it is located now. So in Northern Manhattan, South Bronx and parts of Brooklyn, and we are responding to upwards of 20% of the calls-- of the Mental Health calls within our pilot areas within the operational hours, which is higher than many of the other municipalities that are really handling about single digit numbers of their mental health

calls, to include Denver, to include CAHOOTS out in Eugene, Oregon.

COUNCILMEMBER CABÁN: Can I ask a question? You know, when those-- when those cities put out their their evaluation reports every six months or so, and I've read them, they're about 40-45 pages long, I had the opportunity to take a look at B-HEARD's, and it was seven, eight pages long. And so I think there's like a lack of information for us to be able to really, like, reflect on and think about, you know, where are the pain points? What is working, what is not? Where we're getting more input, and can be better partners in the work and strengthening the program. We know we need peers, we know we need-- we know that there are other pain points that aren't being talked about.

And so like, again, I think that there's-- there's so much promise, and I am a big champion of this. But there's a lot of work that could and needs to be done. And it continues to feel like the prioritization is giving the police more and more and more training to respond to a thing, instead of really looking at these-- these other health-first directives.

DEPUTY DIRECTOR HANSMAN: Understood, and I'll pass it to NYPD on the dispatch and the NYPD question.

CHIEF HOLMES: The dispatch, as far as the community, that's a-- so currently right now, and I am working with Communications-- Chief of communications, where we're going to be doing a group training, kind of overhauled communications.

What that plays on the community is completely different. It can address the community with the questions that the 911 operators are trained to ask or inquire of, when someone is placing a call for service.

But with that being said, I think you mentioned about the NYPD responding to these-- look, as a-- as a responsibility, as taking an oath to protect and serve, we respond to incidents where I said, where we're responding because there's a weapon mentioned, or there's some sort of danger associated with it, someone hears someone screaming, things of that nature.

Do I think arbitrarily that's our that's our assignment, and we should be responding? Only if the circumstances present itself where there may be life-

threatening circumstances. Then we have to respond to rule that out. It's what we do as a-- as a police department.

CHIEF TOBIN: And to answer that, I want to say that the NYPD supports alternative responses to people in mental health crisis, to go-- to be handled by the appropriate agency.

CHAIRPERSON LEE: Okay, thank you.

COUNCILMEMBER CABÁN: And I mean, does that support extend to being an advocate to say that we shouldn't be doing this and other people should get more resources to do it, and, you know, and I-- again, to give an example of like, what you answer to: Some things are seen as a dangerous situation by others or by police officers that are not by mental health clinicians. And it could be-- it could be-- you might say, it's a weapon.

To give an example, I spoke to somebody who responded to a call, where the person was experiencing a mental health episode, and they had a bunch of rocks in their pocket. And that might seem like that's dangerous that you can't send somebody in. The mental health responder said, "No, we want to go in first. We're going to convince them to take

all the rocks and drop the rocks out of their pockets. It's what we know how to do. We know how to we know how to approach folks. We're going to sit with them. We're going to do these things." It's a much different approach than a police officer would take, because of the way that you all are-- are trained, right?

Like you are preparing for a different kind of situation. You're preparing for the worst. Whereas these folks are saying, "No, we recognize these behaviors. We're not threatened by them. We're not scared by them. We're the best people to de-escalate here."

CHIEF HOLMES: I would say that was the case years ago. We are trained for pretty much-- hopefully for any situation. De-escalation is a key, key component to our training, where we go and we don't over respond, right? Take time. Necessary time, active listening, take a step back and see what's going on and assess the situation.

We've been trained that since the Academy this didn't this training didn't begin just with this directive. From day one and police academy you have over 40 hours of training throughout every

curriculum, scenario-based training, preparing you hopefully for the best-case scenario or outcome to the worst case scenario. But it's not where we're just trained in one particular way.

COUNCILMEMBER CABÁN: I'm going to pass it over to the Chair, but I will finish by saying, with all due respect with all of the training, this has been the deadliest year for people experiencing mental health issues who have died at the hands of police, and so that is why-- I mean like this is-- that is why I-- I keep going so hard on this because the training is not showing in the results.

CHAIRPERSON LEE: Thank you, Councilmember.

And I know Councilmember Holden, you also had another question you want to ask?

COUNCILMEMBER HOLDEN: Yeah, just one question. You know, this is for the doctor, possibly. But upon-- when a patient is discharged, whether they were involved in, you know, criminal justice arrest or, but they were brought to the hospital for treatment, is there a report that's required by the state or the city to be generated by a physician or the hospital?

And it's called the-- it was called-- I remember talking to somebody, there's a, there's a report that has to be generated. So these, so individuals don't get, you know, like, kind of just put aside, that we are following up.

DR. FATTAL: The only two reports I'm aware of the NICS database and the safety. So the NICS database that we have to-- if someone is admitted involuntarily, we have to submit that data to the state, and the other one that's related to the weapon registry that we have to check. But other than that, I'm not aware of one.

COUNCILMEMBER HOLDEN: Well, I understand that by law -- this is what I was told -- that hospitals have to generate a report that has to be filed. And H&H is doing it. It's required. It's required from all the hospitals, but that the private hospitals aren't doing it, and that's why people are falling through the cracks in the system. So if we could -- and again, it's really, it's a state-- I was told that it's a state law, that they have to generate a report.

DR. FATTAL: I can't answer for other providers outside of H&H. But, I can look more into this and then get back to you.

COUNCILMEMBER HOLDEN: Yeah, if you can get back to me, because that's important aspect. Because we were told that that's-- you know, that's the problem. That's why a lot of people are under the radar who should be actually treated further in the mental health area. Again, they're not-- there's no report. Thank you. Thank you, Chair. I'm sorry.

CHAIRPERSON LEE: Thank you. And then I just had one-- Oh, we've been joined also by Councilmember Gennaro, so I just wanted to recognize him.

And then just one last question for myself also, as well as a comment is: If you could clarify what-- what are the police officers and NYPD being-- NYPD being trained to look for under "cannot meet basic living needs?"

Because I just wanted to be clear, my understanding was that the "cannot meet basic needs" standard is not in the state law. It comes from the state administration's interpretation of case law. So if you could just clarify that, that'd be great. And like, is it-- is it that they're barefoot? Is it

that they're-- you know, what are the what are the more specific details, if you could go into that a little bit?

CHIEF HOLMES: So it's something extreme, right? Someone has open wounds and-- and obviously not capable of seeking medical treatment, based on their behavior, their thoughts, or their speech utterance, ideation.

Or it's 10, below zero, and you have a T shirt on and you're under cardboard box, and you're uttering to yourself. And upon questioning, you're exhibiting some sort of mental health crisis, compounded with the fact that it's 10 below zero outside. Extreme conditions is usually what they're trained for.

I mentioned earlier reeking of urine, that ammonia smell, your clothes and your skin's not-- not clean or rotting flesh, something extreme is what they are-- those examples that they're trained to.

CHAIRPERSON LEE: Thank you. Councilmember Gennaro, did you have any questions? No? Okay.

Thank you. And I just wanted to thank you for being here and for taking the time to answer our questions. I mean, clearly, this is an issue that many, many of us care about. And on a personal

level, myself as well, I have very close family and friends that suffer from severe mental illness, which is why I got into nonprofit and social work to begin with. And, you know, we know that the system is broken, and it goes beyond just the agency sitting here. There's a lot of advocacy we need to do at the state level, insurance coverage of services, which is very key to make sure that our nonprofits are staying afloat is essential as well.

But the silo issue, I think, is something that you've heard over and over again. And if you could just, you know, something I want to make sure that we do is to follow up. Because I do think that there is a lot more data that we need. And this is sort of just an initial hearing where we want to hopefully start ongoing dialogue, conversation, because we need to make sure that the data is being disseminated to the public and that we have information and access to information.

So thank you so much for being here today. And with that, we're going to move on to our public testimony.

DEPUTY DIRECTOR HANSMAN: Thanks so much.

CHAIRPERSON LEE: So I think we're going to just take a quick few-minute break. And in the meantime, if we could get the first panel ready to go. If you want head-- So we're going to call up the first panel. If you guys could get ready first.

I also strongly urge members of the administration to remain for public testimony. I feel like it would be extremely beneficial to hear from the public.

COUNSEL SUCHER: While we're taking the break, I will call up the first panel. It'll be Eric Vassal, Ellen Trawick, Christine Henson, Karim Walker, and Evelyn Graham Nyaasi. This will be a mixed panel so we'll have in-person as well as Zoom.

All right, we will, we will begin. We're now moving to public testimony.

I like to remind everyone that I will call up individuals and panels and all testimony will be limited to three minutes. Due to the large number of people registered to testify, we will be strictly enforcing the three-minute limit. And as a reminder, written testimony may be submitted to the record up to 72 hours after the close of this hearing by emailing it to testimony@council.nyc.gov. The first

three panels will be mixed, meaning they will have in-person as well as Zoom participants.

For our first panel, just to reiterate, we have Karim Walker, Evelyn Graham Nyaasi in person, Eric Vassell on Zoom, Ellen Trawick, on Zoom and Christine Henson on Zoom.

Kareem Walker, you may begin one when ready.

MR. WALKER: Good afternoon, ladies and gentlemen, the council My name is Karim Walker and I'm an Outreach and an Organizing Specialist with the Safety Net Project at the Urban Justice Center.

I want to talk about compassion and dignity. Because these are central to why we are here today. City Hall's call to hospitalize homeless people in voluntarily and allow police officers to use their discretion should give this body and the city writ large pause in how we treat the most vulnerable and dispossessed in our city in our city today. While Mayor Adams has built this as a mental health directive, we all know who the intended targets are: the city's homeless. Over the past year the Mayor has shown a willingness to use as aggressive as a tactic as he possibly can to criminalize homelessness in New York City. And he's shown a willingness to be

a bully when it comes to homeless people, as the street sweeps have indicated, as evidenced with last week's sweep of the Washington Hotel.

These forced hospitalizations would be no different from the streets, and another part of his plan is to police our homeless neighbors, out of sight without properly addressing their material needs.

My city has worked with homeless individuals who have been threatened with hospitalizations such as a military veteran, sleeping in Washington Square Park, who was forcibly removed and hospitalized by outreach, who refuse to believe that he was an accomplished musician and only-- only after they Googled his name did they realize who he was-- recognize who he was. We work with many in Manhattan and Brooklyn who have been threatened with hospitalizations during-- during sweeps as a-- as a means of harassment, and the forced hospitalization of homeless people who may not necessarily have a mental illness, and by police officers who do not have the medical or psychiatric training to handle these, to recognize a messy healthy person from someone who is that could have disastrous

consequences for the city and the individuals in question. We have misgivings regarding the demographics of those who this directive will impact the most. As we know black and Latino New Yorkers make up the overwhelming majority of homeless New Yorkers. And the two groups that throughout this city's history make up the disproportionate majority of interactions with the police, interactions that repeatedly have ended in violence or worse.

This measure fails to guarantee that the homeless will have the dignity and the respect that they deserve and the encounters with the police will be safe and uneventful.

This directive is also a costly direct assault on the New York City Human Rights Law among other statutes, such as the 4th and 14th amendments of the US Constitution, and possibly the Americans with Disabilities Act, as had been argued in ongoing litigation. Our municipal budget is a moral document reflecting what we-- what we prioritize as a city. And by increasing the budget of the NYPD while simultaneously slashing funding to support public and social services, Mayor Adams has shown his cards and where his loyalties lie.

There is no dignity in a man's plan, nor is there a modicum of compassion. The only way a homeless person can get can get those is through stable housing.

Thank you for your time and I'll gladly answer any questions.

CHAIRPERSON LEE: Thank you so much for your testimony. And I love those words, compassion and dignity, so I second that. Thank you.

MS. GRAHAM NYASSI: Thank you Chairperson Lee, Hanks, Narcisse, and Brewer, and New York City Councilmembers for allowing me to speak at this hearing. My name is Evelyn Graham Nyaasi. I am an Advocacy Specialist at Community Access, a Howard and Harvard graduate with peer specialist training, and a Steering Committee Member of Correct Crisis, Intervention Today NYC.

I'm here because I would like you to reject Mayor Adams's directives to expand the use of involuntary hospitalization. I know firsthand what it is like. One time I had eight to nine police officers come to my home because someone said I had a knife. I didn't have a knife, and I didn't argue a fight with them

because I didn't want to be harmed or killed. So I followed their instructions.

As a result, I ended up involuntarily hospitalized at Bellevue, I was placed in a room that had people screaming and yelling, and we were locked up like animals. It was traumatizing, and it still affects me today.

Because I didn't know my rights, I wasn't released until two weeks later. It is because of my personal story that I have learned that power of peers, and I firmly believe that all Mental Health Crisis Response Teams must be led by peers. Peers can make an individual feel safe, because they understand what they're going through, and furthermore, the police presence can be traumatizing. Even uniforms can be traumatizing. Police do not know how to de escalate the situation. And only about 36% of all new police officers have CIT training, and four hours or four days is definitely not enough to change them.

Peers are being used to initiate conversation with individuals experiencing a mental health crisis all over the US. Trust must be developed, and that can only happen with peers who have lived experience.

I know this firsthand. Because this past fall, I went to Portland, Oregon, and visited the Portland Street Response Program, which is supposed to be like B-HEARD, but it incorporates peers.

I'm asking that you please reject the Mayor's proposal, and instead advocate for expansion of peer specialist. Peers are the best people equipped to support these crises, make them feel safe, and ask them if they'd like to go to the hospital, a crisis stabilization center, or crisis respite, which is a much less traumatizing experience than being forced to go to the hospital.

Thank you all for your time. And I'm available for questions.

Before I leave, I like to ask that you not allow Mayor Adams plan to be forcefully hospitalized people with mental challenges. Instead, New York City should use taxpayer dollars to provide more supportive housing and better health care for those who are unsafely housed. Thank you.

CHAIRPERSON LEE: Thank you. And you had a question?

COUNCILMEMBER CABÁN: Yes. Thank you for your testimony. And I just, I just want everybody here to

know who Evelyn is and what she does. She is an incredible peer advocate and a leader who is teaching all of us a lot. I had the privilege of also joining Evelyn in Portland on that field trip. I was there with a number of other Councilmembers from across the country who deeply care about mental health crises, were they are representing, and they brought different staff members.

And can I tell you that that those folks and myself learned just as much from the Portland Street Response Team as we did from Evelyn, because she's a directly impacted person who has been doing this work for a very long time. And so I would just urge the Administration, and other folks who have any ability to strengthen these programs, and change these responses, to talk to people like Evelyn, to talk to people and organizations like CCIT, who are experts in the space. So I want to thank you for the work that that you do. It is deeply, deeply appreciated.

MS. GRAHAM NYASSI: Thank you.

CHAIRPERSON LEE: Thank you, Evelyn, for sharing your story and also the importance of showing us the importance of peer work, as well as lived experience in this work. So thank you.

And next week, we'll have Eric on Zoom.

SERGEANT AT ARMS: Starting time.

MR. KIM: Hi, Mr. Eric Vassell had an emergency here to attend to. So my name is Danny Kim. I'm an organizer with the Justice Committee, which is a member organization of Communities United for Police Reforms, and Mr. Vassal asked me to read his testimony on his behalf.

"My name is Eric Vassell. I'm the father of Saheed Vassell who was killed by the NYPD on April 4 2018. I'm here to oppose Mayor Adams's directive to force hospitalization on people with mental illnesses. This is not a plan. It is giving the NYPD more power to sweep people off the street just because officers think they don't have a place to stay, or have a mental illness.

This is the opposite of what communities need. We need affordable housing and quality mental health care. I know this firsthand because I watched the city's health care system fail my son long before the NYPD killed him.

Saheed first started to struggle with mental illness after his close friend was killed by the police. We could not find programs in our

community that would help him and treat him like a human. Without anywhere else to turn we would call 911. The police and EMS would take him to the hospital but instead of helping, they just gave him a whole lot of pills and locked him down. For Saheed being in the hospital was like being in prison.

NYPD anti crime and SRT officers murdered my son without warning at a busy intersection in broad daylight. My son was unarmed and not a threat to anyone. None of the officers were ever disciplined.

My son's story is not unique. Muhammad Bah's mother was not able to find services for her son, so she called 911. The NYPD showed up and killed him. Kawaski Trawick, Deborah Danner, Imam Morales. There are too many names. Too many community members do not have homes. Too many struggle with mental illness. And with the pandemic it has only gotten worse.

Instead of making a plan to address this mayor Adams is cutting budgets for housing and healthcare and throwing more police at this problem. Police officers don't have the skills

to diagnose or care for people. They only have the skills to criminalize and arrest people.

I'm calling on the New York City Council to stop the Mayor's dangerous forced hospitalization directive, and to invest in housing, community based mental health care and other services for our communities. Thank you.

CHAIRPERSON LEE: Thank you so much. We'll now move to Ellen Trawick. After that we'll have Christine Hanson, and then Oren Barzilay.

Ellen, you may begin when ready.

SERGEANT AT ARMS: Starting time.

MS. TRAWICK: get to know my name is Ellen Trawick, and I am the mother of Kawaski Trawick who was killed by NYPD officer Brandon Thompson and Herbert Davis on April 14, 2019.

I was appalled to learn that Matt Adams has directed the NYPD to sweep people off the street and force them into hospitals just because officers decide that they were mentally ill or homeless.

Sending the NYPD to respond to people who are struggling with mental illness issues has already caused New Yorkers too many lives, including my son.

Mayor Adams directive will only lead to more brutality.

In 2016, Kawaski came to New York to follow his dream. In 2019, the NYPD destroyed those dreams and stole him away from me.

Kawaski lived in a supportive housing facility in the Bronx. He was living there to receive care for his health. Instead the facility called 911 on him.

Officer Brandon Thompson and Herbert Davis showed up, illegally entered his home, barking orders and refused to answer any questions.

Officer Thompson tased him and shot him within 112 seconds. Neither Thompson nor Davis tried to administer any aid. They just closed the door and left him to die.

From Kawaski's story, it's clear New York City Health Care System and the NYPD does not see black people as humans. Both of the officers who killed Kowalski had-- had been to CIT training. One of them within three days of murdering my son.

That shows you police have no business being involved in mental health response. Yet Mayor Adam is giving them more power in this area.

I'm calling on the City Council to stand with me and my family and other family members who have lost their loved ones to the NYPD in opposing Mayor Adam's forced hospitalization. Instead, New York City must focus on making sure that people like my son get the care they need by investing in community-based service and treat them with dignity. I am also asking city councilors to call on Mayor Adams and Commissioner Sewell to ensure Officer Davis and Officer Thompson are fired, and to stand with me at the NYPD trial officer of Officer Davis and Officer Thompson, which will start on April the 24the. I'm sorry. I just want to say thank you you for having me here today. Thank you.

Thank you so much, Ellen, for sharing your story.

COUNSEL SUCHER: We'll now move to Christine Hanson. You may begin when you're ready.

SERGEANT AT ARMS: Starting time.

MS. HENSON: Hi. Hello. Thanks for having me, and allowing me this opportunity to speak. My name is Christine Henson and I'm the mother of Andrew Henson, who is affected by autism and limited speech abilities. When he was 16, he was assaulted by several police officers. Since then, I have been

afraid for Andrew's life. A lot of what I've heard today is making that feeling worse. I'm here to oppose the Mayor's involuntary hospitalization directive and Intro 273. The NYPD should be completely removed from responding to people with mental illness and people affected by autism. In 2018, I had a meeting with the principal. I requested a speech evaluation at Bronx Care. She arranged for it to happen that day, and she had a staff member, the assistant principal corps for EMS to transport us to that location, Bronx Care. Over two and a half dozen officers from two different precincts were present.

When we got out of the ambulance, Andrew told me he wanted to get something to eat. So he took one step, as we had to go get food. Within seconds, the EMT worker put his hand on him and told him you're not going anywhere. And I said we're here voluntarily. And then police officers rushed over and they piled on top of my son. Five officers helped my son's arms behind his back while his neck was choked and twisted. And again my son is affected by limited speech abilities. I saw my son's body go limp while his hands were held behind his back. They

were twisting him as if he wasn't human. He was taken inside into the waiting area, where his face was placed down on a seat and his knees were pressed down on the ground. He was forced in a position. My voice was ignored when I say he has special needs. My son needed care, voluntary care. Instead, my son was forced and criminalized and mistreated and violated. When we should have received something to receive assistance for him, he was traumatized.

So he's re-traumatized now, because he's been recently affected by police officers again. Since 2018, he regressed. I now have to buy my son diapers. That excessive force that he experienced has altered his life. I live my life moreso now than ever fearing for his safety, because he's a young male of color, and he's someone that was affected by a violent type of assault by police officers. He didn't deserve that.

There is no amount of training that will prepare NYPD officers to respond to people like my son with autism or people with other disabilities and mental illness. The purpose of NYPD is to arrest and criminalize people, not to care for them. Intro 273 may be good intention, but it will only teach--

SERGEANT AT ARMS: Time Expired.

CHAIRPERSON LEE: Oh. Go ahead and finish. Sorry.

MS. HENSON: Please. If we keep sending armed officers to help people in distress or people with limited speech over disabilities, we will keep getting violence and deaths, and Intro 273 must be opposed. We need to completely remove NYPD from responding to those who are struggling with mental illness or disabilities. We need to keep them safe. We need to get police out of schools. We need to have them respected. They are human too. They just need a different type of love and care.

Please, I thank you for this opportunity. I just would like to see my son live a very long time without being mistreated ever again. He cries when he sees police officers, and he shakes. I've never seen that in anyone.

Please, I'm asking with respect to save his life and his safety. We shouldn't have to live in fear. Every day of his life, I live in fear. And he doesn't deserve that. He just deserves to live. Thank you so much. Thank you for this opportunity. Thank you so much. Thank you.

CHAIRPERSON LEE: Thank you, Christine.

COUNCEL SUCHER: Next, we'll hear from Oren Barzilay. You may begin when ready.

SERGEANT AT ARMS: Starting time.

MR. BARZILAY: Good morning, Committee Chairperson and honorable Councilmembers. My name is Oren Barzilay. I'm a 25-year veteran of the FDNY EMS, and I'm president of Local 2507. I am here today to spotlight a very considerable issue for our city EMTs and paramedics, who despite their pivotal role in serving and protecting New Yorkers, fear Mayor Adams policy to forcibly take people believed to have mental illness to hospitals against their will has increased in already significant number of assaults on our members.

Over the past two years there have been over 200 reported assaults on active EMS workers. From where I am, I can tell you that it is more than that. EMT assaults are at an all time high, doubling in the last year, and many hundreds of members are not even reporting them. Why bother due to the lack of any action at all by both the department and the City?

When we arrive at the scene of an emergency, we don't carry guns like NYPD has. We don't have access

like our counterparts, firefighters brethren. We roll up to the scene of an emergency with a doctor's back to provide medical care. The Mayor's policy doesn't change things. We need significantly more funding and getting trained people into the system. The policy does not consider the severe staffing shortages among our workforce and the lack of training handling these matters.

FDNY EMS call volume have doubled in recent years yet headcount has remained the same or dropped. It's placing an additional burden on the EMS system.

My members are unarmed and get routinely assaulted as it stands now. We know that forcing people with mental health issues to unwillingly comply with the policy can place EMTs in harm's way. My worry is that this policy is exacerbating the danger our members are faced with on a daily basis. The City is not doing much about the assaults on our members as is. If you're faced with such high chance of getting assaulted in your workplace, it's an employer's responsibility to keep the workforce safe. That protection of our members is absolutely not happening right now. EMS is being totally and completely starved of necessary resources to allow us

to work safe and protect the city's citizens at the same time. Where are we going to put all these patients that need mental health? The state closed down state psychiatric centers like Creekmore in Queens, which can has thousands. EMS is so beyond short staffed that you would think that our call volume reaching 5000 calls a day, that the department would take steps to increase resources.

Instead, we are tasked with more responsibility that only put EMTs in more dangerous.

SERGEANT AT ARMS: Time expired. You're asking people who are making $17 to $18 an hour to put their life on the line. We must not forget the lives of EMTs and paramedics lost while on duty by the people we work to serve and assist. The policy may be well intentioned, but our city's leaders have to recognize that these new responsibilities add more strain on our severely understaffed, overworked, and underpaid workers.

The dedicated women and men of EMS and the citizens we are sworn to protect deserve better than we have been subjected to. Thank you all for your time and consideration.

CHAIRPERSON LEE: Thank you so much. We'll move on to the next panel. And for those family members that are still on and listening, thank you so much for waiting, and for sharing stories of your family members. I know it must be painful, so I just wanted to say thank you.

COUNSEL SUCHER: We'll now move on to our second panel which will also be mixed between in-person and Zoom. For in-person we'll have Beth Haroules from NYCLU, Elena Landriscina from Legal Aid Society, and Siya Hegde from Bronx Defenders. On Zoom, we'll have Selena Trowell from Communities For Police Reform, and then Anthony Feliciano. Selena, you will be the first to testify on this panel, so you may begin when ready.

MS. TROWELL: Good afternoon. My name is Selena Trowel, and I'm testifying on behalf of Vocal New York Homeless Union who was a member of Communities United For Police Reform. My role at Vocal New York is that of the Homelessness Union organizer, where I do street outreach and engage and build collective power among those who are actively and formerly homeless through membership. In addiction to my role as an organizer, I'm also a licensed social worker

and a lifelong resident of District 41 Brownsville Brooklyn, where the rate of adult psychiatric hospitalization is nearly triple the citywide rate.

The Administration has yet to provide the public with a plan of transparency and accountability, and also provide proof that we are not wasting our time reinventing the broken wheel of the 80s. For decades to treatment-first approach has failed hundreds of New Yorkers, and today will continue to perpetuate the cycle of involuntary confinements, short-term treatments, and discarding of human beings right back to the streets because the city has refused to prioritize utilization of available housing stock as a public health approaches housing and mental health crisis. A study done in 2019 showed that housing, when connected with supportive services, specifically for those with severe mental health complexities was extremely cost effective.

Once you question if we have an administration that has identified 2000 empty supportive housing units with thousands of people on the streets, why did the city opt to only cherry pick at individuals for a copycat pilot program. In 2020, 26 studies in the United States and Canada compared treatment-first

versus housing-first models. It found that housing-first programs decreased homelessness by 88%, and improve housing stability by 41%. And for those who are immunocompromised health, it reduce homelessness by 37%, viral loads of 22%, depression of 13%, emergency department used by 41%, hospitalizations by 36%, with the mortality rate by 37%.

Coercive mental health treatment is a form of carceral institutionalization that further exacerbates the health and trauma of those on the street. The answer, according to decades of research has and will always be housing. Why do we continue to ignore decades of evidence-based empirical data that tells us housing is in fact mental, physical, and emotional health care? The Mayor's directive is antithetical to providing a solid infrastructure of trust, housing, services, and community support. New Yorkers need a public-health-based approach that is addressing mental health and homelessness that puts public health workers and peers at the forefront of engagement and expands voluntary mental health care services and supports.

The trauma of police guns, garbage trucks, and involuntary removals, are being toted under the

pretense of care and compassion and housing. It is deeply concerning to see police be used to fill the gaps in the public health sector where there while there are simultaneous cuts of expert critical infrastructure.

SERGEANT AT ARMS: Time expired.

MS. TROWELL: One more minute please, for the Department of Mental health and Hygiene, the Department of Social Services, the Department of DHS, and Department of Housing and Community Development. We are calling on the Mayor and this administration to end all considerations and implementation of this harmful and socially irresponsible directive, and to invest in housing and care that is decarcerated, trauma-informed, and evidence-based.

Also in acknowledging Black History Month, I am also testifying in honor of the life and legacy of Joyce Billie Boggs Brown, with a history of street homelessness, drug use, and mental health complexities, Ms. Brown, a black woman who in 1987, would single handedly seek out legal teams and successfully petition that then Mayor Ed Koch in the city for her release from a psychiatric facility after being swept off the street and involuntarily

admitted under the failed program of Project Health. After becoming stable and housed, she would travel to the likes of Harvard and Yale University to lecture about how to fight for self agency and housing in New York City. Thank you for your time.

CHAIRPERSON LEE: Thank you.

COUNSEL SUCHER: We'll now move to our three in-person panelists, and then Anthony Feliciano, you will go after these three individuals testify. So first, we'll hear from Beth Haroules. You may begin when ready.

MS. HAROULES: Thank you for holding these oversight hearings. They are well delayed. This process has been rolled out in November, and we didn't hear anything today that provided us with any information about what exactly is going on, when Mayor Adams has directed the mental hygiene arrests of potentially hundreds of thousands of New Yorkers who are unhoused and dealing with mental health issues.

Our written comments address the variety of resources that are being diverted here into a failed strategy of involuntary psychiatric hospitalizations and forced treatment. We do an analysis of how this

policy in fact allows removals that are not justified under the state or federal constitution, or the rest of the complex web of laws and guidance that govern in this field. We just heard about Joyce Brown Billie Boggs. Miss Brown was a client of the New York Civil Liberties Union in connection with her struggle for self-determination. And today to see OMH and the city perverting that case law that looked to a very extreme set of circumstances that justified involuntary retention. She was never swept off the streets in the way that this policy contemplates.

Certainly the policy reflects and exacerbates bias. Everything that we have heard from the Mayor, the Administration, and from the partnership of the Governor perpetuates bias and stigma and draws a direct line between a person who is unhoused and suffering with suffering, experiencing mental health challenges and violence that is just about to be triggered against the public. People with mental illness, people who are unhoused, are more likely than anyone else to be themselves the subject of violence and trauma.

We didn't hear and we know the council is very interested in making sure there's appropriate

collection of data, transparency, and accountability. Here our testimony provides you with a number of categories.

We did not hear an answer to the question of how many New Yorkers have in fact been brought in for evaluation under a mental hygiene arrest by law enforcement under this policy. We also didn't hear how many people who had been brought in on a mental hygiene arrest basis were in fact admitted. A person who was brought in for observation has no right to counsel, Mental Hygiene Legal Services does not represent those folks when they are in a psych setting until they have been admitted, until status has been conferred. There are no discharge planning provisions that will attach to a person who's brought in for observation and released in that 72-hour period. We didn't hear any of that today. We didn't hear any plans. We didn't hear any details. We heard absolutely nothing other than the information that has been released by press release and very selectively by discharge of particular information to the New York Post.

To hear that the telehealth backup support went live last week is just astonishing. We don't know

who, what clinical lines are staffing that supportive backup. What we heard today, though, is very concerning. It's NYPD all the time out on the street under failed crisis intervention training, and a video that they watched at the start of their shifts.

That is unacceptable. It is immoral. It is unconstitutional.

Thank you for having this hearing today. We look forward to working with the Council. We did submit comments on the two incidents before you. I share the concerns of the family member who testified with respect to attempting to train the NYPD to respond to people with autism. It leaves them completely unprotected. I'm Willowbrook class counsel at the NYCLU. There are numbers of people with developmental disabilities who are not protected by that particular end. And there are numbers of people with disabilities who are not protected by that and you can talk to your NYPD and mandate them to behave towards people with dignity and humanity. They should never be interacting with anyone's disabilities. Thank you.

CHAIRPERSON LEE: Thank you so much. And we definitely have shared interest in receiving a lot of

that data and pressing them on that. So that's something that we're going to follow up with as well. So thank you.

Hello. The Bronx Defenders thanks the council's joint leadership for holding this very important oversight hearing.

My name is Siya Hegde, and while I testify today in my capacity as Housing Policy Counsel to the Bronx Defenders civil action practice, my testimony really does encompass a holistic defender perspective to highlight our collective concerns around this directive and its far-reaching consequences on the communities that we serve in the Bronx.

So as holistic defenders we are positioned to defend against structural systemic failures of directives like this that trigger our clients family separation, threats of eviction and displacement from homes, lack of access to essential support services, and violation of their civil liberties. Black and Latino identifying people of color in the Bronx have suffered decades of over-policing, surveillance, and other racially discriminatory violent practices by law enforcement agents that are completely inexcusable.

Rather than committing to addressing the unmet needs of New Yorkers who are unhoused or at risk of being unhoused. This directive sets a dangerous precedent for public safety, while reinforcing such historic discriminatory measures.

So since it took effect, there are two anecdotes, two stories that I'd like to uplift our client Mr. A, a queer identifying black man with serious mental health conditions was sent to a psychiatric emergency room against his will. This all took place during a verbal dispute with a family member who alleged that Mr. A was refusing his medications without any display of violent behavior exhibited on his part, and a licensed social worker from our office who advocated on his behalf to law enforcement agents and EMS staff. He was eventually deemed ineligible for admittance by hospital personnel, with the treating psychologist describing his situation as unjust.

As additional context here, Mr. A is fighting an eviction case And of grave concern the Mayor's directive, as we see, was abused as a means of circumventing court process to displace him from his home.

Similarly, another client Miss P, a black woman with underlying mental health conditions, who was a victim in an alleged domestic incident was forcibly grabbed and pinned to her bed by police officers who handcuffed her violently, and she was injected with what appeared to be a sedative by EMT personnel. As she allegedly resisted arrest and verbally expressed her desire for treatment and therapy, she eventually charged with assaulting an officer and an EMT personnel and taken against her will to a hospital.

Though she is no longer admitted to that hospital at present police intervention led to her criminal prosecution and her children being removed from her care and custody by ACS.

As these stories demonstrate the critical dangers of forced institutionalization do not make communities safer. Instead, as we've heard, they mimic the deleterious harms of carceral punishment when law enforcement agents are given untethered deference to make clinical diagnoses and presume an individual's threats to public safety in the absence of medical recommendations.

Therefore, the Bronx defenders urges the Council to rollback this initiative and instead invest in

community mental health services and housing investments that directly to the needs of this vulnerable group and offer voluntary support without entangling people in more harmful systems.

We expressly asked the council to permanently fund programs like the MOCJ emergency reentry hotels, emergency housing that provides barrier free holistic support and social services, including humane compassionate medical care, and offer residents access to vocational and educational opportunities and pathways to permanent housing.

Thank you so much again, for the opportunity to testify. We do intend to submit written comments and we very much appreciate your thoughts and considerations. Thank you.

CHAIRPERSON LEE: Thank you so much, Siya.

MS. LANDRISCINA: Thank you. We applaud the Committees for their oversight over this important issue. Mayor Adams would have us believe that individual bad choices have caused people with mental illness to be unable to care for their basic needs. He has said for example, that people who urgently need treatment quote, "refuse it when offered." This type of rhetoric obscures how the government is

furthering discrimination and racial injustice. The city is responsible for providing a comprehensive system of community-based care for people with disabilities. Under federal disability rights law, the city is required to administer this system in a manner that enables people with disabilities to be accommodated in the most integrated setting appropriate to their needs. This law recognizes that unnecessary institutionalization is discrimination.

Most people with mental illness can be served in the community. What that looks like is people living in safe integrated housing where they can be decision makers and maintain their relationships. It looks like people having individualized support to help them navigate systems and obtain care. In the words of a legal aid client, housing keeps the body and soul together. Our client lived in a shelter for 14 months. He was also involuntarily committed for an entire summer which he described as traumatizing. By contrast, housing offers stability.

Our practices represent many people who are not in housing. The Mayor's Office estimates that approximately 40% of the shelter population has mental illness. The state estimates that 4000

individuals with mental illness live on the streets. The city is effectively doubling down on this crisis. Rather than provide services in integrated settings, the city's directive shunts people into hospitals. Our clients experienced the consequences of the city's failure to develop an effective system every day. They rotate through a revolving door of institutions, jails, shelters, hospitals, rarely receiving the treatment and services and housing that they need. The city lacks adequate outpatient services, residential treatment programs, housing and supportive services, and these deficiencies have a devastating impact. First, people with mental illness spend longer periods in jail, because DAs and judges refuse or reject proposed release plans until housing is secured. Our attorneys move mountains to find scarce housing to free our clients from abysmal jail conditions.

In other cases our clients are discharged to shelters that are unsafe, and there they languish as their applications for housing and services are slowly processed in an overly bureaucratic system.

The mayor's proposal to further cut social services will exacerbate these problems. The city

must ensure that voluntary services are available and accessible. It should maximize the state's proposed investments in mental health to provide adequate care. Without such efforts the city effectively condemns our clients to a vicious cycle of institutionalization and the involuntary removals policy does nothing to break the cycle. It keeps it spinning instead. Thank you.

CHAIRPERSON LEE: Thank you so much.

COUNSEL We'll now turn to Anthony Feliciano on Zoom, you may begin when ready.

SERGEANT AT ARMS: Starting time.

MR. FELICIANO: Thank you for the opportunity to testify. My name is Anthony Feliciano. I am the Vice President for Community Mobilization at Housing Works. Housing Works urges the Council to exercise its oversight authority to reject the Mayor's Adams proposal to scale up involuntary law enforcement driven responses to New Yorkers with unmet mental health needs, who struggle to survive on our streets and subways.

This directive erodes the confidentiality of the medical information. While coercive mental health treatment has not proven to have better outcomes than

voluntary. It is disproportionately applied to black, Latinx, immigrants, LGBTQI people and other communities of color while often over-diagnosed and underserved. It skips over the issue that was seriously underfunded public health mental health system, an almost completely lack of safe and appropriate housing placements for people with Serious Mental Illness. The NYPD has a track record, as we all know, of being violent and deadly when responding to people experiencing, or perceiving to be experiencing a mental health crisis, and abusing New Yorkers experiencing homelessness. At Housing Works, we know from regular experience how difficult or impossible it is to access for Serious Mental Illness. We are unable to access desperately needed mental health even for residents of our supported housing programs. Indeed, a significant challenge facing Housing Works and other supporting housing providers are in the unmet needs of residents who experience significant mental health crisis, often combined with substance abuse disorder.

We offer 700 units of supportive housing for the most vulnerable New Yorkers, including many residents, people dealing with co-occurring mental

health and substance abuse issues. While the overall majority of residents manage these and other issues to behavioral health care provided by Housing Works and other community based providers, not infrequently will a resident experience a crisis that will necessitate transfer by an EMS to the hospital, and invariably these residents are released within a few hours with no outpatient treatment plan.

In one extreme case last week, Housing Works called emergency services four times over the course of three days up for a resident experiencing psychotic episodes. Each time he was released back to us without any intervention, to the frustration to all. Supportive housing is a compassionate and effective intervention, but while access to inpatient and outpatient mental health and substance abuse use disorder treatment, untreated residents pose great issues and concerns for all of us.

One of our asks here is the Mayor must make a major aim of transparency about how a voluntary removal directive be implemented, and the impact on communities and neighborhoods. The Mayor's office should make public the details of how many more New Yorkers are being involuntary detained, on what

grounds, how long they're being kept in the hospital, and what kind of care support they receive during and at discharge. We also call on the Council to demand decisive action to promote the housing and services required to meet the need of many shelter and unsheltered people.

COUNSEL SUCHER: Time has has expired.

MR. FELICIANO: And finally, I think we need a lot in terms of stabilization also. We heard about the MOCJs, but also want for us to understand the State and the City's connection here when they asked for more psychiatric beds.

We need to know where those beds are going. We need to have community input and community-driven initiatives that are around mental health. And right now, what this directive does is it again harms the most vulnerable communities in New York. Thank you.

CHAIRPERSON LEE: Thank you, Anthony. Good to see you. And Councilmember Brewer had a couple questions, I think?

COUNCILMEMBER BREWER: Thank you. Just for any of the panelists here, and thank you all for your service. The-- I mean, when I talk to the community mental health providers, they just don't have the

staff, they can't retain staff, et cetera. So I'm just wondering if that is what you are experiencing in terms of trying to find locations for endless support and ongoing support for your-- for the people you're representing.

MS. HAROULES: I mean, certainly, we are experiencing a massive staffing shortage. But staff who work in these particular community-based programs, including programs for people with limited English proficiency, are not recognized in terms of worth and value, which goes to why there is a workforce retention issue.

This is a very difficult job, for a person to provide hands on compassionate services to people with disabilities, and they're not recognized. And you know, we see you know, the funders, government sheltering behind the pandemic. This was an issue that existed before the pandemic. The pandemic obviously has made it worse. What we're seeing here is a diversion of resources into a policing model as opposed into service supports, including housing supports. We really urge the council during the budget hearings to focus on that. We do not need more policing resources.

COUNCILMEMBER BREWER: I understand that. I'm-- I'm very specific oriented after--

MS. HAROULES: Yeah. Workforce.

COUNCILMEMBER BREWER: Okay. Anything from the Bronx?

MS. HEGDE: I'll echo the sentiment that yes, we are in a severe staffing shortage. And I'm not saying that just from the angle of support services on the ground that are operating in connection to courts. But you know, in our office, we do have a fairly large staff, one of the largest one largest public defender offices in the country, really. And to think that our staffing operation of social workers who are so critical, so-- so-- I mean, the example that I gave. It's like if that social worker was not on the line with NYPD, even despite her incredible skill set and holistic assessment of what the situation was, you know, I really fear for what folks on the ground who are-- were the most vulnerable, have to risk here in terms of advocates who are looking out for them.

And I think that's something that we've seen from a funding angle from the angle of, you know, legal service, holistic providers and care, and to think

that there are ways that this directive could harm court process and you know, to use to circumvent court process that we see in housing eviction proceedings, where the numbers in the Bronx are absolutely so voluminous as is, is a real, real concern. So something that we need to keep mindful of with staffing.

MS. LANDRISCINA: And I'll just say I agree. I mean, we hear about staffing, and that really goes to how the entire system is not adequately funded, so that people in the workforce are being recognized and valued.

COUNCILMEMBER BREWER: Thank you.

CHAIRPERSON LEE: Thank you so much. And as someone who came from a language-culturally-specific nonprofit organization, I can tell you that it is extremely difficult to find social workers and workforce as is. But then especially on top of that, if you add the language component, it's even much more difficult. And it took-- and on the other side of the spectrum, you know, it took four years for me to start up our outpatient mental health clinic because it-- we saw so many rates of suicide going up in our community, which is why we felt the need to

create a clinic from the community itself that they trust and that they know, which I think is very important, but the licensing piece is extremely difficult. So that's a separate issue that we could spend a whole day on.

But I'm-- just to emphasize that I think that's something that we need to advocate for on this-- on the state level as well.

COUNSEL SUCHER: Thank you so much. This panel will now be moving to our next one, which will also be a mix of in person and Zoom. For in person, Joshua Stanton. And then on Zoom, please be prepared to testify following Mr. Stanton, it'll be Greg Hughes from Mobilization For Justice. Antonine Pierre from Brooklyn Movement Center, Toni Smith from Drug Policy Alliance, and Danielle Regis from Brooklyn Defender Services. Mr. Stanton, when you're ready, you may begin.

RABBI STANTON: Good afternoon and thank you so much to the Committee Chairs and Councilmembers. I'm Rabbi Joshua Stanton speaking on behalf of Tirdof: New York Jewish Clergy for Justice, which is a joint program of T'ruah: The Rabbinic Call for Human Rights, and Jews for Racial and Economic Justice, the

latter of which is a member of Communities United for Police Reform.

I'm testifying today to express my deep concern about Mayor Adams's involuntary removal directive. Throughout the centuries and indeed the millennia. Jewish tradition has both acknowledged mental health as a human need, and has urged us to assist those struggling to find treatment and solace not in isolation, but in a communal context.

Removing individuals in psychiatric distress, who are not a danger to themselves or others from their neighborhoods or public spaces further isolates and stigmatizes these New Yorkers, and denies them the community contact that they need in order to thrive. Well, I agree with Mayor Adams that we must find solutions to the crisis facing unhoused New Yorkers suffering from mental illness, but instead of investing in genuine care and compassion, the Mayor's directive proposes additional police encounters, which hold the potential to become violent. Giving the NYPD significantly more scope and authority to detain people is playing fast and loose with the legal rights of New Yorkers, especially given the NYPDs troubling track record with individuals

experiencing or perceived to be experiencing a mental health crisis.

Just to give you a sense of how far back this goes, Jewish tradition urges us to care for our neighbors, especially when they are in trouble, and in fact, irrespective of cost for at least half a millennia. We learned from the 16th century text known as the Shahanarol[ph], that if you see your neighbor is in trouble, you are obligated to save them or hire others to save them. You are obligated to trouble yourself and to hire others to save them. You may not shirk of your duty because of this, and you must save them at your own expense, even if they are not able to pay. If you refuse to do so you're guilty of transgressing the negative command, "do not stand idly by while your neighbor's blood is shed."

I know the members of this committee-- these committees rather, and that the entire City Council does not want to be associated with those who stand idly by while-- while our neighbor's blood is shed, and indeed, while our neighbors are in deep distress.

So I urge the council to reject the Mayor's directive, and instead invest in genuine care and compassion, which means housing, mental health

services, and social supports. Unless the city of New York adequately invests in the long-term health and well being of New Yorkers and affordable housing, and mental health crisis will continue. May add a personal word in under 30 seconds? Thank you so much.

So as a matter of Jewish law and tradition, in fact, homelessness is against Jewish law, but not for the person who is facing homelessness. It's actually against the law for society. It is against the law for all of us. And it goes against all kinds of social mores In Jewish tradition that have been around for at least two millennia that we allow homelessness to exist, and the fact that we are further blaming people who perhaps as a result of homelessness, or perhaps not are facing mental illness, the fact that we are penalizing them, and might be putting them in dangerous situations is unconscionable. Thank you so much.

CHAIRPERSON LEE: Thank you, Rabbi.

COUNSEL SUCHER: Next, we'll go to Craig Hughes. After Craig will have Antonine Pierre, Tony Smith, and Danielle Regis. Craig, you may begin when ready. Time has begun.

SERGEANT AT ARMS: Time has begun.

MR. HUGHES: Hi. Thank you Chairs for holding this hearing today. My name is Craig Hughes and I'm a Social Worker at the Bronx office of Mobilization For Justice. I've worked with homeless individuals with Serious Mental Illness in New York City for more than 15 years, and I can't urge the Council any more strongly to push back on the involuntary removal initiative.

We can't accept the Administration's framing here. It needs to be placed in context of more than a year's worth of efforts to remove homeless people from sight, often using absurd spins on words like dignity and compassion. To be clear, nothing about the Mayor's multiple sweep initiative is dignified or compassionate. Rather, they're being deployed to legitimize the broken windows policing approach of this administration, which guides the Administration's engagements with homeless people.

Homeless people have long been the target of broken-windows policies and practices, which take at their core the baseless argument that of homeless people were conceived, of as signs of disorder, a word which the Mayor often uses are removed from

site, somehow crime will magically disappear. What this has meant for decades is the criminalization of homelessness and poverty and the sustained harassment of homeless people, which has overwhelmingly harmed black and brown people in New York City. A basic timeline of those broken-windows efforts targeting homeless people under the Adams administration would include the January 6th announcement of an omnipresence of police in the subways, the January 24 blueprints on gun violence that announced plans to lean heavily on coercive practices towards homeless people with mental illness, the February 28 subway safety plan which was a mass sweep initiative, the March 25th above ground encampments initiative, which was another mass sweep initiative, and the November 29th announcement of involuntary removal.

For many individuals with Serious Mental Illness this has meant being pushed out of sight and being criminalized while cycling in and out of hospital and jails, often for quality of life crimes, rather than getting support that actually helps.

In our testimony would go into this in detail and give a series of recommendations. I'll highlight one major area that isn't being discussed much today,

though it was briefly discussed in the Committee's report for this hearing, which is that of supportive housing.

The supportive housing system is marketed as the panacea for unsheltered homelessness and housing for those with Serious Mental Illness. The reality is far different. As a result of organizing by SHOUT (Supportive Housing Organized United Tenants) in 2021, the council passed what became Local Law 3 of 2022, mandating a report on who does or doesn't get into supportive housing. The data show that supportive housing providers reject people from housing for any reason they want, and those reasons are facilitated by the Department of Social Services. Often the Department of Health and Mental Hygiene is also aware, as is the state OMH office.

This is called creaming, which is actually which is actually often what amounts to disability discrimination, and it makes it almost impossible for people on the street with Serious Mental Illness to exit homelessness and enter housing. In other words, those who will be targeted by the Mayor's involuntary removal initiative, also find themselves unable to access supportive housing.

SERGEANT AT ARMS: Time has expired.

MR. HUGHES: If I can just take one more minute. In other words, those who will be targeted by the Mayor's removal initiative also find themselves unable to access supportive housing. The main resource market is to support them.

Instead of reforming the front door of supportive housing, the Administration has opted to police homeless people out of sight. As of last fall, there were some 2600 empty supportive housing units. We strongly urge the City Council to press the Administration on this. For tenants in supportive housing, there is an eviction crisis. Sometimes this looks like an informal evictions. Often it looks like formal eviction evictions instead of providing the support to help people stay housed.

Of note neither the city nor the state track evictions from supportive housing. Officials do, however, often meet with industry lobbyists who have opposed reform efforts. Our other recommendations include pushing back at every turn on the broken-windows theory that added that Mayor Adams is pushing forward, ending sweeps, providing outreach teams and clinicians with actual support and resources.

And just one final note for the Committee. You know, there's been a pattern under this administration when asked for data that might be sensitive to come to the Council and say, well, we don't have a lot to get back to you. And it's a pattern across committees and across officials.

And I will say that there's a difference between not having something, and deliberately being unprepared with something. And the Administration has decided, as what appears as to be policy that they will try to avoid this with the Council, giving the Council data that the public desperately needs to know and is needed to hold them accountable. Just a reminder that the council does have subpoena power, and the council's can subpoena the Administration for the data they are being-- they're refusing to give that is desperately needed to inform the public's knowledge and assessment of policies like the violent involuntary removal policy that we need to be able to really comment on with the information that they as they said themselves they are tracking. So thank you. I apologize for going a little bit over.

CHAIRPERSON LEE: Thank you so much, Craig and for the work that you do. And next we will go to...?

COUNSEL SUCHER: Antonine Pierre, you may be you being begin when ready.

SERGEANT AT ARMS: Time has begun.

Hi. Just thank you to the Chairs and thank you for your coordinated effort to hold this joint hearing on a really important topic.

MS. PIERRE: My name is Antonine Pierre and I work with the Brooklyn Movement Center, which is a black-led group that organizes in Bed-Stuy and Crown Heights. The BMC builds power so that black central Brooklynites are able to play an active role in shaping the decisions and institutions that impact our daily lives.

Nearly three years into a global pandemic, we have to face the truth of our city's mental health crisis, not punish people for not being able to meet their quote/unquote "basic living needs." We're all suffering from long-term untreated trauma, and managing conditions like anxiety, depression and PTSD on a daily basis. The changes that were made to all of our lives in lockdown, mass unemployment, and the harsh economic conditions black, indigenous and other people of color have experienced during the COVID-19 crisis have harmed all of our mental health.

While the Mayor would like us to believe that the people being removed from the street are served by being ushered through the revolving door of the city's broken mental health system by NYPD officers, we should remember there are actual people with actual family members like us who care for them when they're not well.

If you've ever cared for family and friends with mental health conditions are in crisis, you know that a police officers presence can turn an already stressed out person into an agitated and panicked one. Responding to crisis often looks like pleading with someone to go back in the house, to please take their medication, or to go to sleep after days of being awake.

We are not going to train cops out of being cops. The tragic murder of Saheed Vassell in Crown Heights by the NYPD on April 4, 2018, tells a story of a broken system that is more likely to inflict harm than care for black, indigenous, and other people of color suffering from chronic mental health issues. While we support the development of Community Mental Health Guide and Portal, this community support is

undermined by retraining police officers who are just in the wrong agency to do this work.

This resource would be better allocated to more widespread community training that can help create a culture of care around mental health. This plan from the Mayor is an attack on black mental health at a time when we need to be rebuilding community health infrastructure. We deserve a new vision for supporting New Yorkers through crisis that honors our dignity and moves people in need from the streets into stability. Mayor Adams Giuliani-era policies will only give the same results we've already gotten: Long-term psychiatric incarceration with no pathway to wellness. A generation of black families in central Brooklyn has already been torn apart by the City's involuntary hospitalization policies in the 80s and 90s that locked up our loved ones under the guise of quote/unquote "treatment". An appropriate mental health response should take into account more than the acute symptoms of the city's mental health crisis. It should help secure housing employment, use development program and comprehensive mental health care for New Yorkers.

SERGEANT AT ARMS: Time has expired.

MS. PIERRE: Getting this right looks like safety and care, not thinly veiled incarceration and fear. Thank you.

CHAIRPERSON LEE: Thank you so much.

COUNSEL SUCHER: We'll now move to Toni Smith. And after Tony Smith will have Daniel Regis. Toni Smith, you may begin when ready.

SERGEANT AT ARMS: Time has begun.

MS. SMITH: Thank you. Good afternoon. My name is Toni Smith. I'm the New York State Director for the Drug Policy Alliance, also a member of Communities United for Police Reform. Thank you to the joint committees of the Council for holding this very important hearing. The Drug Policy Alliance is the leading organization in the United States promoting alternatives to the war on drugs and we oppose the Mayor's directive. It will be harmful to people struggling with substance use who are likely to get swept up in the enforcement of this directive by continuing policies that punish people for substance use, perpetuate stigma, and ignore evidence-based care. This directive goes far beyond anything related to mental health, mobilizes the NYPD to sweep up essentially anyone who is experiencing

homelessness. As we know that NYPD has a terrible record of responding to people experiencing or perceived to be experiencing a mental health crisis, Routinely abuses homeless New Yorkers primarily inflicting harm on our black and brown New Yorkers our folks. The mayor's directive attempts to simplify the problem as people not being able to identify that they need support.

In fact, our voluntary care systems are significantly limited on the basis of cost, cultural competency, capacity, insurance, causing many people who are voluntarily seeking care to be shut out. This is particularly true for people with co-occurring health needs, including substance use disorder. We need more low barrier, person-centered, voluntary care options, and more supportive housing. Forced treatment is criminalization by another name, and like criminalization, it is not effective to address root causes of instability and unwellness.

Inadequate funding for education, housing, health and other social services create the conditions that destabilize people's lives and contribute to health issues, intensifying the services people then require to achieve health and stability.

For the many people who will be swept up through this directive who have a substance use disorder, being forcibly hospitalized can lead to painful and sometimes life-threatening withdrawal symptoms and place them at an increased risk of overdose death.

This directive tries to mask the function of police. Police are the frontline of criminalization, not public health, and the disruption and trauma people experience at the hands of the NYPD only creates more of the instability and health challenges that the Mayor claims to be addressing.

So thank you. We're calling on the City Council to prioritize funding for actual public health solutions and oppose this directive. And we'll provide more in our written comments.

CHAIRPERSON LEE: Thank you so much, Toni.

COUNSEL SUCHER: Daniel Regis, you may begin when ready.

SERGEANT AT ARMS: Time has begun.

MS. REGISTRATION: Good afternoon. My name is Danielle Regis and I am a Supervising Attorney in the Mental Health Representation Team of the Criminal Defense Practice at Brooklyn Defender Services. I've represented people in the Brooklyn mental health

court for the past five years. Thank you for this opportunity to testify.

BDS is gravely concerned about the Mayor's plan to expand the use of forced hospitalizations of people who are experiencing housing instability and may be living with mental illness. The dragnet plan will most likely result in numerous unnecessary police encounters that have the potential to risk the safety of those individuals. Even for those who may need treatment, involuntary removals are inherently traumatic. People are torn from their homes, communities and support systems. For the people experiencing homelessness, their belongings are often thrown away. This forcible often violent removal creates a traumatic association with the hospital, a place that should be associated with access to treatment and care, not as a punishment. Instances of armed police instead of EMTs or Mental health professionals responding to someone experiencing a mental health crisis too often end in arrest, abuse, or even death. Often, people who we represent are charged with resisting arrest and assaulting a police officer when they decline transportation to a hospital. They are then arrested and charged with a

violent felony offense, a bail-eligible offense, often resulting in sending more people with mental illness to jails, where they have limited, if any, access to mental health treatment.

Instead of relying on failed practices that channel people in crisis into course of treatment or the criminal legal system, the city must invest in services and housing. New Yorkers with Serious Mental Illness are disproportionately homeless or housing insecure, which creates additional barriers to accessing treatment. The city shelter system is overcrowded and unsafe. I have clients sitting on Rikers Island right now decompensating in horrific conditions with inconsistent access to mental health support, because they are unhoused and the judge is unwilling to discharge them into the shelter system. I worry every single day that I will need to call the family of a person that I represent to inform them that Rikers Island has claimed their loved one's life.

The city must invest in housing that allows people to come home with dignity, both to decarcerate Rikers Island and to prevent more people from cycling

into criminal legal systems simply for displaying symptoms of a mental illness in public.

This must include fully funding and maintaining the MOCJ reentry hotel program. This transitional housing model has been life changing for the people we serve.

The City also needs to invest in proven programs like supportive housing, scattered site housing, safe havens, and crisis respite centers.

SERGEANT AT ARMS: Time has expired.

MS. REGISTRATION: As a public defender, I have seen how critical housing is for my clients. When they have a safe and stable home, they can engage in treatment more effectively. When their basic needs are met, they can choose to access medication, health care, counseling, and services. The city cannot arrest and involuntarily hospitalized its way to mental wellness and public safety. People experiencing mental illness deserve access to housing and treatment and in a non-coercive manner. involuntary commitment and expansion of Kendra's law are not the answer.

Thank you for your time and I welcome any questions.

CHAIRPERSON LEE: Thank you, Danielle.

COUNSEL SUCHER: We will now move to our next panel which will also be mixed. We'll hear from three Zoom participants and then two in person. So while I call up the Zoom can actually-- no scratch that. Alright, so we'll hear from Dr. Samuel Jackson on zoom, Dr. Michael Zingman on Zoom, Dr. Ashley Brittain on Zoom, and then in person we'll hear from Luke Sikinyi, and then Dr. V from the Mental Health Project Urban Justice Center as well.

Dr. Samuel Jackson, you may begin when ready.

DR. JACKSON: Great, thank you. Good afternoon, everyone. My name is Dr. Jackson. I'm a psychiatrist at a large safety net hospital, a chief resident and provider of psychiatric services for people experiencing homelessness in transitional housing and in outreach. Today I've been a part of the hearing listening in, but going and seeing patients out on the streets, in the shelters, and in our CPEPs, the exact thing that we're talking about all day.

I'm also representing today an advocacy group called New York Doctors Coalition.

My uncle who has schizophrenia experienced homelessness for many years and was shot by police while experiencing a mental health crisis. So I know the pain, the family's fear, and that they feel when someone in behavioral health crisis interacts with police, and that at times it can be lethal and deadly. I talk to families weekly who are afraid to call the police in times of crisis knowing that this call for help can be deadly. We need to emphasize non-police response first, and that police only are involved if there's a crime or a weapon in play. I want to ask the group, rhetorically, a question. This directive is to bring those experiencing homelessness with mental illness to emergency departments. It's a public health intervention. Has there been a study done that shows if these this population this specific group who are homeless with Serious Mental Illness has gone to an ED or a psychiatric emergency room in the last year? As a provider of someone, of people who are have Serious Mental Illness, both who are housed and who are unhoused, I can tell you that they frequently go to emergency departments and inpatient units. So these people who we're proposing to help by bring them to

emergency rooms are already coming in. But they don't get the treatment that they need once they come in. Respectfully, Dr. Fattal outlined what the disposition planning would be for people who come in. It was very generic. And I would think, as a rule -- but I'm curious to see data -- as a rule, all of these people who would get it have already had it done in the last year. They've had a psychiatric evaluation, they've had coordination of care, they've had an appointment with a PHP or a clubhouse or something that they didn't engage with.

If there are interventions being done that don't have housing linked to them, more harm can be done to the individuals and to the system. 25% of police-involved killings involve someone with a mental health crisis. Black Americans are two times more likely to be killed. Black Americans with mental illness are 10 times more likely to be killed.

I'm just going to add in the last 30 seconds that there are solutions in New York City that need to be scaled up. Rehabilitation centers out of Bellevue are cost effective and bring people to housing. But we're short so short staffed in our hospitals, we haven't been able to scale this up yet. We don't

transition people to safe havens, which are tailored transitional housing centers for people who are chronically homeless with Serious Mental Illness. The capacity of the system has to be brought up before people are brought to emergency rooms, because we're understaffed and stressed and already cannot provide these people, who are already coming to the emergency rooms the care that they deserve. Thank you very much.

CHAIRPERSON LEE: Thank you so much, Dr. Jackson.

COUNSEL SUCHER: Dr. Michael Zingman, you can begin when ready.

SERGEANT AT ARMS: Time has begun.

DR. ZINGMAN: Hi, my name is Dr. Michael Zingman. I'm a resident physician in psychiatry at Bellevue Hospital, and Secretary Treasurer of my Union, the Committee of Interns and Residents, or CIR, which represents more than 6500 physicians in New York City.

When Mayor Adams first announced the mental health involuntary removals directive my fellow CIR members and I were outraged. We found it appalling that as patients face long wait times in our overcrowded hospitals, as people are evicted because

they can't make ever-increasing rent, as our neighbors face the constant threat of incarceration and deportation. Our mayor would focus his attention on increasing police power to further criminalize and involuntarily hospitalize houseless individuals.

We understand that this directive may result in critical danger for the people it impacts, particularly if they are people of color, undocumented, people with developmental disabilities or LGBTQ+ individuals. As a psychiatrist who took an oath to do no harm, I cannot stand by as houseless New Yorkers are further criminalized and endangered by police and then forced into hospital stays that by their very nature cannot address the needs of these individuals.

Let me be clear: When somebody is brought into the hospital by the police, no matter how hard we as staff work to provide quality care, we cannot change the violent way that the patient arrived, and we cannot provide true care. True care requires patient trust and safety which this directive casts aside with abandon. Rather, the Adams directive will make physicians and other health care workers an extension of the carceral system. It will force us to compound

the trauma of folks already experiencing the daily trauma of houselessness by keeping them in the hospital against their will. This will also erode patient's trust in their physicians and the healthcare system, which is key to providing quality care and improving mental health outcomes.

As so many great people have stated today there are real needs in our community that Mayor Adams and this Council must address. We need access to permanent and affordable housing, clean air, healthy food, jobs that pay fairly, and long-term community based mental health care.

These are the things that I know as a physician would most positively impact my patient's health. And that's the directive that I wish we were here to talk about today.

In my time left, I just would comment on a few things that were either discussed or not as potential solutions. You know, I think mobile crisis units like B-HEARD, where police are not the first responders, are really important. At Bellevue and soon at Kings County we will have an extended care unit, which is a longer-term inpatient psychiatric

hospital unit in which we connect people to ongoing either respite or supportive housing.

SERGEANT AT ARMS: Time has expired.

DR. ZINGMAN: Early interventions, also transitional housing units, and supportive permanent housing. Thanks.

CHAIRPERSON LEE: Thank you so much, Dr. Zingman.

COUNSEL SUCHER: Dr. Ashley Brittain, you might begin when ready.

MS. BRITTAIN: Hi, thank you so much for allowing me this opportunity. My name is Ashley Brittain. I'm a resident physician in emergency medicine in the Bronx and also Regional Delegate for the Committee of Interns and Residents. I'm here on behalf of myself, and my union Express, as many others have done before me a deep opposition to this violent directive.

I'm also here to explain uniquely what happens on the other end of the process in the emergency department. I believe we've heard from psychiatric residents. But the emergency department is also involved in this as well. I have to warn you that what I'm about to share with you for those that have not been through it can be intense.

When someone is involuntarily brought into the hospital by the police, which is not something that is rare in our line of work, after suffering that immense trauma, they will be placed into a yellow gown to indicate that they are a elopement risk. This is for their safety, as well as the safety of others, and they're there because we're concerned that they're going to leave. And so the yellow gown marks them as that risk so that everyone involved in their care knows that that person does not have the civil liberties to leave on their own. They'll be told that we need their blood and their urine to test before they can then see the psychiatric team. And if they don't cooperate, they'll be restrained, either chemically, or in rare and more extreme occasions, physically. They may wait in a crowded emergency department for hours or days for a psychiatric bed to open up.

We've had some people anecdotally that have been in the emergency department for a week, two weeks while waiting for a psychiatric bed to open. I just want to give that a moment to sink in.

It is beyond evident that this is not the healthcare we have dedicated our lives as physicians

to provide. There is no other way to describe this process than as an extension of the carceral system, one that will contribute to this ongoing process and problem of patients cycling in and out of our hospitals without ever receiving proper long-term mental care in the community. I also believe that one of the most important responsibilities I have as a physician is to uplift and safeguard my patients autonomy. I'm very passionate about this.

Their ability to make decisions about their own life and their own rights is a human right. And this directive for Mayor Adams seems to operate under the principle that if someone is homeless, they forfeit that basic right. I refuse to accept this, and our City Council should refuse to accept it. Instead, our elected officials here today should join me in demanding may or revoke this directive immediately as an urgent matter of racial, economic, and disability justice and of public health. Thank you.

CHAIRPERSON LEE: Thank you so much.

COUNSEL SUCHER: We'll now move to our in-person panelists, Dr. Victoria Phillips from the Mental Health Project at the Urban Justice Center as well as Luke Sukini from the New York Association of

Psychiatric Rehabilitation Services. Dr. V may begin when ready.

MR. SIKINYI: Hi, and thank you for having us today. My name is Luke Sikinyi, and I am the Director of Public Policy at the New York Association of Psychiatric Rehabilitation Services. More importantly, I'm someone who both uses services-- mental health services in the city and state and also someone who has extensive experience providing those services to individuals directly.

So I have my written statements here. There's a lot of voluntary alternatives that we have put forward to you all for your reference, but I'm not going to belabor that right now. I think the important thing is to really look at this plan and look at what it truly means.

So the first thing to think about here is this mental health emergency is a public health crisis. And I really want to stress that because it doesn't make sense to me as a provider of services and someone who has used services, that we have a public health crisis. And we decide the first thing we throw at it is police officers.

There are no other public health emergencies where police officers are the first responders are the best people to respond. We know that many of you have worked in the services or hospitals, and we know that that is not the way to go.

Second, this expansion of "danger to self" to include things that are not of imminent danger, suggest that police are not the people to be here. This isn't a public safety issue if there is no imminent danger. So I'm not really sure once again, why we're using police officers.

Third, you heard it yourself. The police commissioner said they're not the best people to respond to these issues. And if they know that, and we know that, why are we continuing to send them? And more importantly, why do we continue to think that we're going to get a different outcome if we're not changing the process.

The directive is the expansion of an old practice which has not worked. Many of these people who have been scooped off the street go into hospitals, they come right back out, and they get sent right back in. And we start all over again. I've been there I've provided those services, and I've struggled to wonder

what we're doing wrong. And the truth is, we're not investing in our community-based services. We know a lot of services that do work that have been effective and getting people into the sort of help that they are asking for, and keeping them out of hospitals, keeping them out of the carceral system.

We can't keep putting people back into the system and expect a different outcome without intentionally providing improvements. This starts with discharge planning. But any good discharge plan falls apart if the services to continue that plan in the community are not there, if the workforce is not there to actually carry out those plans.

So I sit here to ask you all: One, reject these, the Mayor's plans because it is not a real solution. It's a quick fix, but, two, we need to invest in this workforce, because this is what-- these are the people who are actually carrying out this good work. These are the people who are creating those relationships with individuals that are providing compassionate care, because they know them, they take the time to do so. And it is difficult work, and we should be paying them accordingly, so that people

come into this field, stay in the field, and continue to help people recover. Thank you.

CHAIRPERSON LEE: Thank you so much.

DR. VICTORIA PHILLIPS: Peace and blessings, everyone. Okay, I'm Chaplain Dr. Victoria Phillips. Everyone calls me Dr. V. And today I'm here representing the Mental Health Project at the Urban Justice Center. You might know me for many other things. I also want to highlight that for the last six and a half years, I was part of the advisory board for the Department of Corrections, and currently, I'm the co Chair of to deal with these young adult Taskforce.

So let me just start off by saying, I'm a Brooklynite, and Shirley Chisolm once said you don't make progress by standing on the sidelines, you make progress by implementing ideas. And I'm here to tell you that Mayor Adams's idea is faulty and asinine.

I just want to start off by saying, I'm very disappointed in my own Councilmember, I won't say her name on a record right now, but she knows who she is, because earlier today when NYPD said they have not trained all their officers and CIT in the last eight years of having the training available, my

Councilmember responded with, "Okay, thank you." And I want you to understand, why not? You have an $11 billion budget, and for someone to sit up here in front of Council and say, "Well, we have 30 persons a class to make it more intimate." Again, you have an $11 billion budget, get the training done. Heartbeats mean something to me. As an Army brat on domestic soil with a mother buried in a military cemetery, every heartbeat on domestic soil means something to me.

I also want to say I have CPEP individuals from SROs over the last 20-plus years in my line of work, I've even been held hostage myself in a microshelter. And I say these things because I no time did I utilize any brutality, any weapons. I utilized my training my de-escalation and not once that I have to call NYPD. I also want to say B-HEARD needs to B-HEARD and step up. It needs to be a 24/7 access. Just like all ERs are, because mental health is a physical matter. It is something that occurs 24/7, and the city is not doing good enough. I also want to highlight that the NYPD said a video will go out to the officers. They did not discuss if the officers actually watched the video, if they're

quizzed on the video, if the video even documents if they stopped the video. And I want to know with an $11 billion budget, what is going on with that?

And I would like the Council to actually flush out -- because the video does not flush out -- would be scenarios and anything like that. So again, $11 billion is falling short for the people of New York.

And I would like to address -- I usually try to keep petty stuff off the record, but I had to stop Councilmember Holden in the hallway. I usually do that with people who express white supremacy ways and bigotry in the council. So I stopped him in the hallway, and I'm bringing it up for a reason because I said, you know, "You said certain things that do not line up. We're having a hearing"-- Let me finish. Let me just finish. "We're having a hearing today on individuals who have not been charged with a crime, and you've said several times arrest records being mixed with medical records, and do you not understand HIPAA." And he said, "Well, why do they have to have HIPAA, if they're brought in by the police?" And I said, "Again, the hearing is on people who have not been charged with the crime. HIPAA is very real. And HIPAA is for you, and I,"

and he responded, talking to me with his hand like this. And I said, Please don't talk to me with your hand up. And he turned to walk away. And I want to highlight that on the record, because if I am a professional trying to talk to a lawmaker about a very real issue with their constituents, and that is his response, what is the response for the police?

And lastly, I will finish with this, and I want my Councilmember to pay attention. Two Sundays ago, I was called to the First Baptist Greater Church on Eastern Parkway to give-- to give a teaching on policing and mental health in the community and how the community should respond, and I'm very nervous to have NYPD interact with my community for many more reasons than I will stay today. But I know for a fact police lie. And so on my way home from church, I told my son to come downstairs with the dog, and I will take him and drop him off. I say that because I got one block from my apartment with my son in the car and had officers make a U turn, whoop-whoop, and stop me-- 30 more seconds. They stopped me. And then he won't I was recording. I'll give you the video if you want. And I was recording. And he walked-- one of the officers walked up to me-- eight

officers, one sergeant and seven uniformed officers in regular uniform. And the officer who walked into my driver said, "I'm stopping you because you have a light out." Regular stop, right? I said, "Oh, I was not aware, I'll go get it fixed in the morning." They was obviously doing some type of training thing. So I started talking to the sergeant because I want all the attention on me and none of it directly to my son. And I say this because they could not find nothing on me. I am a citizen, a productive citizen. And I do what is right.

And because that-- that aggravated them that I knew my rights, the sergeant even said, "Oh, you sound like someone who knows your rights," because I was asking about the COs, the Cos at the present. And I say that because they could not find nothing.

And you know they did, they gave me a criminal court ticket for a suspended registration, which is not true. I had the registration, I have the copy from the DMV, the very next day I went to get another one. And I want to say that because a regular civil stop turned criminal. And if I do not go to court, there will be a warrant for my arrest.

So easy to get swept up in the criminal legal system. So easy for an officer to lie on myself and any of my community members and for your to allow this to be implemented, for you to sit and thank police officers you do with police officers, and the DOC and not highlight the needs of your constituents is wrong. And it has to stop today. And you all need to start holding Councilmember Holden and Councilmember Vicki with all the bigotry, responsible and accountable. Peace and blessings.

CHAIRPERSON LEE: Thank you so much.

DR. VICTORIA PHILLIPS: Any questions?

CHAIRPERSON LEE: No. That's what I'm asking. Do you guys have any questions?

COUNCILMEMBER NARCISSE: Well, thank you for the work you've been doing. You seem very passionate about it. And-- and I like that because the passion brings what's been going on. I understand we cannot continue doing the same thing over and over and expect different results.

So what would your recommendation be right now, for us as a city council. I hear all the things you said. But now take it a step-- [breathes in]. Yeah.

DR. VICTORIA PHILLIPS: I don't need no breath. I can answer you.

COUNCILMEMBER NARCISSE: Okay.

DR. VICTORIA PHILLIPS: Right now city council needs to expand the respite. There's not enough in every borough. Period. There is no reason someone in crisis has to go to an ER when they are respites in the community. That's one thing you could do right now.

Also, you can hold NYPD accountable for these frequent trainings that has been available for the last eight years. There is no reason constituents have died on your watches. And NYPD is allowed to float in and float out with, "We're sorry, but we'll do better." So that is something that can be done right now.

Right now you can also ask the doctors what needs to be done. You could put social work-- you know what when I worked in hospital, I worked in Bellevue and I worked in Kirby, and when we didn't have enough staff, we had to float, whether we want to go to that unit or not. So why aren't your floating people? Why aren't you moving staff in HAC to put them in Rikers where they need to be. Mr. Carter died last

year. Every city agency failed him. The hospital, DHS shelter, intake at Rikers failed him. And so we can't even take care of people in custody, why are we taking people off the street to hospitalized them, when we're going to fail them again.

Right now, you need to have your people-- you're hospital right? Hospital Committee. Make sure HAC is doing their job. I see all these other Councilmembers who are asking about discharge. This-- wardens call me because discharge doesn't even work. It doesn't even work when people have mental health diagnosis, a Brad H. diagnosis, and they're getting ready to get released. And DOC staff hasn't even followed up with them. And what is-- I've even testified right here in this council, wardens will reach out to me because of that. Those are things that you can make sure right now. Why isn't there a triage unit that actually trains officers, and a triage unit to actually go to housing units in jail? Because they all work together. So there is-- I could talk to you offline. You're my Councilmember, so I could talk to you for days about what we could do right now to implement. I have no problem doing that. Any other questions?

CHAIRPERSON LEE: No, thank you so much.

COUNCILMEMBER NARCISSE: That's it. Thank you.

DR. VICTORIA PHILLIPS: Thank you for the questions.

COUNCILMEMBER NARCISSE: And by the way, I have a lot of mental health in my own family that I have to deal with. And so I appreciate you.

DR. VICTORIA PHILLIPS: It's not easy.

COUNCILMEMBER NARCISSE: It's not easy.

DR. VICTORIA PHILLIPS: And after my brain surgery, I was diagnosed with depression and anxiety. Do you imagine how I feel after 8 cops pulled me over for a bogus charge? And threw my name in the system? Go ahead.

CHAIRPERSON HANKS: Thank you very much, you know, you-- you've added much to this conversation. And I appreciate that. So when we're talking about the respite. I'm from Staten Island, so I'm unfamiliar with that. What is that, and why do you say you need more?

DR. VICTORIA PHILLIPS: Well, I don't have the exact numbers in my head. But I think it was less than 60 right now in the whole city, if I'm not mistaken.

[BACKGROUND VOICES FROM CHAMBER]

Well, there's less than 60 beds in total.

[BACKGROUND VOICES FROM CHAMBER]

Yes. That's what I'm saying. And so, so that's kind of like a break, a timeout.

[BACKGROUND VOICES FROM CHAMBER]

Yes. But that's kind of like a timeout for-- for a basic explanation of it. And so what it is, is that you could pretty much call, family members could call, social workers could call the individual. And you could call to see if they have a space available, a bed available. And what that means is it's literally like a checkout. You're allowed to come in there for like a week, have services, be directly engaged around your mental health concerns. And like someone said in the audience, it is peer run. And so it's just-- it's just a restart. It's a reconnect. And that's why I say we need to expand it because it's truly a help, rather than an hospitalizing someone. Sometimes all you need is a break. You know, it's almost like when you-- I don't know if you have kids or anything--

CHAIRPERSON HANKS: I've got four. I need a respite like right now.

DR. VICTORIA PHILLIPS: Well then you understand my-- my example. You call a loved one, "Girl just take them for the afternoon. I need a break." So it's a mental health break.

CHAIRPERSON LEE: Okay. So see, these are the things that we're learning from this, you know, and, and I know that, you know, your-- your colleague or Councilmember may not have said, "Thank you," but, you know, we're looking at this holistically, right? And so there are a lot of folks out there and including in law enforcement and in these hospitals that are doing a good job. So it's only proper to say thank you, and thank you for your testimony, as we would say to you. There's a lot of emotion surrounding this, and I think that it's folks like you that make us smarter about it.

And one of my last questions to everyone that was testifying was basically what-- what do you need from us? And it's-- and we understand, like the heightened emotion that's involved in this, because we want to protect people who are severely mentally ill that may hurt someone else. We want to protect people who have not gotten the treatment that they need, but they don't need to have to be having their

civil liberties violated. So these hearings, kind of, you know, we break this out.

And so the respite something I learned today. How do we understand how to build capacity with our local organizations that you know, the police can't do everything--

DR. VICTORIA PHILLIPS: They sure can't.

CHAIRPERSON HANKS: --and it doesn't make them you know, villains. But I think after a while, that that kind of is what the result is because so much of it has been put on them. So we have to look at this, you know, holistically, and-- and the things that you're saying add context to that. So I would love to talk to you offline about respites. Because like I said, I'm from Staten Island, and we have those issues as well. And I think that we need to figure out how to build out more of those things and, and mitigate some of these issues. But I really do thank you for your testimony. And I appreciate your passion.

DR. VICTORIA PHILLIPS: Thank you for asking the questions.

CHAIRPERSON LEE: Yeah. Thank you so much for your passion, like, Chair Hanks was saying, and, you

know, this is, again, a very-- there's a lot of issues around the systemic problems that we have around mental health. And I just want to thank you, and all the folks that are still here that will testify for your-- for your testimony and for adding to the conversation. And, you know, I know that I want to be respectful of my colleagues. And I know that we may have differing opinions on things, but we do all know and understand that this situation around the mental health crisis needs to improve. So I just wanted to say thank you again, so much.

COUNSEL SUCHER: Thank you. We'll now move to Betty Khalid on Zoom. Dr. Betty Khalid, you may begin when ready.

SERGEANT AT ARMS: Starting time.

DR. KOLOD: Good afternoon, I hope you can hear me I had to run out. I'm a public health and primary care physician for people who use drugs, and I'm speaking in opposition to the Mayor's involuntary removal directive. And that's on behalf of New York Doctors Coalition, a network of over 800 New York City Health Professionals and health justice advocates who support housing first, as a public health intervention.

I'm going to share a few anecdotes that highlight the true gaps in psychiatric care for people experiencing homelessness and the link to overdose, the leading cause, and increasingly so, of death among persons experiencing homelessness. We know this matters because the latest health department overdose data reflects the unrelenting acceleration of overdoses in New York City.

My patient Alexander walked into my clinic, like the Deputy Speaker's brother, asking for help staff were frightened by his disorganized behavior. He said that he knew how he would hurt himself and described violent assaults saying that he didn't want to be like that anymore. He was voluntarily escorted to our Psych ER, and on arrival, he was handcuffed and strip-searched after they found heroin in his pocket. He immediately retracted his statements about hurting himself and others, and he was released from our crowded overwhelmed ER within minutes. He now declines all mental health referrals.

I just say this to say that coercive carceral mental health does not work, and instead has proven deadly for New Yorkers, especially those with marginalized identities.

My patients cannot access mental health care. Referrals to psychiatry take months, even for those in psychosis. Often people who use drugs are ineligible. My patient Ashley has schizophrenia. She's sleeping and injecting alone in stairwells because she's terrified of going into crowded shelters we referred her to an ACT team months ago, we have not received a response.

My other patient, Jeffrey, is staying in a shelter and was turned away from psychiatric care because he has a remote history of opioid use.

However, my patients Barry and Sam, who have schizophrenia and bipolar disorder were relieved to move into their apartments recently. Their opioid use has stabilized or completely stopped, and as they wait for their psychiatric referrals to pan out, they are at least safe.

So to address mental health gaps that are that are frightening the public and potentially fatal for affected individuals, we need permanent housing, universal health care, financial support, investment in community based health care, and to break down mental health and addiction silos.

The involuntary removal directive and cuts to the City Health Department, Department of Social Services, DHS, and the Department of Housing and Community Development will only exacerbate the problem. Thank you.

CHAIRPERSON LEE: Thank you so much.

COUNSEL SUCHER: We'll now move to in person panels. Our next panel will be Jessica Fear from VNS Health, Fiodhna O'Grady from Samaritans of New York, Casey Starr from Samaritans of New York, Helen "Skip" Skipper from Justice Peer Initiative, and Cal Hedigan from Community Access.

Is Fiona or--

CHAIRPERSON LEE: She was here. Okay.

COUNSEL SUCHER: Is Cal Hedigan here?

Jessica, you may begin when ready.

MS. FEAR: Is this on? Okay. Great. Thank you so much. I just want to say thank you to The joint Committees for hosting this hearing. I appreciate your stamina today. I believe that stamina is going to be required of all of us to be able to address this problem successfully. I have all these prepared written comments, I'm actually going to go a little bit off script, based on everything that we've heard

everyone say today. I kind of want to boil it down, you have my written testimony. There's lots that I say in there that speaks to the need. I just kind of want to boil it down to what I feel like I'm hearing from everyone, and where I feel like we come from.

I am with VNS Health. I'm the Senior Vice President for Behavioral Health. VNS Health, formerly the Visiting Nurse Service of New York, our behavioral health teams have been in the community serving individuals with Serious Mental Illness for over 35 years. We do it on the street. We do it in the homes. We do it in the shelters. We go and find folks wherever they need us. This past year, we served over 20,000 New Yorkers. We have five ACT teams. We have six mobile crisis teams. We have five IMT teams. We provide 958 training for the city.

I say all this to say, when we talk about the investment in community based resources, we could not be more in support of that as a sustainable solution for the problem that everyone has been speaking to very passionately and eloquently today. We do applaud the increased investment in capacity.

However, I cannot stress enough how imperative it is for the community-based mental health programs to be funded, to keep those who can be stably sustained in the community at home in the community where they belong. This will absolutely free up the treatment capacity for those who actually need stabilization in hospitalization.

What we know is that we have watched -- across our mobile crisis teams -- we have watched referrals to mobile crisis double over the last five years. Of those referrals -- and some of these statistics we didn't get to hear today, so I'll share some with you on our end -- only 5% of the referrals that come to our mobile crisis teams need to go to the hospital, are transported. And of those 3% of adults and 1% of the youth are transported involuntarily. What that means is we are able to intervene, reduce the crises and the need for hospitalization and unnecessary hospitalization and keep people at home in the community where they belong.

We cannot do that -- here we go; we're out of time -- we cannot do that without the proper workforce to address this, right? And people have said this throughout the day. I just want to

underscore that the workforce crisis will-- is imperative. It's imperative that we solve this. Increased capacity will not be able to be realized unless we have the people to staff the positions to do the work. And those of us who are the community-based providers, who are the safety net for the individuals that we serve, we don't have the staff to do it today. And without additional investments, we're not going to be able to do it tomorrow. So thank you for your time.

CHAIRPERSON LEE: Thank you so much. Good to see you, Jessica. And I just wanted to let everyone know that if you have written testimony, I promise you that the staff and the Committee does read every single word, so no worries.

MS. FEAR: Thank you

COUNSEL SUCHER: Fiona, you want to go next?

MS. O'GRADY: Hello, and thank you Chairs Lee, Ariola, Chair Hanks for the opportunity to speak today. I'm Fiodhna O'Grady, and I'm representing the Samaritans of New York. It's a Suicide Prevention Center. Been around for 40 years and we operate New York City's only anonymous and completely

confidential suicide prevention hotline. And we also operate education programs in all five boroughs.

Samaritans provides immediate and ongoing support to those in distress, and it's also a safe alternative to existing clinical government-run programs. We are the go-to service for the underserved, the untreated and those most impacted by stigma. And I'd like to echo -- I think it was Chair Lee who was saying, we're part of the "one size does not fit all and therefore we exist." Samaritans hotline acts as a safe point of entry to mental health services, especially for people of color, LGBTQ, young, undocumented people, and people living with mental health conditions or disabilities, and for those experiencing homelessness 24/7. Before the pandemic suicide rates had been increasing for two decades. And while they remained stable during 2020, they're on the rise again, CDC 2022.

For prospective New York City DOHMH estimates that someone dies by suicide every 16 hours in New York City. And what we say is violence expressed outwardly is homicide. And think of the care that we apply and the amount of energy we apply to combating

homicide. Suicide is violence expressed inwardly. And we need more care.

While mental health is an important aspect of suicide and suicide prevention, our efforts cannot be confined solely to the mental health sector. And that is why we have decided that we're coming here today also, because obviously, housing instability and homelessness are two important social determinants of both physical and mental health. And I think we've heard it again from Councilmember Barron, Councilmember Cabán, the Bronx defenders, this lovely lady who sat here before us, and involuntary removals and forced institutionalization are policies that seek to hide the problem. They do not expand access to housing, nor do they address the structural and individual factors underlying homelessness.

As a city we need to examine all the factors contributing to homelessness, and adopt a holistic approach. This means addressing systematic inequalities, providing access to stable housing, health care and education and offering options for mental health support.

Samaritans wants to thank the City Council for their support, which allowed us to respond to over 60,000 calls in FY 22 in our role as an essential member of the New York City Safety Net. We-- we applaud all your efforts at this hearing today. And in the interest of compassion and dignity, community mental health care is everything. Thank you.

CHAIRPERSON LEE: Thank you so much, Fiodhna.

COUNSEL SUCHER: Casey Star, you may begin when ready.

MS. STARR: Thank you to the Committee Chairs here today and to everyone who is also still here and giving voice to this. I'm Casey Starr, and I am the Co-Executive Director of the Samaritans of New York.

Samaritans is the only anonymous and completely confidential crisis service in this city, and we prioritize autonomy and agency of an individual in crisis. A caller's absolute anonymity to our service ensures that no action will be taken without their consent, and this helps to build trust, it reduces feelings of helplessness and isolation, and it's been shown to increase engagement in services and help-seeking behaviors.

From the 1.4 million call Samaritans has answered from New Yorkers in crisis, we have learned that trust, autonomy and dignity are at the heart of helping someone. And what we've learned by listening to the voices of people who call is reflected in the extant research.

Unfortunately, we've also observed significant resistance to centering these values in social services and governmental policies. So as the only crisis service that does not engage in non-consensual interventions, including 988 and DOHMH, said that that's NYC-WELL, and in this city, that does happen when you call. Not always, but it can. We know that alternatives work. We're proof of that. And we're deeply troubled by the Mayor's plan to address homelessness and the move towards forced institutionalization and forced carceral care.

Nonconsensual interventions and policies, while well-intentioned, have severe unintended consequences. There is a real risk for physical danger and violence as well as exposure to just the fear associated with engagement with law enforcement, who are ill-equipped to evaluate and safely respond to mental health crises.

Psychological trauma and a worsening of mental health status is a actual consequence. Involuntary interventions have been shown to increase feelings of shame, reduce the likelihood that a person will disclose future suicidal ideation or seek help. Institutional settings often isolate people from their communities and support networks. This can further marginalize a person, especially someone who is already vulnerable and can exacerbate their challenges. Additionally, we know that suicide rates increase dramatically post hospitalization, especially for those who were involuntarily treated. And that doesn't even touch on the financial instability that this can cause, especially for a population him who are experiencing homelessness.

This poses a costly model for the city and for the individuals. Rather than preventing harm, these practices actively are harming and traumatizing the people they seek to help. So I yield the rest of my time.

CHAIRPERSON LEE: You can finish off. Yeah.

MS. STARR: Okay. People who experience homelessness have a higher rate of suicide attempts, and it's estimated they die by suicide at nine times

the rate of the general population. All New Yorkers deserve the same opportunity to make decisions about their health, wellbeing, and treatment, regardless of their housing status. People access help when they have choices they are comfortable with and services that make them feel safe. Mayor Adams said that we need to rebuild trust in our city. And we agree: If people don't trust you, you're not going to get very far. But to do that New Yorkers need compassion and not coercion. Coercion is not the basis for trust.

CHAIRPERSON LEE: Thank you.

COUNSEL SUCHER: Helen, you may begin when ready.

MS. SKIPPER: Oh, excuse me, I'm sorry. I don't go by the name Helen most of the time, so I didn't know you were talking to me.

COUNSEL SUCHER: I apologize.

MS. SKIPPER: No problems. Good afternoon Council. I need to take my time, and I need to be intentional in my thoughts. I came with prepared testimony, but I'm not going to speak my prepared testimony. You have my written testimony. I'm not going to speak my prepared testimony, because I'm just going to talk about what everybody else has said repeatedly about how we need more community-based

services, about how we need more peer support, about how we need expansion of services, and a better paid workforce. We already know that. Everybody that has sat here before me has said that. What I am going to speak about is the fact that I don't feel represented and I don't feel heard. It is about the fact that I am directly impacted by the criminal justice system, by the mental health system, by the substance abuse system. It is about the fact that we are sitting here talking about policy and procedure.

But yet we are not represented here in this room. You want to talk about crafting policy and procedure. But I guarantee you if the Mayor had someone with lived experiences on his team, he would have never came with a plan such as this. I sat here all day, where members of departments sat here and attempted to quantify their actions with numbers. And I can get academic myself. I am a criminologist. I'll be entering into a Master's Ph.D program in the fall.

I can speak about numbers, but I prefer to stick with the qualitative. I prefer to stick with the narrative. You cannot build policy about vulnerable peoples without inviting us to sit at the table. We are the subject matter experts in the room. Yet when

it comes time for us to speak, when it comes time for the community to give testimony, I am looking at an empty chamber. When I sat here this morning with these talking heads, the Council Chambers was full. Yet today, at this moment, I sit here and I see less than a handful of Councilmembers. You are listening to me now. Ten minutes ago, whoever was here was on their phones. Where is the respect for the community members and those of us who were directly impacted? We are closest to the solution. [BELL RINGS]

And I'm going to take my time with this. See, I can turn that clock off because I've been watching it and I think is running fast. Anyhow, let me tell you: Those that are closest to the problems are closest to the solution. I have said this time and time again. Are you guys even listening? How can you build a plan to support or what you think you support, but you don't include the voices of those who are directly impacted. And yes, I'm directly impacted for 25 years. I went through the criminal justice system, the substance abuse system, the mental health system for 25 years, yet you still try to involuntarily confine us. You still try to take away our voice and choice, like we don't matter. Yet

I'm sitting here speaking to you just as comprehensively, just as coherently, just as intelligently as the next person. Use us. We are here. We demand to have a seat at the table. You have my written testimony, Councilmembers.

CHAIRPERSON LEE: Thank you for your time.

COUNSEL SUCHER: Thank you.

MS. SKIPPER: Oh, and I'll take questions if you have some.

CHAIRPERSON LEE: No, I just wanted to say thank you for that. Because oftentimes-- I always say this as a community person myself, as someone who's experienced it. But just the importance of having that lived experience and have a seat at the table. The seat at the table, and the voice is important. And that was a lot of what we were trying to advocate for on the nonprofit side as well, because we felt like there was a lack of that. So I just wanted to say, I appreciate you making that point.

MS. SKIPPER: Thank you.

CHAIRPERSON HANKS: Thank you so much. So when you speak about, you know, a seat at the table, and I appreciate your-- your testimony. And you know, as Councilmembers, we try really hard. We are sitting

here, and-- and so it does matter that you have somebody and a face to talk to. So I appreciate that.

But when it comes-- because I mentioned before the capacity building. In what way do you think that that seat at the table-- given, you know, this is a big city. We all have the best intentions. But, you know, we sit here and these are why we have the hearings, to break down these policies, to listen to what everybody needs to say and say, "Okay, where's that happy medium? And where are we missing it?"

So my last question to all the folks -- you called them talking heads -- was, you know, what do you need from us? And so how do you envision that seat at the table. Logistically, how would that work, if you have any ideas?

MS. SKIPPER: Yeah, well, for starters, we meet to fix how we hold these proceedings. Just like you had a chance to ask questions of the talking heads. We would like that opportunity as well. Um, they come. They sit for a couple hours, and then boom, they're gone. I've been here since nine o'clock this morning, and I sit patiently waiting for my chance to speak. I have a couple of good questions for them as

well. You know, they should be held accountable for what they say. And again, like I said, if the Mayor had people who are directly impacted on his team, I guarantee you the plan that he put forth would be entirely different, because we who are directly impacted who has been through the systems would have pointed him in a different direction, because we would have shown him how wrong he was to think that we can take the voice and choice from people. There are better ways. You know, and that is what I mean by a seat at the table as you build these policies.

CHAIRPERSON LEE: So we would like you to submit your questions that you have that-- for-- for the folks who testified, and you could send it to the same place you submitted your testimony, and we'll get back to you.

MS. SKIPPER: Thank you. I appreciate your time.

COUNSEL SUCHER: Thank you to this panel will now move to our next in person panel.

It will be Sarah Blanco for Center for Justice Innovation, Nadia Swanson from Ali Forney Center, Christina Sparrock, from Centered Intervention Training, Lena Allen from Fountain House and Nadia Chait from CASES.

Sarah Blanco, you may begin when ready.

MS. BLANCO: Can you hear me? Okay. Good afternoon Chairs and esteemed Councilmembers. My name is Sarah Blanco. I'm the clinical director -- fancy word for social worker -- at Midtown Community Court Midtown, a project of the Center for Justice Innovation, formerly known as the Center for Court Innovation or CCI.

Today I'm here to talk about our work serving people with mental illness, substance use issues, and co-occurring disorders, specifically our community first program and our Midtown misdemeanor mental health court.

Before I go into this, I want to say have 20 years of experience of working on mobile crisis, ACT teams working with folks living with mental illness whose autonomy has been taken away, who have been hospitalized and who have not had a voice at the table as so many people have spoken today.

I want to just go jump straight into our misdemeanor mental health court part that we do have at midtown community court.

Unfortunately, folks with mental health issues are still being arrested. They're often being

arrested at a time where their mental health is destabilizing, something that's happened in their life, and they're either compensating or they're very, very traumatized. We are seeing this court part was launched by OCA back in February. It's open every Friday on at midtown community court. And folks are put into this court part, or either the clients or the legal stakeholders have identified the person as having some sort of mental health issue. It's a voluntary part, clients do not have to take part. We are not here to pathologize and further criminalize folks who live with mental illness.

What makes us very, very different than other court parts -- and I want to acknowledge I am talking about a court part, I am talking about someone who's been arrested for a misdemeanor, and we understand by the time the person comes to our court, they've been through arraignment, they've also been off also been very traumatized, often by the arrest process. And they've also been cycling in and out of the criminal legal system, where treatment was probably a better option, and usually was.

So I just want to highlight that hallmarks of our misdemeanor mental health court part or specialized

court part, when clients come into our court, it is not like a downtown criminal Court. They are met by social work staff case managers, to say hello to them, to treat them, like people to walk them through the process, to introduce them to their attorneys, to adhere to the pillars of procedural justice. This is what's happening, this is what's going to happen next. The social workers, case managers stay with the client from the beginning of their case to the end. We sit with them in court. We provide programming. We meet with them as real people. They are not defendants to us, they are real people.

Since launching the court part, we have identified several common themes among the clients referred to us. As I said, they're arrested at a time when there's something very traumatic happening in their lives, and it's causing a mental health issue or it's exacerbating a current mental illness. Our staff, our social work staff, our case management staff work with the legal stakeholders to develop treatment mandates. So while you might go to court and the legal parties mIght say, "You have to do five sessions, or five programs or whatever to to get through your court case," the legal stakeholders have

so much trust in us that they rely on the social work staff to co create with the client, what they would like to see in their case.

So our mandates are very short. But we're not saying you have a charge that this is what you're going to do we sit with the client. We listen to the client. We give space, so they can let us know what they need. We do not mandate mental health treatment, we really build a bridge to whatever services they want. And that can be when they come up and meet with us. They're often hungry, disconnected and unhoused, we can provide food clothing and a cell phone just to start that build trust out. From there, we co-create a treatment plan with the client. We have on site services from counseling, mental health services, case management, benefits assistance. We can link them pretty much immediately to all of this stuff, and it's built an enormous level of trust.

I will say that because we case conference weekly with our legal stakeholders, the attorneys, and the court attorneys, and we can show-- we can give context to the client. We can talk about their lives. We come to really, really quick dispositions.

Our cases-- often the clients' cases are often over in 33 to 44 days. This allows them to move on with hopefully some of the services and needs met through our social work and clinic staff and our amazing stakeholders, but they don't have the burden of a court case over them, which is-- that in itself is so incredibly stressful. And it can be paralyzing. You want to get a new job, but you have an open case. You want to do something else, but you have a new case.

I will say some of the highlights other than like the constant engagement with our clients, upon completion of the clients court case, we really tried to break down the hierarchy. The client can get his certificate of graduation. We clap for the client. The judge gets off the bench and we highlight their successes. We acknowledge the challenges, but we highlight their successes.

Clients have recorded that this is the first time in the justice system. They've actually felt physically looked at, heard, and felt like there-- I don't know, some state were supportive, but some say they just felt like they were treated like a human being. A lot of the clients we see in misdemeanor

mental health court continue to talk to us and work with our staff on a voluntary basis posts mandate, because they want to continue to get the help they decide they want.

I know I've run out of time. I just want to highlight that misdemeanor mental health court midtown communities court is unfunded. To continue to address these-- these rising case loads, these clients with a lot of needs, we need more money to support staff and programming. We don't want folks to be circling through the system. We want them to walk out with their needs addressed, and for them to to kind of move on with their lives. Thank you.

CHAIRPERSON HANKS: Thank you so much. I thank you for your testimony. As the Chair of the Committee of Public Safety, I've-- I've seen and witnessed the-- the benefits of the mental health court in Brooklyn and I-- I've experienced firsthand, the applause. And I've also experienced this when judges do use their discretion saying, "Okay, this person is not ready, and they need to be remanded."

How do you see the Center for Court Justice Innovation, what their role is, because we heard many of the public testifying that they need to be at the

table, but I also believe that -- I'm from Staten Island, so you see the one little like Justice Center. So we're working in earnest to get a mental health court in Staten Island, as well as a community court and how important those pieces are.

So is this-- how do you see an integration with the Mayor's plan? And seeing that, that piece needs to be in there? Because we've been all saying, "Well, what happens when they're let go? And what happens? What is the off ramp? What is the on ramp? What does that look like?" And I think that you know, the Center for Court Justice is just what the doctor ordered, and I've seen the great work that has been done. And it's-- it's-- how do we-- in your perspective, how do you see the integration of-- because I think this is an important piece, right? That we just-- you weren't up here testifying with everyone else. But I think that that would have been a really nice bookend to-- we do have all of those-- those pieces.

So how would you know, notwithstanding funding, because we get it, everybody who comes here and wants funding-- but how do you see that role playing so

that even if we can advocate for funding, we're asking for something very specific. Thank you.

MS. BLANCO: Okay, I'm just trying-- Can you repeat the question? I'm just trying to--

CHAIRPERSON HANKS: How do you see your connection? If you know, you're-- you're saying that this is the Center for Court Justice and Innovation. How do you see that component in the current plan that the Mayor has-- has released for involuntary remanding?

MS. BLANCO: I mean, to be blunt, I don't see it as part of the plan. We don't-- we are not here to take people to the hospital who might appear that they are not doing well. I think those terms have been not defined yet. They're really, really broad. There's not been training. There's-- there's talk of bias. And I think what is going to happen if this plan goes through, we're going to see more people arrested and harmed. And so I think an off ramp is something we have-- or if an intercept model is to be proactive, we have a community-first model that works with folks on the street to try to engage them in services before they're involved in the criminal legal system. Or if they already are, we can provide

the supports to help them get through it. I think misdemeanor mental health court is a specialized court part that can sensitively, in a trauma-informed way, work with folks who are experiencing mental health issues, rather than cycle them in and out of the hospitals. Right. We'll get there. Thank you.

MS. BLANCO: Thanks.

COUNSEL SUCHER: Nadia Swanson, you may begin when ready.

MS. SWANSON: Hello, thank you to the Committee for hearing our testimony today. My name is Nadia Swanson. I'm a licensed clinical social worker with 12 years of experience, and the Director of Technical Assistance and Advocacy at the Ali Forney Center.

AFC is the largest and most comprehensive service for LGBTQ youth, ages 16 to 24, experiencing homelessness. Over 2000 youth a year access our 24/7 drop in, clinical services and housing programs. And we oppose this initiative not only for the youth we serve every day but also because we know that nationally 44% of unhoused adults experienced homelessness before the age of 25.

We are all in agreement that we want all New Yorkers to be able to get the care they need. But

this is not the way to do it. It is harmful, criminalizing, stigmatizing. Having police be the first response to mental health needs to a complete lack of understanding of the issue. For youth, just the presence of police will enact their fight-flight response, creating the self fulfilling prophecy the cops will need in order to justify their choices.

Someone with mental health needs, someone in psychiatric crisis, and someone who is enacting violence are not the same thing. And when you just handle it correctly, it is done with thoughtfulness equitably, honoring their worth and self-determination. This initiative conflicts with our professional values and code of ethics that we're licensed to uphold. We go through years of specialized education, internships, exams, supervision and ongoing work to confront our own biases in order to be able to assess the nuance of imminent risk, and when other services for safety can be provided.

NYPD can't do that in a few hours of training, especially with the values of the NYPD. We have seen too many times that people are killed during a mental health call. This is especially true for LGBTQ youth

who are disproportionately black, brown, and trans and it does not address the specific needs of LGBTQ youth.

Because of this AFC does everything we can to avoid police interactions for our youth. Others have shared stories about the violence, dehumanization, and the trauma that our youth face.

So I'm going to share a quick story. One day at our drop in center, I responded to a youth that was screaming in the hallway about wanting a gun to shoot themselves. Over the course of the next hour I sat on the floor with her, listened, built rapport, was able to keep them with me instead of her running away, using my clinical skills, give tangible resources, art materials to express themselves allowing them space to be in privacy without the pressure to speak. And by the end she was calm. And I was able to determine that she was not actually thinking of harming herself, and was reacting to how the New York City system had failed her.

We were able to end with the safety plan, find them emergency shelter bed and outpatient services.

I see my co workers do this every day. If she had been confronted by the police at that first

moment, it would have ended in a physical violence against her, and you can't learn how to do all of that just described in an hour training video.

This initiative is infuriating. It's a waste of time and resources especially when we all know the answer: housing. We need early intervention for degenerative SMI, no-barrier affirming mental health care peer to peer support expanding programs like B-HEARD, which has been very successful at our drop in in Harlem, RHY mental health shelters and housing, housing, housing. Thank you.

COUNSEL SUCHER: Christina Speric, you may begin when ready.

MS. SPARROCK: Good day Chair and members. Today I'm requesting the Mayor's mental health plan to be re evaluated as it relates to the use of police to involuntary remote people they deem to have mental health conditions into hospitals without the individual even being a danger to themselves or others. I want to also ensure the city does not merely substitute mental health professionals for police, as some, I'm not saying all, as some mental health professionals are harming our neighbors who need care and place them in dire circumstances.

The solution instead should be centered around pair specialists, people with lived experience and a fully-transformed mental health crisis response.

Before I continue, I would like to introduce myself my name is Christina Sparrock. I'm a Certified Public Accountant living with a mental health condition. I'm a staunch mental health advocate and a founder of Person Centered Intervention Training, Mental Health Response Pilot, or PCIT, which is a peer-run up agency that destigmatizes mental health conditions and supports communities.

The PCIT program is a person-centered, strength-based, trauma-informed, and empowering model that meets people where they're at, removes the emphasis on what's wrong with the person, and focuses on what happened.

For instance, if a person needs immediate housing and has an emotional break, connecting them with housing, and offering involuntary support as opposed to police is the way to do it and not incarceration or hospitalization.

Not only is PCIT effective for people living with mental conditions, but it benefits others living with

substance use issues, those who are just as involved, unhoused, and the general population overall. Whether it's a law enforcement officer, a teacher, a surgeon, or a psychiatrist, mental health conditions can affect everyone. It's not a them issue. It's a we issue.

In addition, PCIT employs peer specialists who are vital to the success of the program to help divert people from law enforcement to treatment and services. Peer specialists understand and have walked in the shoes of others' needs and know the path to recovery, and mental health condition is not a crime. It's about normalizing the condition, providing people with the services based on their unmet needs, and having empathy and patience.

Sadly, at the System for Mental Health Emergency has always been public safety or law enforcement as far as first responders, and things have been hugely exacerbated by the Mayor's new policy. And law enforcement now has the authority to involuntarily remove people they deem to have mental health conditions into hospitals without even knowing-- not without the individual you or even being in danger to themselves or others. Notably, hospitals can be very

traumatizing, and traumatizing. I know; I've been there.

Although the mental health professionals are a better option than police for engaging with people with mental health conditions, there are still red flags within the mental health system that must be addressed and rectified.

According to the recent article in [inaudible] Psychiatry, there is a growing body of evidence of mental illness, stigma, and health care. There's biases, there's discriminative practices, a whole lot of things, by people who took an oath to first do no harm, and to fact to continue to do the harm.

Without being treated with dignity and respect, without having access to trauma informed person centered care by peers, people with mental health conditions decompensate end up in hospitals, jailed, unhoused, unemployed, and fall victim to crimes and continue to be subjected to a plethora of emotional, physical, psychological tax due to no fault of their own. Right in my backyard, District 35, people living with mental health conditions, substance use misuse, and other you know unhoused, and just have now fallen victim to community-based organizations

and to mental health organizations which unfortunately led to unwellness. People in the community were neglected, didn't receive mental health treatment, no continuum of care. People of color were getting less services than their white counterparts. A person, continuum of care, she ended up missing. Persons-- people were overdosed. The peer specialists worked in the-- reported a hostile environment. They were bullied. They went on medical leave. They were hospitalized. They would quit. They were reported to HR, but humiliated. It was horrible, right?

Funders and the funders were misinformed.

I would like to share details more after, if you want to know more about it, because I would love to share it too, and offer it, and ask that you investigate.

Many vulnerable people consequences are forced to be silence. Peers are silenced all the time. While city/state funded foundation funding agencies go unpoliced and unpunished leads us to say, and for the reasons set forth, this is why innocent people fall victim to our systems and end up unwell, unhoused, and under the Mayor's plan are involuntary removed by

the police. I can get removed by police in my own neighborhood because I have a mental health condition.

So as a solution -- I have more to say anyway -- as a solution, I have three requests for city council. First to support and fund peer-run response pilots like PCIT. Second to mandate culturally responsive trauma-informed, person-centered, training designed by peer specialists, because we know what's best for our you know, health and how we want to be approach, to train all health professionals and police, and also to create an independent peer advisory council that has access to data on quality of services of all health professionals, advise on best practices, assist in introducing and reviewing legislation, and issue public reports so we can all review them. Thank you. Any questions?

CHAIRPERSON LEE: No. I was just going to say, You took the words out of my mouth. Because when you were talking about that, I wanted to actually follow up with you afterwards. So I'll definitely make sure to get your contact information.

MS. SPARROCK: Thank you.

CHAIRPERSON LEE: Okay.

COUNSEL SUCHER: hank you Next we'll hear from Lena Allen from Fountain House, you may begin when ready.

MS. ALLEN: Good afternoon committee Chairs and members. My name is Lena Allen. I'm a Policy Analyst at Fountain House and I'm here to testify against the directive to expand the use of involuntary removal to address mental health needs in New York City.

Fountain House appreciates this issue is receiving the attention it deserves, because robust and respectful policy to support people living with Serious Mental Illness, especially those who are unhoused, is long overdue. Fountain House, as the originator of the clubhouse model, knows based on our almost 75 years of experience, that real progress can be made with solutions that are rooted in person-centered public health approaches.

While respecting the Administration's increased focus. We are concerned about any effort that utilizes short term and voluntary measures as a starting place. We are equally concerned about steps that rely heavily on law enforcement because we know

public health workers are better positioned to be at the forefront of engaging this community.

We cannot and should not ignore people who are living on our streets but must ensure that our care efforts center on dignity and agency. Fountain House has partnered with other or community-based organizations to spearhead efforts that enable people not only to become housed but to recover and thrive. The key element is building trust.

40% of our members have been unhoused, a quarter have been involved with the justice system, and some have had experiences with involuntary treatment. Many of our members feel fearful of this new expanded directive, because their behavior could be misinterpreted and put them at needless risk of an encounter with law enforcement. Our members, of which there are 2000 in New York City, are people living with Serious Mental Illness who choose to voluntarily be part be part of our recovery community. Our members, staff, and partners are deeply committed to working together to protect our community, share our stories, and advocate for what we know does work.

Without a comprehensive plan that moves people from crisis to recovery, the approaches announced will not address the revolving doors to hospitals and jails and can further stigmatize people living with SMI.

And beyond the moment of crisis, the city must resource community based recovery models including respite centers, supportive housing, peer models, and club houses like Fountain House, which will greatly reduce the need for crisis response in the first place.

Mayor Adams stated in his speech, people living with severe mental illness deserve care, community and treatment and the least restrictive setting possible. We agree, and believe that now is the moment to develop the continuum of care plan, and to do so in partnership with people with lived experience, as well as organizations and professionals who have effectively served this community.

The greatest city in the world can and should be the most humane and visionary and caring for our most vulnerable. Thank you.

CHAIRPERSON LEE: Thank you so much. Nadia.

MS. CHAIT: Good afternoon. Nice to see you, Chair Lee. I'm Nadia Chait. I'm the Senior Director of Policy and Advocacy at CASES, and we are an organization that's dedicated to serving New Yorkers who have Serious Mental Illness and who have had interactions with the criminal legal system.

To be blunt, our clients are those who are most likely to be caught up by this directive in ways that will be very harmful to them, and that will lead to their removal from the community, and from the services that we provide that are actually helping them. So we strongly oppose it.

But you've heard a lot today about all the reasons why this is bad. And so I'm going to focus on the things that we should do instead, because there is a clear need to help New Yorkers who are experiencing Serious Mental Illness as particularly those who are living on the streets.

We strongly urge the council to work with the Mayor to increase funding for intensive mobile treatment, to eliminate the waitlist for these services. CASES is the largest provider of intensive mobile treatment, which is a team-based model of pure specialists, behavioral health specialists,

psychiatrists, and nurses who provide wraparound support to individuals who have Serious Mental Illness, and are homeless or were recently homeless. These are individuals who have been repeatedly failed by our systems and fallen among the gap the, you know, gaping holes between the different silos of services. But IMT is incredibly successful. And IMT is built on the premise that when individuals receive the services that they need and are offered the services that they need, that they will engage with services in a voluntary fashion, and that we do not need to use involuntary commitment as a first step in serving individuals. Our understanding is that there's currently a 600-to-700 person waitlist for intensive mobile treatment services, which is unacceptable. And while the city does have an RFP out to add five additional teams, that will not eliminate the waitlist that'll serve about 135 additional individuals. So we strongly encourage increased funding for intensive mobile treatment.

We also would like to see more support for the clinic based services, which -- Councilmember Lee I know, you know, the funding challenges of clinics very well -- but at CASES, we really struggle with

the need to provide holistic support for our clients under a model that is based on a fee-for-service, you do a thing, you get billed and that doesn't really treat our clients as the complex, wonderful people that they are, who might need criminal justice support, who might need housing support, who might need someone to go and visit them in the community, rather than making them come into the clinic.

So we had certified community behavioral health clinic funding, which was a SAMSA grant. Unfortunately, our grant expired and our clinic currently operates at an annual deficit of $700,000 per year. That is not a loss that our agency can continue to maintain. We are the only clinic in Harlem or the South Bronx, and one of the only clinics in Manhattan that is dedicated to serving folks with Serious Mental Illness and criminal legal system involvement. And so we urge the council to explore ways to better fund services like ours.

And last, I'll just close with talking about the need to better serve those who are caught up in the courts. We are the pretrial service provider for Individuals who are facing trial in Manhattan in New York County. So we provide supervised release

services to a range of folks who are arrested and facing trial and Manhattan.

We find that unfortunately, those with mental illness are more likely to fall between some of the gaps that make it harder for them to succeed in pretrial services, particularly individuals who are homeless. And so to fill this gap, we would really like to see what we're calling a community care van, which would be a van located right outside of criminal court so that when folks are leaving arraignment, they could immediately go into the van for a clinical psychiatric and substance use intervention. The van would have a shower and a bathroom, we would be able to provide folks with clothes, food, and escort them to the services that they need. So instead of having individuals who were arrested because of their mental illness, left without help, or sent to Rikers, we would be able to provide them the holistic support that they need. Thank you.

CHAIRPERSON LEE: Thank you. And unfortunately, that deficit is all too common with a lot of these outpatient nonprofit clinics. So hopefully, there's a lot we can change on the reimbursement system in

and of itself, which needs to be fixed. So I totally agree with you on that point. And I just want to thank all of you for the work you're doing in the community. So thank you. Thank you.

COUNSEL SUCHER: Thank you to this panel. Our next in person panel will be Ruth Lowencron, Ramon Leclerc, Simone Gamble, Ari Kadesh, and Alexandra Nyman.

Alexandra, you may begin when ready.

Good afternoon Chair Lee, members of the Committees. My name is Alexandra Nyman and I serve as the CEO of the Break Free Foundation that provides scholarships for individuals suffering from substance use disorders, so that they can attend a rehabilitation and outpatient program at no cost to them. Thank you for this opportunity to testify.

It is my firm belief that involuntary mental health hospitalizations cause obstacles to quality, evidence-based mental health care by creating a fear of forced treatment and fraying a person's trust in the mental health care system.

A family member of mine went through this when they were in college due to being in mental health crisis, and being confronted by an officer instead of

a mental health professional did not remedy this situation but intensified it. This confrontation resulted in them having a severe panic attack as the officer was not equipped to de-escalate the situation, but kept escalating things to the point that my family member did not feel safe.

After the officer called an ambulance. My family member was rerouted twice to two different hospitals before they were able to get to the proper facilities, causing my family member to be worried and panicked about how much this ride would cost them, which should be the last thing that you're experiencing when you're going through a bout of mania.

Instead of finding relief during their hospitalization, for the first 24 hours, they sat on a stretcher in a hallway waiting for an open room to open up getting little to no sleep. They were not able to contact me so I had no idea where they were for roughly 72 hours.

When they got into a room and were admitted into the behavioral health unit, they were lumped in with patients of varying mental illnesses. There was chaos in the halls screaming throughout the

corridors, with medication shoved down their throat forcefully.

This shut my family member down from talking about the experience until after years of intensive therapy. While my family member did not have a co occurring disorder, which further exacerbates this dire issue, and is not an unhoused individual, they were not given the qualitative treatment they needed.

I'm lucky that they're still here with us and that they are in recovery to this day.

People who struggle with behavioral health issues are marginalized and face stigma that can lead to severe consequences. Chair Hanks and members of these esteemed committees, you must realize that this policy perpetuates the belief that many people hold that individuals with mental health issues are dangerous. But in reality, they're more likely to be victims of crime and excessive use of force by the police than to cause harm.

I urge this committee to put an end to this policy. In the words of my esteemed colleague, Matt Kudish, the CEO of The New York chapter of NAMI, the city has the power to provide on-site treatment as well as treatment in homeless shelters or supported

housing, but has chosen not to. The time to make these changes and to address the mental health crisis within our city is now, but causing generational trauma and the process and resistance to behavioral health care is not the way to go about it.

Thank you for the opportunity to testify today and your continued leadership and partnership. I can answer any questions you may have.

CHAIRPERSON LEE: Thank you so much and good person to quote Matt Kudish. I know him personally myself, so he's a wonderful human being.

COUNSEL SUCHER: Before we move on to the next panelist, Ruth, I apologize. I'm just going to call the remaining in-person registrants to see if they're here, and for them to come up and please get ready to testify. So Stephen Nathaniel Reesie, Kate Whitmore, Jason Bowen, Christine Henson, and Richard William Flores. If you're here, please come to the table and get ready to testify for-- following Ruth. Thank you. ruth, you may begin when ready.

Thank you. Ruth Lowenkron. I'm the Director of the Disability Justice Program at New York Lawyers for the Public Interest. My office is a proud member of CCIT-NYC, Correct Crisis Intervention Today, New

York City. I just want to point out that that is constituted of over 80 organizations that advocate in this space, and I think it's a really good link to one of my profound comments. I have prepared my testimony, and will share it with you.

So you're going to get a little melange of summary. Having sat here all day, there has to be an advantage. I have all kinds of other thoughts that occurred to me. And one of them is: So not only are these ad organizations, or as my mother would say, "anyone who's anyone", is a member of CCIT-NYC. But have you ever been at a hearing where everybody has-- speaks in the same voice and says no to what the Mayor is doing? I think it's profound. And I think that really has to be underscored. There isn't a single person, other than the city agency, and I want to say to follow with Skip said: I think it's not only an entire disrespect, that they are not here, but in an outrage beyond that. We are the taxpayers. They don't want to hear what we have to say on this? How dare they leave the room without listening to what we have to say, without listening to the fact that nobody supports what the Mayor says.

So that's one profundity. And the others are perhaps just summaries. As I said, outside, I think there is no doubt that this is not only immoral, it's illegal as my colleague Beth Haroules spoke about. There is litigation about this. It is not hard to see why it's illegal.

And I think I'm going to try and break it down just a little bit, and then put it together with testimony we heard from NYPD.

So what this policy allows is for the police to stop individuals whom they think may have a mental health illness -- they don't know, and how would they know, and how could they know? So they think they have mental health illness, and they think they are unable to take care of their basic needs, whatever that might mean, because lord knows it is not defined anywhere.

What is so critical is that this is an absolute departure from all law that says that if you want to -- if the city, the police want to detain an individual, they must show that the individual is a danger to themselves or others. There is no pretense to even the idea that we are saying that the person has a danger to self or others. Perhaps they do, but

very more so what if perhaps they don't? And I think it's very telling, when we got a list of examples. I've been going a whole time talking about the Mayor saying about kickboxing. Kickboxing? You're kidding me. How does that show someone's a danger to themselves? Well, today I heard the ultimate insult, or the ultimate incredulity, when the when the NYPD said oh, you know, if someone reeks of urine -- and then perhaps I didn't hear her right, so she repeated herself. So someone reeking from urine would be thought of to be a danger to themselves. I do imagine there could be certain circumstances when that's true. I have a vivid imagination. But that doesn't mean that we are hearing something that we can rely on in terms of what the NYPD is being trained. It is very, very scary. If that's their idea of who the people are that they can be picking up.

I know the bell is ringing. So I'm going to say just a few more things, I think it's really important to know that if you would like to see, in addition to the incredibly compelling experiences, we heard of people and their family members, what my office has done is obtained the body-worn camera footage of a

number of the individuals who are killed at the hands of the police when experiencing a mental health crisis.

Under the banner "picture worth 1000 words", it is incredible. As one person said, first they escalate. Well, I don't know if that person said that. First they escalate. And then when all else fails, and they shoot the individual -- here's the part we heard already -- then they don't even try to take care of the individual they've shot.

So listen, the other elephant in the room. Let's be real here, and others have talked about this. This is not about helping people with mental health issues. Because if it were, we know how to do it. We absolutely know how to do it. This is about sweeping people with mental health issues away, so the rest of the city does not have to look at them, so the rest of the city does not have to feel like, "Oh my goodness, we're somehow failing and, ooh, look at that person." Let's call it for what it is. That's exactly what it is, and know that if you called it really helping someone, you would have a plan.

And that goes to two other quick thoughts. One is, I want to correct the record, when Jason Hansen said that he worked with the community. Again, I am hugely part of that community. I do not know anyone who was consulted on this. I think this was done in secret. The police didn't even know about it, as we've all heard.

And the last thing I want to close with is another statistic that picks right up off of my colleagues statistic. And that is not only are people with mental health, more likely to be victims than perpetrators. But we think, because the newspaper inundates us, because the Mayor tells us it's so, because popular culture tells us it's so that those people, quotation marks, with mental health issues are hugely dangerous and violent.

Well, that just is not true. They are no more dangerous and violent than anyone else in the population with or without a diagnosis. And I think that's a hugely important statistic to leave with. I will stop shouting at you now.

CHAIRPERSON LEE: No, thank you for that. Thank you for that. And you're passionate as well, because I know NILPI has done a lot of work around this, and

so I really appreciate your efforts on this. So thank you.

MS. LOWNKRON: Thank you, Councilmember.

COUNSEL SUCHER: You may proceed next when you're ready.

MR. BOWEN: Hello? All right. Hi, everyone. My name is Jason Bowen, my pronouns are they/them, and I work as a peer advocate at the Community Access Crisis Respite.

So for a brief Intro for folks who might not know, again, what Respite is. Respite is meant to be an alternative to hospitalization for folks in crisis. It's meant to be a place where folks can come for short-term residential support. Everyone that works there is a peer, meaning we have our own lived experience. You know, we cook meals together, we do workshops. Sometimes I sit with folks and hold their hand while they cry. Sometimes we go on walks and look at the sun or look at the moon together. You know, it's really just an experience of being with each other. Really that bone deep, loving, caring on another person that is so, so needed.

And yet, you know, it's meant to be an alternative to hospitalization for folks in crisis.

And the respite center that I work at has an average waitlist of about five to eight weeks. Weeks. So people are calling, "I need somewhere to go now. I need crisis support." And it's constantly, "Well, you can try calling NYC-WELL. You can try calling 988. You can try going to the hospital." Been there. Done that. I've tried it. It's not working.

You know, at the Respite that I work at, I just came off a 12 hour shift actually. I worked overnight last night. I worked 8pm to 8am this morning and came straight here. And I'm going back tomorrow. And that's because you know, for a place to function 24/7/365, you need staff. I'm-- I'm grateful to be 22 years old, and then I've got the stamina to work 12/24 hour shifts, but we shouldn't have to do this. We should not have to do this.

And the work that we're supposed to be providing as peers is emotional care and support. I chose to become a peer because you know, I-- I come from a family who has a history of intergenerational trauma. I have my own traumas. And I came to be a peer because I was lucky enough to go to school in the city, and when I was having my-- you know, going through my mental health experience as an undergrad,

I was essentially told, you know, that either I should drop out because I wasn't fit enough to be at school there, or that if I did have a crisis that the police or campus security were warranted to come into my room and hospitalize me.

So these routes of involuntary coercion, not care are not unique to this legislation, are not unique to this era. This is systemic. It is the basis of the mental health system in this country. I mean, we have to literally look historically.

The first diagnoses of psychology in this country, you can go back to 1861 journal reviews, Drake Domani was one of the first diagnoses that existed in modern psychiatry. What was that? Drapetomania was what enslavers could diagnose enslaved people who ran away from plantations with. They could be diagnosed with drapetomania and forced to return to a plantation.

This is the same roots of the way that police act now it's involuntarily committing people to hospitals, involuntarily putting people in carceral settings, depriving them of the care that they need. Care does not look like putting someone in a setting where they can't go home, they can't call their

family, their phone is taken away from them, their clothes are taken away from them. It's horrible. It's horrible.

And we can, you know, I talk to people inside our, you know, hospitals. I talk to people inside Rikers every day. And I encourage everyone, you know, if your family if you haven't gone to that, do talk to people. Build those relationships. You know, we need to fund our programs. We need to fund nonprofits. But also, we need to love on each other.

You know, I'm so privileged to have built up my you know, crisis response skills, my radical mental health first aid, I want-- you know, I volunteer at a community garden. I share these skills with the folks in my garden. I want everyone to go knock at your local bodega, to go knock at your local restaurants to say, "Do you know what to do if someone's experiencing a mental health crisis? Do you know tools to call besides 911? Do you know who to call in your neighborhood? If you're going through crisis, do you know what family members you can call?"

The some of the things we can do, you know, are so complicated, but there are so many things we can

do individually, and with your support and funding that are so simple, so implementable, so clear. I'm 22, and I can see it clear as day and there are people who have been fighting so much longer than I have black, queer, trans, indigenous, ancestors who are fighting every day. And you know, that's all Thank you. Yeah.

CHAIRPERSON LEE: Thank you for that. I have a couple of questions, but I'm going to wait until the panel finishes first and then-- go ahead.

COUNSEL SUCHER: Sure, you may begin when ready.

RICHARD: Sorry, I'm currently homeless. And I'm residing at the BRC shelter on 47th Street. I've been a resident there since October 21 of 2021. Before I became a resident there, the volunteers used to come to speak to me on the subway. I didn't know about the BRC. I didn't know about the Manhattan Conservatorium. I didn't know that these agencies existed. I went to the drop-in centers to try to receive help against my will, because I became homeless because a family court judge committed perjury. They literally lied in court. And that lie became me being homeless.

I had a lawyer appointed to me for free by the city whom I saw before the court date, and brought him documentation to show what was allegedly being said about myself and my family. And he told me that documentation didn't mean anything to him. He told me that I had to find a job in a month, and if I didn't find a job in a month, I would be homeless. And this is documentation that I had from the hospital, being hospitalized several times, Documentation showing what had happened in the home, documentation showing what had happened with the police. And he literally told me, that didn't matter. He said, "If you don't do this, you're going to become homeless." And so I became homeless.

When the volunteers saw me in the street, I became aware of the fact that they weren't just looking at me as being a statistic. They were looking at me as someone who would become a victim to the legislation in this country. And I said to myself, "Wow, what what am I supposed to do now? I went to court, I had a lawyer. Perjury was committed in court. And now I'm, I'm a homeless person." I've worked in the financial industry in the city. I've worked for Chase Bank. I've worked for Toronto

Dominion. I've worked for many, many banks. I know it's kind of long.

And what I'm trying to surmise is, what I think is not being addressed here by-- by the Mayor's policies is that how, how could he dare treat an American citizen like that? How could legislation be passed like that?

It's a question that I think about every single day. Now, you talked about services. You talked about people being taken away from the streets. Everyone's talked about the work that they've done here for people. The work that they do every day. What I-- what's amazingly dismaying to me is that the BRC is a phony agency. They abuse people there. They routinely use racist comments, discriminatory practices. I emailed the Mayor. They called me back. I emailed the governor, they sent two detectives to the BRC shelter who gave a false interview with me about my complaints about what had gone on there. And the detectives called me back and said, "Sir, we don't have any evidence of the allegations that you made." And I said to them, "Sir, if he's if what I'm saying didn't happen, why would I text you?"

Now this is being done under the banner of men of mental illness, schizophrenia, paranoia. And to be perfectly honest with you, it's a trick. And it's somebody that's being done on purpose to incarcerate people, to make people sick and kill people.

The mayor and the governor are well aware of this issue.

And I guess lastly, what I'd like to say is the Mayor and the governor have to be held accountable for the fact that they too, are committing perjury, and they're spreading lies, they're spreading racism, they're spreading discrimination under the banner of the law.

And this legislation has to be changed. It has to be revamped to help the people in the way that they really need to be helped, or else this is going to go on, and 20 years from now. The kids who have been affected the young people have been affected by the policies that are being put forth today, there'll be sitting before the next committee, talking about what's affecting them. And this is just going to go on and on and on, despite the efforts of all the people trying to make things better, despite the efforts of your committee trying to make things

better. The governor, the Mayor. It's almost as if it's almost absurd, like-- like, it doesn't really matter. They're saying that it matters, but yet it doesn't really matter. They're putting these policies forward without a true conviction, without-- without a true plan.

I could sit with the Mayor, I love listening to the people here. Every single day, I would love to sit with him. And if he asked me, "Richard, do you have any solutions?" I could provide solutions. I'll say, "Sir, I'm the one that's living at the shelter, not you." Right?

He went to the shelter the other day to spend time with the migrants there. And he said the conditions were deplorable. He said the conditions were awful, et cetera.

I thought a lot of it was a political show to be to be quite honest with you. Because he's been mayor for quite some time. Governor Hochul has been here for quite some time. And the first thing you will look for, for them, is for them to be perfectly honest and factual about what's going on, and not play a semantical game or a political game about what's going on. They should just simply tell the

truth. And therefore, when the budget proposals are are made, that money is supposed to be used to actually help the people.

I testified to the New York Senate in 2020, to the entire Senate, and the budget proposal was being passed back then as well. I told him my personal story, I told them what I thought about what they were doing, I told them about what their policies were doing. When we returned back to New York, with the agency, the group that I was with, guess where I was? Out on the street. And I'd been on the street-- I was on the street for seven years, in bone chilling weather, cold blue weather, denied shelter at Bellevue, denied shelter at the drop-in centers. Seven years. And that's-- that's a very traumatizing thing for them to turn around and say, "Okay, now we're going to provide you services," it's almost adding insult to injury, you know? It's really absurd.

So, the reason why I wanted to testify today is because perhaps it might help yourself, and help the Mayor, and help the Governor try to think about what strategies are going to be used, and what would be useful, hearing it from someone who's actually living

it every single day, you know, and it's-- I have to say, it's one of the hardest things I've ever had to deal with in my entire life.

And if these testimonials are taken seriously, then I think everyone here would hope to see some change. And not just talking about it, but doing something about it. I think it's high time that they do something about it, if they want actual change to happen. If he was sitting here, right now, I could sit with him and tell him exactly what's going on there. And they're supposed to say, "Okay, this is what we're going to do. Now, this is what we're going to change because we want these people's lives to be better." It's not just housing, as everyone said. It's a comprehensive strategy that needs to be used and maintained. And so far, so far, that hasn't happened.

I would love to be able to speak to the Mayor and speak to the Governor in person, and have the kind of conversation that we're having right now. That's it.

CHAIRPERSON LEE: Thank you, Richard. And I'd like to have-- well, on a separate note, I'd like to talk to you separately about your situation. But it just seems like also, there's an opportunity here as

well, because there are so many great community partners that hopefully we'll be able to connect you with, that are right here in this room, not to put you on the spot. But you know, so to really get down to the to the root of it. And to see-- I mean, I know, it's just one example, but your case, I think, highlights a lot of the-- the issues that we need to work on and dissect. And so I just want to thank you so much for being here and taking the time to just testify, and for waiting until now to share your story. So I really appreciate that. And I just want to say thank you.

And then just to the other folks who are on the panel, something that you have brought up Jason was-- and this is a question for anyone, actually. But one of the feedbacks that we-- we would hear all the time from THRIVE, the previous version, was the mental health first aid training was one of the things that did seem to work well.

And I know that for us also, when I was at my CBO, we actually reached out to our faith-based leaders in a lot of the immigrant communities that were first gen that typically would -- me growing up in the church, right? -- they would typically say

things like, "Oh, you just have to pray harder," or pray it away, right? And I was actually, to my surprise, pleasantly surprised, because they were almost like craving and hungering for that type of training. Because I think they knew and understood and realized that, you know, there is a difference, for example, between spiritual and mental health issues.

And I think, you know, not just the faith based communities, but other communities, like you're saying, in your community garden and other folks that are around, you know, is that-- you know, and we actually offered it and translated it ourselves because there was no one to translate it for us. And so we did this whole train-the-trainer model, and I'm just wondering if-- if that is an effective type of training that you think we should also implement, not just within the city agencies, and amongst the staff for example, but-- but also something that can be offered to any community member that's interested in it. So I just wanted to get your thoughts on that real quick.

MS. LOWENKRON: Hi. I have some thoughts on training. And I think it allows me to talk just a

little bit about the B-HEARD program, which I think has gotten a really good sell job, that it perhaps doesn't really deserve.

And one of the concerns -- just one of the many concerns -- is its failure to appropriately train or in any event, to let us know how any of that training has happened. It's very similar to what we're hearing with the Mayor's proposal, or better said policy, since it's in place, that there's training going on. And today we just heard, "Well, yeah, there's this video." There's not a whole lot of information about it.

And so having said that, and to respond to your question, I think the answer is that you absolutely have to make sure that you're doing training that is culturally sensitive, and you have to make sure that you are involving people who have lived experience in doing the training. You have to have a review of the training. How's that training going? I was I could barely hold myself back from screaming, when we were told about the CCIT training that someone had seven years ago. Well, who's going to remember that? So another important part is that, you know, repeated.

Exactly, yeah. So I think those are some of the hallmarks. I hope that's what you were asking.

CHAIRPERSON LEE: No. No, it is. And also, just to reframe the question a little bit and feel free like, any of you, if there is an example of one that you would recommend?

MR. BOWEN: Yeah, so, um, well, I actually wanted to talk about two things. One is kind of a direct response to your question. One is just on the piece about police training in general, the CIT training.

You know, I think it just it gets tiring to hear the conversations about police training over and over again, after a while. I think-- I mean, we can look straight to what has already happened. And we can look to Minneapolis. Minneapolis in 2015, they were granted a $4.5-- almost $5 million grant, to invest in police reform, to invest in crisis intervention training. And yet, we still saw a video of eight minutes of kneeling on George Floyd's neck after you know, years of crisis intervention training. And I know this is not to the question you're asking.

But continuing to give resources to a system that is broken, the policing system was never meant to heal us. It was never meant to take care of us. It

was meant to, as you know, Ruth was talking about, it was meant to create public order, it was meant to exclude certain people from that idea of order. You know, giving more money to that system to eventually, you know, train itself to do it something better.

You know, as someone who works in mental health, I crave trainings, I desire to learn more, because I actually see, you know, people-- people in healing, people in struggle, people in growth as people, and I desire love to learn more. I love to learn ways to sit with them, and to be human and to be whole with them. And if it's an exhausting thing for someone to sit down for a 30 minute training, then, you know, maybe don't want their help in the first place.

And then just in terms of, you know, radical mental health first aid, I can speak for myself a little bit, and then, you know, offer some other thoughts. For me, you know, I mentioned I'm young. I really became more radicalized more politically aware, more aware of my own experiences, too, as someone who lives with, you know, what is called a serious quote/unquote, mental illness throughout the pandemic. And so for me, I turned to a lot of online spaces.

There's a really wonderful group called Project LETS, which is campus based peer-support collective that has now expanded to not only campus based. They also do research and a lot of anti carceral mental health response, but project LETS is a great group. Cat-911 is also an anti-carceral, community-based, radical mental health response based out of California, and they actually have an abolitionist mental health crisis rapid response, four-day training on YouTube for free. I was able to attend it live, but it's available on YouTube completely free. I've shared it with multiple members of my community before.

And you know, I do think that, you know, scaling up models of mental health first aid for our communities is super-duper essential. I just get wary when those things get delegated to, you know, positions like this.

You know, I think with the power that the City Council has, we live in not only the richest country, but one of the richest cities in the world, and I get tired of solutions that ask for so little. You know, it makes sense for when we're getting together with, you know, a few of our community members, and we're

trying our best. You know, we can only get-- you know, maybe we can't get the interpreter, we can't have someone to do things in multiple languages. But when the city with all of its resources is like, "Yeah, we're going to have this one training one time. It's only in one language. No ASL. No, you know, Spanish or Mandarin." It's-- it gets tiring.

So, yeah, I think those things are needed, but they need to be accessible for folks of all, you know, communities. You know, there needs to be childcare, et cetera. You know, I think if we're going to invest in those things, we should really invest in them. You know, dream for the world that we want to live in, not continue asking to get by with the bare minimum.

CHAIRPERSON LEE: Thank you for that. And yes, I was referring more to the, like the peer-led trainings, because I do think that I've seen those become really effective and impactful. So I just-- but yes, I hear everything you're saying. So thank you. And I wanted to you wanted to also respond to that.

MS. LOWENKRON: I just want to say one quick thing. And that is that a really good model for the

training is what comes out of the CAHOOTS Model that I don't think was mentioned, that has been doing mental health crisis response for over 35 years with incredible success. And it's what the Daniels Law that has just been reintroduced at the state level is based on, and with a tweak that we've have of it, ensuring that it is peer-led, and they have their crisis response teams, about 75% peers.

What Daniels Law has is a mandate that there is, on every team up here, but the training from the CAHOOTS program, I think is really important.

MS. CHAIT: To piggyback off and that with a CAHOOTS, they responded to 17,700 911 calls in 2021, which was 17% of all of the 911 calls, which dealt with a mental health crisis. Here in New York, we average about 139,100 911 calls that deal with deep emotional distress, just to add to that.

MS. LOWENKRON: Yeah. And I hope you're not suggesting by that-- that it's that it's a-- I'm sorry?

I mean, yes, it's a smaller city, a smaller model, but it's being adopted in Los Angeles and San Francisco. Denver has a similar model. Albuquerque is moving towards that. So I mean, yes, we have to

scale it up. And CCIT NYC has a proposal. We've talked about it a lot, I'd be happy to talk more about it with you. But we definitely think it can be scaled up, and the sponsors of Daniels Law certainly think it can be scaled up.

So I'd love to talk to you more about that. But I just wanted to raise it in this context, as it-- for its training, because they do extensive training of all of their workers.

MS. NYMAN: So as the peer run training that you also mentioned, I created a 35-hour training on [inaudible] intervention training. And it's all peer run. It is 35 hours, and is able-- I train the community members. I train New York City Parks Department and other people as well, and got certified in it.

As for your mental health first aid, I took the mental health first aid training. I really think it's effective. The only issues with it, it's it needs to be-- when you do any training, it has to be geared for a particular audience. So if you're training faith based organization, you have to put in some scripture in there. You know, if you're training people in the black community, you got to do

this scenario. You're training people from the Jewish community, you got to put a little spice in there too, just to make it relevant to that community, because then they can be able to understand, because it resonates with them. And then it's more applicable. You bring in like real current issues and you know, history or something, current events and a paper, make it relevant. And I think it's effective. Yes.

CHAIRPERSON LEE: Thank you all so much. I appreciate you taking extra time.

MS. CHAIT: So I just kind of wanted to answer your question on that. One of my thoughts on training with religious leaders. It's something that I get very upset about personally. When-- when I was younger, my mother took my younger brother to talk to our Catholic priest, after he had come out to her as being gay. And he had told my brother that he would burn in hell, and that the only way that he could be saved was if he did not act on his urges. And he told him he could still come to church, but that you know, he might be corrupting the people around us.

And that led to his first of many suicide attempts. And so I think in training, these

religious leaders, we have to be very sensitive, and also make sure that when they're speaking, they're speaking to a wide variety of individuals that may go against their personal beliefs, but not to use those beliefs to pervert religious beliefs and the trust that their congregants have within them.

My mother suffers from OCD and depression. And she would seek counsel and advice after she lost my father, from our priest. And so she really thought she was doing the right thing in reaching out and talking, and she never imagined that that would happen.

I do also want to talk about a program that I know of that is not faith-based that addresses individuals with substance use disorders and co-occurring disorders. We have around 1.4 million New Yorkers that have a co-occurring disorder, which is around 7% of New Yorkers. Only around 10% of those individuals actually seek out and receive treatment for that. It can be for a multitude of different reasons, some people just don't really click with AA. Some people just want to try to medicate with substances for their mental health issues. And I have found that programs like Smart Recovery For The

Individual is something that is very helpful in giving you task-based things to do, instead of basing it on scripture. Which for some people that can feel more productive, because then you're taking these productive steps, you're learning these tools, you're not always having to go to a meeting and being like, "Yes, I'm an addict. I've been in recovery for X amount of time." You're owning your recovery, and you can come to these meetings, or you could stop going after you feel that you have properly learned in immerse yourself within the toolkit.

So yeah, that's my thoughts on that. And there's also the craft method of recovery for families, for friends, for peers to learn so that they could learn how to cope with their loved one who may be suffering from a substance use disorder or co-occurring disorder.

And just in general, I think that we should be offering more awareness on Narcan and fentanyl testing strips. These different things that may not seem to directly correlate with mental health. But it really does, because most people who are using substances they're doing so I'd be a place of profound pain. Yes, thank you.

CHAIRPERSON LEE: Thank you.

COUNSEL SUCHER: Thank you to this panel. We will now move to remote testimony. For remote panels, I will be calling out groups of names. So maybe about three or four names at a time so you can prepare to testify. As a reminder, once your name is called a member of our staff will unmute you, so please accept the prompt before speaking.

Our first remote panel will be Jeremy Kidd, Sandra Gresl, and Deborah Berkman.

Jeremy, you may begin when ready. Thank you.

DR. KIDD: Good afternoon. My name is Dr. Jeremy Kidd. I'm an Addiction Psychiatrist at Columbia University, public sector outpatient psychiatrist in Washington Heights and Inwood. And I'm speaking to you today as President of the New York County Psychiatric Society, an organization representing over 1600 psychiatrists in New York City.

Our members work in a variety of settings, outpatient clinics, inpatient hospitals, emergency departments, jails, prisons, and homeless shelters.

I want to echo some of the points that have already been brought up today, but also to highlight what someone said earlier that I am profoundly

impressed at the number of organizations and individuals that have come out today to speak against this policy. And it makes me wonder who that Mayor's Office consulted before implementing this policy, because it certainly hasn't been any of our members that I've spoken with.

We at NYCPS wish to voice our concern about the Mayor's directive. While we agree with the Mayor that housing and mental health crises in our city require immediate action. We believe that this directive inappropriately over-relies on the NYPD and does not adequately address the root causes of homelessness or untreated mental illness.

We hope that City Council will provide oversight in three areas. First, New York State law already dictates that people can be admitted involuntarily to hospitals if they have a diagnosable mental illness, and are at risk of harming themselves or others due to that illness. However, when poverty and homelessness are the primary contributors to someone's inability to care for themselves, psychiatric hospitalization is not clinically warranted. And City Council can provide oversight to ensure that due process and civil rights are

protected during the implementation of this initiative.

Secondly, inpatient bed capacity as you've already heard in New York City is severely limited. Our members working in emergency departments report that patients who need psychiatric hospitalization frequently wait hours or even days for a bed to become available, and City Council can help us track the impact of the Mayor's directive on emergency departments.

I was also pleased to hear some of my psychiatry and emergency medicine colleagues sharing information about what's actually happening on the ground, as opposed to the idealized version of discharge planning and inpatient hospitalization prevented by some of the Administration officials earlier. Unhoused people with mental illness need stable affordable housing and a housing-first model, access to community based mental health care. Involuntary removal, emergency detention, and involuntary hospitalization provide none of these.

The pre-pandemic shortage of psychiatrists has only gotten worse. With many outpatient treatment programs unable to fill vacancies. City Council

oversight can determine whether the Mayor's directive results in people gaining access to housing and outpatient care. We do not believe that it has.

Earlier someone mentioned intensive mobile treatment assist programs like the ACT system. And that's a wonderful--

SERGEANT AT ARMS: Thank you. Time expired.

CHAIRPERSON LEE: : No, I was just going to say take a couple of minutes to close out. I mean, a couple sentences sorry. Thank you.

DR. KIDD: So in summary, the New York County Psychiatric Society asks City Council to ensure that the Mayor's directive does not impede on the civil rights of unhoused individuals with mental illness, and to monitor the impact of this directive on already-crowded emergency rooms, and overtaxed outpatient mental health services.

We're happy to be a resource to the council in the Mayor during this process. Thank you for your time and attention to this important matter.

CHAIRPERSON LEE: Thank you so much for joining and staying on remotely.

COUNSEL SUCHER: Sandra Gresl, you may begin when ready.

MS. GRESL: Thank you. Good afternoon, and thank you to the joint committees and everyone participating in today's hearing. I appreciate your patience and endurance. My name is Sandra Gresl. I'm testifying today on behalf of the New York City Bar Association, where I currently serve as Co-Chair of the Social Welfare Law Committee. My testimony is also informed by my experiences as a senior staff attorney in the Mental Health Law Project at Mobilization for Justice.

The New York City Bar Association has submitted written testimony that outlines in greater detail our primary legal and policy concerns regarding the Mayor's new directive. The testimony reflects the expertise and insights of the Social Welfare Law Committee jointly with the Civil Bars Civil Rights Committee, Disability Law Committee, Mental Health Law Committee, and the New York City Affairs Committee.

First and foremost, I'm here today seeking the Council's support to secure a commitment from the Administration to halt its rushed implementation of the involuntary removal directive, and instead to take the time needed to meaningfully address the

serious concerns raised in response to this directive by individuals with lived experience of mental illness and or homelessness, and the larger medical, legal, and service provider communities.

I'll just briefly outline the City Bar's three primary areas of concern with this directive.

Firstly, as has been mentioned earlier, the directive allows involuntary removals for reasons that fall outside the scope of what is permitted by our state and federal constitution and related state mental health laws, and I'm referencing the expanded basic needs standard here.

Earlier, we had one city agency representative who said she was not prepared to comment on the legal reasoning underpinning that standard. And another city agency representative who stated that court counsel reviewed the directive but didn't offer any additional information or context as to their interpretation.

The Bar's said second concern is that the directive is at odds with the city's obligations under federal, state and city anti discrimination law and at least two distinct ways. Firstly, involuntary removals could deny people access to public spaces

such as the subway and the streets based on their mental illness, or the perception of it, and a much broader set of circumstances than is allowable under the Americans with Disabilities Act, and without any provision for a reasonable accommodation.

Second, the initiatives focus on hospitalization, and the absence of adequate and appropriate community based services is inconsistent with both federal law and aligned state commitments to ensure the availability of treatment options.

Our written testimony details the City Bar's perspective on each of these points. Further, we invite the city to use us as a resource and would welcome the opportunity to meet with the Council and city attorneys to discuss these issues further.

Thank you so much.

CHAIRPERSON LEE: Thank you so much, Sandra.

COUNSEL SUCHER: Next, Deborah Bergman. You may begin when ready.

MS. BERKMAN: Chairs, Councilmembers, and staff. Good afternoon and thank you for the opportunity to speak to you today and thank you for you know, hanging in there for so long and waiting for our testimony. My name is Deborah Berkman, and I'm the

Supervising Attorney of the Shelter Advocacy Initiative at the New York Legal Assistance Group.

I've worked with numerous people experiencing street homelessness, who live in fear of being incarcerated because they are impoverished, and I've represented several individuals who have been subjected to involuntary removal. The mayor's current initiative criminalizes poverty and twists the standards of the Mental Hygiene Laws.

Additionally, it won't be effective at mitigating street homelessness. Mental Hygiene Law Section 941 authorizes removal if a person appears to be mentally ill and is conducting himself in a manner which is likely to result in serious harm to himself or others. But the law specifically states that examples of likelihood to result in serious harm or threats of or attempted suicide, or homicidal or other violent behavior. These examples refer the spoken threats of physical harm.

The city's published guidelines. On this section, twist the definition of likely to result in serious harm to himself or others to mean a person who appears to be mentally ill and displays an

inability to meet basic living needs, even when no recent dangerous act has been observed.

The city's guidance goes on to state that if a person appears to have mental illness and can't support their basic human needs, to an extent that causes them harm, they may be moved for evaluation. That's a gross misreading of the words of the Mental Hygiene Law. Even more egregious in the NYPD's communication to its officers about this directive it uses as an example of someone appropriate for involuntary removal to be someone who appears mentally ill, and is not able to seek out food, shelter, and other things needed for survival.

This is nothing short of a declaration that extreme poverty constitutes grounds for involuntary removal, and Mental Hygiene Law Section 941 makes no mention of poverty being a factor to consider when determining whether involuntary removal is appropriate. Sleeping outside is not evidence of mental illness. It's a function of lack of resources and a fear of congregate shelter. In fact, the majority of my clients experiencing street homelessness have tried to stay in DHS congregate single adult shelters, and haven't been able to

remain there due to assault and trauma they endured while they were there. Quite simply, they are too scared to go back.

Ordering the hospitalization of people deemed to mentally ill to care for themselves, even if they do not pose a threat is not only cruel and inhumane, but will also undoubtedly be ineffective at helping people transition to inside.

I have two clients who had been removed, and neither left their sleeping spots permanently.

My first client Mr. V was escorted by an ambulance purportedly because he needed help. On the ride to the hospital Mr. V conversed with the EMTs and once the ambulance reached the hospital, the impatient EMTs released him before he even made it into assessment, presumably because they believed he was not a danger to himself or others. He then returned to his usual sleeping spot.

My other client was admitted to the hospital for two days after involuntary move removal but immediately returned to his old sleeping spot. In order to truly mitigate street homelessness, the City must create low barrier shelters with small rooms that are more accessible. Most of my clients who are

experiencing street homelessness would and do come inside when offered such placements. Thank you for the opportunity to speak.

CHAIRPERSON LEE: Thank you so much Deborah, and for the work that NYLAG is doing. Appreciate it.

COUNSEL SUCHER: Next we'll hear from -- I'll go through the names: Lauren Galloway from the Coalition for Homeless Youth, and then Carolyn Strudwick from Safe Horizon, and then Erick Eiting, and then Sam Cukoscka.

Lauren Galloway, you may begin when ready.

MS. GALLOWAY: Well, good evening. My name is Lauren Galloway, she/they, and I'm the Advocacy Coordinator at the Coalition for Homeless Youth. CHY has advocated for the needs of runaway and homeless youth, known as RHY, in New York State for almost 45 years.

Thank you to Chair Lee and the rest of the Committee for holding today's hearing on the mental health involuntary removal, and Mayor Adams' recently announced plan.

I'll be submitting longer written testimony to address the mental needs of homeless youth and young adults, but like many nonprofits and other sectors,

runaway and homeless youth, RHY, providers and the majority of whom are funded by DYCD, echo the concerns raised by many legal service organizations that the city's broad language and the NYC removals directly would allow removals that are unjustified under the US Constitution and state mental health law.

The city's language announcing this initiative both reflects and will exacerbate biases against unhoused young people and young people with Serious Mental Illness in violation of the anti discrimination principles, and the NYC removals directives will disproportionately affect people of color.

This initiative directs resources into a failed strategy at a time when the city has reduced investments and effective strategies that connect people to long-term treatment and care, and this plan fails to address what the Mayor is proposing regarding youth specifically. CFY has no comments regarding the legislation being discussed. We would like to briefly outline some concerns and recommendations regarding youth and young adults that will be impacted by the Mayor's plan.

First recommendation: There are currently no mental health shelters, and currently DYCD RHY programs are not funded to provide this level of clinical services that many youth need. Therefore funding for mental services at RHY shelters needs to be prioritized.

Second, RHY providers encounter barriers when referring youth to supportive housing, or inpatient clinical services. The city must improve its coordination through the CAP system to ensure that youth regarding long-term and permanent housing that supports mental health needs to improve.

Third, there needs to be a clear policy regarding what training is responding to the entities that are providing services to RHY. I'm talking about NYPD, FDNY, and EMS.

Fourth, there needs to be a coordinated discharge plan between DYCD providers and the hospital. And lastly, there needs to be a plan regarding how minors will be treated under, this plan specifically those that are involuntarily committed and could be negatively impacted if communication and discharge from psychiatric services are linked to returning to unsafe home environments that they are like

previously led. This plan must account for youth that are not served through ACS. I'm here if you have any questions, and thank you and I look forward to our continued partnership.

CHAIRPERSON LEE: Thank you so much. Just one quick question. You said you guys receive funding from DYCD. Is that correct?

MS. GALLOWAY: Well, we're the Coalition for Homeless Youth, so we have over 65 providers, 29 right here in the city, and those are all funded through DYCD.

CHAIRPERSON LEE: Got it. Thank you.

MS. GALLOWAY: Yeah, of course.

CHAIRPERSON LEE: And thank you so much for the work you're doing, because the youth piece is something we don't talk enough about. So thank you

MS. GALLOWAY: Completely agree, Councilmember Lee. Thank you also for sticking around. I appreciate you.

COUNSEL SUCHER: Thank you. Next we'll hear from Carolyn Strudwick from Safe Horizon. You may begin when ready.

MS. STRUDWICK: Good afternoon, and thank you for the opportunity to provide this testimony. My name

is Carolyn Strudwick. I'm the Associate Vice President for Street Work Project, the homeless youth program at Safe Horizon. And my colleague Lauren and others touched on many pieces, so I won't be repetitive, thank you.

But what I want to highlight is why the Administration's plan directs resources in a failed strategy for youth, is that the Administration is approaching this homeless crisis with the mindset that unhoused youth are refusing support, rather than seeing an understanding that our current systems are vastly inadequate.

What we have is structural violence unattended. What we're dealing with is systemic racism. And the majority of homeless youth are obviously, disproportionately youth of color. Our system already to view RHY suspiciously, and that young people of color are actually a proxy for criminality. And what the thing is that what we have been facing as providers is unnecessary obstacles in terms of getting adequate housing, supportive and permanent housing for young people on the streets. And most importantly, what we have a major concern with is the Administration plan to use police officers to engage

with youth of color. Too many of our clients for NYPD does not represent a safe response. RHY people have been violated, from when they've been young. They have witnessed trauma and abuse in their own neighborhoods at the hands of police. And the bottom line is that we fear that interaction between police officers and young people would only lead to an increased violence and death. We have experienced this firsthand at Street Work Project, where we lost our client, David Felix, an unarmed young man who was running from the police, and was murdered by NYPD.

Another incident took place when NYPD entered our premises because we were forced to call 911. They came in riot gears, pinned the young person down. Staff had to deescalate the situation. We lost that young person to our service because they no longer felt safe to come to our program.

The police response is counterproductive to the therapeutic services and support we're trying to give marginalized and already traumatized young people. Safe Horizon does not support police response. And what the Administration needs to do is prioritize resources towards safe, permanent housing, create structures and communities that give proper mental

health, school and educational opportunities, decent paying jobs, and peers in community centers to help build youth, not over-policing of our environment.

We need to learn from the history of our country and understand where racism plays a role. I need the Mayor to understand, and he's a man of color, I know he's police, but we need to understand systemic racism is the issue here, not policing our communities. Thank you.

CHAIRPERSON LEE: Thank you so much.

COUNSEL SUCHER: All right. Next, we're going to call Erick Eiting. You may begin once ready, thank you.

DR. EITING: Thank you. My name is Erick Eiting, and I'm President of the New York County Medical Society. In addition, I run a training program for LGBTQ medicine. And I'm also a medical director for an emergency department and a frontline emergency physician. But I'm here speaking on behalf of the New York County Medical Society, not on behalf of my- - it is clear that we're seeing an increase in the number of mental health conditions that we're seeing across the city and across the nation, tThat's both

in new diagnoses, and also in people who are having a worsening and deterioration of existing conditions.

The emergency department is a great place for us to be able to address your acute life-threatening conditions. But it is the wrong place to address your chronic issues that don't give-- have limited abilities for us to intervene.

When I think of a an analogy, right? It's somebody who's having an acute severe asthma exacerbation, who maybe perhaps needs to be on a ventilator or needs multiple doses of medications in a very short period of time, the emergency department is a great place to be. But somebody who's suffering from severe chronic asthma and doesn't have access to medications, is living in a housing environment that is triggering their asthma to go off, and really isn't helping you to deal with the underlying conditions, the emergency department is not the right place to be.

We've had several conversations with elected officials across the city and state and one of the comments that was brought up with somebody suggested that patients would come into the front door of the emergency department and then 20 minutes later go out

the side door. And I had to say, "I don't know that that's a that's an incorrect analysis for what ends up happening," because we don't have the tools and are really not the right setting to be truly addressing some of the issues that are happening here.

I just want to paint a picture of what happens. And I know some previous speakers have brought this up. But you know, it's not uncommon for a patient who involuntary is brought into the emergency department for them to be upset, for them to be agitated. In fact, there are times when we've had to provide sedating medications, because they're so upset about what's going on. And we've even seen healthcare workers get injured, because people had been really disappointed.

And I think the biggest and hardest part to see is when patients see health care workers then as part of this failed system that really hasn't helped them address their underlying conditions, and then it becomes that much more difficult, if not impossible to engage these patients. So, so it actually becomes a situation in which can be dangerous.

It really is all about making sure that we come up with a model where we can meet patients where they're at. And that starts with the three pronged approach.

One is enhancing outreach teams. We want to make sure that we're able to engage our patients, meet them while they're at, understand what their issues are, collect information, truly understand the barriers, and be able to provide patients with those linkages to care that are so important to make sure that --

SERGEANT AT ARMS: Thank you. Your time has expired.

DR. EITING: So the last thing that I want to bring up as part of the model is mental health urgent cares. This was a model that we used when I worked in Los Angeles County and I think that there's tremendous promise in there.

So thank you, everyone for-- for putting this hearing together this has been a long day, but really important and great testimony and we appreciate the opportunity to continue to work with you in the future.

Thank you.

CHAIRPERSON LEE: No, thank you so much, and thanks for bringing up the mental health urgent cares because I don't think that has actually been brought up today, and that's an important point to make. So I just want to thank you for that.

COUNSEL SUCHER: Great. I'm going to call some names if you're here either please come up to testify or raise your hand on Zoom. Ramon Leclerc. Simone, Gamble, Cal Hedigan, Ari Kaddish, Kate Sugarman, Amy Doron, Eileen Mayer, Lucena Clark, Christine Henson, Steven Nathaniel Reesie, Kate Whitmore, and Sam Kokoschka. If you're in person or on Zoom, please raise your hand indicate that you're here.

Okay. Lastly, if there's anyone present in the room or on Zoom that hasn't had the opportunity to testify yet, please raise your hand.

Okay, seeing no one else, I would like to note that written testimony which will be reviewed in full by committee staff -- I can't stress that enough; we do read every single piece of written testimony that is submitted -- maybe submitted up to the record up to 72 hours after the close of this hearing by emailing it to testimony@council.nyc.gov. Chair Lee, we have concluded public testimony for this hearing.

CHAIRPERSON LEE: Thank you. And I just want to say again, thank you to everyone who has testified and for sharing your personal stories, lived experiences, and it's been really incredibly amazing hearing everyone's feedback. And so I have my notes, lots of notes, and so we will definitely take it back, and this-- this is something that we will continue as an ongoing conversation.

So thank you all to those that are here presently, a few folks, and then also online as well.

So thank you, and with that-- how many times do I gavel? Okay, I'm going to gavel out and close it. Thank you.

[GAVEL]

# C E R T I F I C A T E

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


Date 02/13/2023