Testimony

of

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Executive Deputy Commissioner, Division of Mental Hygiene
New York City Department of Health and Mental Hygiene

before the

New York City Council Committee on Mental Health, Disabilities and Addiction

on

Oversight – the City's Mental Health Response to Community Violence, and Intro 1890

November 16, 2020
New York, NY

Good afternoon, Chair Ayala and members of the committee. I am Dr. Hillary Kunins, Executive Deputy Commissioner of the Division of Mental Hygiene at the New York City Department of Health and Mental Hygiene. I am joined today by Susan Herman, the Director of the Mayor's Office of Thrive NYC, and Jessica Mofield, Director of the Mayor's Office to Prevent Gun Violence. On behalf of Health Commissioner Dave Chokshi, thank you for the opportunity to testify today about the City's efforts to respond to the health and mental health consequences of violence and trauma.

The de Blasio administration is committed to supporting communities that have experienced violence or other traumatic events. Recognizing that violence and traumatic events can occur in any setting, the Administration works across several City agencies and Mayoral Offices to support individuals and communities in need.

Trauma is a response to highly stressful events that can manifest in a wide range of physical and emotional symptoms. The impact of traumatic events, like violence, affects not just the immediate victim, but the surrounding community as well. Trauma can manifest in different ways, including having intense reactions immediately following and up to several months after a traumatic event. For example, people may feel anxious, sad, or angry; may have trouble concentrating and sleeping; and may continually think about the event that occurred. Physical responses to trauma can also surface in the form of headaches, stomach pain, fatigue, increased heart rate, and feeling easily startled. Typically, these experiences decrease over time, but can sometimes continue and interfere with daily life.

Existing research underscores the importance of providing support to individuals who experience trauma. Trauma that goes unaddressed increases the risks of mental health and substance use disorders and chronic diseases. People that experience traumatic violent events as children are more likely to receive diagnosis of a substance use disorder and/or a mental health disorder. We know that 28%-45% of people who were the victims of a violent crime manifest symptoms of post-traumatic stress, which includes significant mental and physical health consequences. Additionally, events that include violence have disproportionate impacts compared to other traumatic events. Young people of color are more likely to be victims of gun violence and women and members of LGBTQ community are disproportionally harmed by gender-based violence. As a result, these groups are more likely to experience the mental health consequences of unhealed trauma. However, with proper supports and programs, people and communities can heal, decrease or eliminate symptoms, and improve their wellbeing and function.

In low-income, communities of color, and other marginalized communities, trauma is often complex and multifaceted. Evidence shows that violence results from social structures that limit access to basic needs - structures that are fueled by racism, residential segregation, neighborhood disinvestment, and lack of opportunities. Where these structures persist, people are often exposed to violence and the trauma that results from it. A trauma-informed response both provides individualized treatment, and also addresses social and environmental conditions that cause re-traumatization. As a public health agency working to become an anti-racist organization, we understand the imperative to resolve these systemic and structural barriers.

Using a growing body of scientific evidence, we are able to better understand what leads to violence, and to advocate for and help implement strategies to reduce people's exposure. We have seen promising improvements with community led violence prevention initiatives, which also address the social structures that drive its occurrence. This means that initiatives are designed in collaboration with community stakeholders to meet both short-term acute events and long-term healing. It is especially critical to use this approach because communities disproportionately affected by trauma have often experienced broken promises from the government and other programs seeking to support their communities in times of need. Through community involvement we can build trust and provide sustainable solutions. From this approach, we can prevent violence by addressing poverty, providing jobs, healthier housing, and education. City programs – across many agencies and the Health Department seek to address these root causes of violence and mitigate trauma. I will now describe some of these key programs.

In 2018, the Office to Prevent Gun Violence within the Mayor's Office of Criminal Justice, launched the Mobile Trauma Unit (MTU) program. It has five units, one in each borough. The MTUs provide targeted services and response to communities where violent incidents occur and connect victims of violence and families to services and resources. These services include public education and outreach on violence prevention and mental health. Each MTU is staffed with a bereavement counselor who is able to connect community members to therapeutic services, and also conducts trauma and proactive response to community violence. MTUs also offer education and employment services, as well as de-escalate and mediate situations that have the potential to become violent. The MTUs are often stationed at community events/ activities and emotionally charged spaces following violent incidents to mitigate possible conflicts. The MTUs form a vital component of the city's response to community violence, and MOCJ continues to find ways to expand their reach and improve services. In addition to the acute response to gun violence provided by the MTUs, the Mayor's Action Plan for Neighborhood Safety (MAP), helps to coordinate mental health responses in NYCHA developments, and works with city partners like the Health Department to better connect community members with available mental health services. MAP also coordinates broader community-building and healing responses to violent incidents within NYCHA developments.

The Crime Victim Assistance Program (CVAP) is the cornerstone of the NYPD's effort to serve the needs of the thousands of New Yorkers who unfortunately find themselves the victims of crime. NYPD, in partnership with the Mayor's Office of ThriveNYC, implements CVAP to serve all New Yorkers in precincts and Housing Police Service Areas citywide. The program is operated by Safe Horizon, one of the nation's leading victim services organization. Prior to this Administration, victim advocates were available in just three precincts and through District Attorneys' offices, which only provide support to those victims whose cases are prosecuted. Now, every victim of crime has access to immediate services right in their neighborhood through CVAP. The program embeds mental health support alongside services like safety planning, crime victim compensation, supportive counseling, connections to individual or group therapy, advocacy for accommodations with employers and landlords, and more. Together, this model helps address the physical and emotional effects of crime along with the legal and financial challenges can persist long afterwards. Since the program launched in 2016, over 174,900 people have received support or services through CVAP.

At the Health Department, we work to prevent the health effects of trauma by intervening before or after a moment of crisis to engage individuals and provide support. For example, the Department's Health Engagement and Assessment Teams (HEAT) provide a health response to people experiencing mental health, substance use, and/or co-occurring disorders and health issues. HEAT provides short-term engagement, support, and linkage to services at critical moment in time.

Drug overdoses can also be traumatizing events for individuals. Our nonfatal overdose response system, called Relay, sends Peer Wellness Advocates to provide support, advocacy, and connections to care for people in emergency departments who are recovering from a drug overdose. Peer Wellness Advocates help people through a stressful moment in their lives and provide tools and education to build resiliency, connect them to continuing services, and reduce future risk of overdose.

NYC Well, for which the Health Department has oversight and contracting responsibility, is a key ThriveNYC initiative. NYC Well offers emotional support and connection to care via call, text and chat in over 200 languages. NYC Well counselors are available 24 hours a day, 7 days a week, to provide brief counseling and service referral for New Yorkers. If necessary, NYC Well can make a referral to a Mobile Crisis Team to intervene with people experiencing or at risk of a mental health crisis.

The Health Department also provides services to support communities during and after traumatic events. As part of our COVID-19 response, the Mayor's Task Force on Racial Inclusion and Equity recommended that the Health Department redirect our existing Mental Health First Aid (MHFA) efforts to launch the *COVID-19 Community Conversations* (3C) program, which provides community training and discussions about the mental health impact of the pandemic, structural racism, coping and resiliency skills, and informs residents of available mental health resources. Soon, we plan to launch the second phase of this work which will be discussion-based workshops delivered virtually or in-person and include topics that focus on grief, trauma, coping, resilience, and mental health.

Our Brooklyn Rapid Assessment and Response (BK RAR) provides trauma support to communities in Brownsville and Bedford-Stuyvesant, neighborhoods that are disproportionately affected by health inequities that increase their vulnerability to mental health crisis and risk of premature mortality. The program seeks to increase the neighborhoods' capacity to plan, prepare, and respond to traumatic incidents to mitigate the negative effects of trauma on individuals and community and increase community resilience. The program provides virtual psychoeducation sessions and training, healing circles, and ongoing mental health training and support to local community based organizations, providers, and advocates.

Another resource is our Resilience and Emotional Support Team (REST). REST is comprised of qualified, trained mental health professionals from the Health Department that can be mobilized on an ad hoc basis to provide on-site disaster mental health services. The REST members provide information, referrals, psychological first aid, and crisis counseling to individuals within communities in crisis. The program and its members are only used during local large-scale

emergencies, such as during coastal storms or currently for the COVID-19 pandemic. Early in the COVID-19 response, REST members provided onsite emotional support at quarantine hotels and many testing sites in the Bronx and Brooklyn.

I will now turn to the legislation being heard today, Intro 1890. The proposed legislation would require the NYPD, within 24 hours of a determination that a violent or traumatic incident has occurred, to notify the Department of Health and Mental Hygiene of such an incident. The bill defines a violent or traumatic incident broadly, as meaning an act or series of acts causing serious physical injury or death, including but not limited to gun violence or suicide. The Department would be required to conduct outreach to community members affected by any such incident and provide them information regarding available mental health, social services, and legal services provided by the City and City-funded organizations.

The Administration supports the intent of this legislation, and as you have heard today, we work across City agencies to reach individuals affected by traumatic incidents and provide new services to mitigate trauma's negative effects and prevent future trauma. Innovative programming supported by this Administration, like the Mobile Trauma Units, the Crime Victims Assistance Program, the Mayor's Action Plan for Neighborhood Safety, NYC Well, and the Brooklyn Rapid Assessment and Response all provide tailored interventions to respond to different aspects of individual and community trauma. The Administration looks forward to further discussions with Council regarding the scope and agency processes required by this legislation, as well as any potential costs that may come from this bill.

We rely on the feedback of our partners in the City Council and members of the community like those here to testify today. I want to thank you for your continued partnership, feedback and support as we continue to care for the health of New Yorkers during this critical time in the city's history. I am happy to take your questions.

PUBLIC ADVOCATE FOR THE CITY OF NEW YORK

Jumaane D. Williams

**TESTIMONY OF PUBLIC ADVOCATE JUMAANE D. WILLIAMS
TO THE NEW YORK CITY COUNCIL COMMITTEE ON MENTAL HEALTH, DISABILITIES, AND ADDICTION - HEARING
NOVEMBER 16, 2020**

Good morning,

My name is Jumaane D. Williams, and I am the Public Advocate for the City of New York. I would like to thank the Committee on Mental Health, Disabilities, and Addiction Chair Diana Ayala for holding today's hearing.

The year is almost over, but it is undoubtedly one of the most challenging ones in our City's history. From an ongoing pandemic to a rise in violence, New Yorkers have been stressed and exhausted from moving from one crisis to another. At the Committee's September 22nd hearing, the Department of Health and Mental Hygiene revealed a survey that showed 36 percent of respondents reported depression in the preceding two weeks. This shows there is a major mental health crisis happening that needs a thoughtful and meaningful response.

The bill by the chair before the committee today is a start. It would require the New York Police Department to notify DOHMH of a violent or traumatic event within 24 hours. DOHMH would notify providers with this data. Afterward, mental health counseling and other services would be provided for people affected by these incidents. I agree with it as the legislation acknowledges that mental health is not a police matter, but a health matter. I also support having police data in the hands of the community. To reduce community violence, we need the community. Without their input, any solution would not be effective.

Generally, we should rethink the narrative of responding to community violence. The recent uptick of violence in communities should not be an excuse to engage in fear mongering. We have heard false narratives of bail reform, budget cuts, and a ban on chokeholds as reasons for a spike in crime. Considering we are enduring a pandemic and a serious economic crisis, I disagree with these reasons. An effective response must take steps to stop violence, save lives, and engage communities for real solutions. Everyone must participate to make it work.

This means the police's role in responding to mental health calls must be revised. I welcome the announcement of the Mayor and the administration in advancing a solution. I also thank the mayor for acknowledging a recommendation from my Improving New York City's Responses to Individuals in Mental Health Crisis report. The City will finally see a non-police response to

mental health calls. Just last year, there were around 170,000 calls to 911 that were related to mental health.

Still, the plan needs more details on where and how the program will operate. In addition, the plan includes a team that will respond to mental health calls without officers. However, they may still be called if a situation becomes violent. But how can we be sure it is actually violent? Saheed Vassell was a 34-year-old Black man who was mentally ill. In 2018, police responded to calls to 911 that claimed he held a gun. The police fatally shot Vassell, who actually held a pipe. This tragic event should not happen again, and we need to ensure that if police are called.

Our current strategy is to not only send police as mental health responders, but also have the police become the entry point to our criminal justice system. According to the Mayor's Management Reports, 29 percent of the average jail population in 2010 were people with a mental health designation. In 2019, this rose to 45 percent. In the first nine months of this year, as the City began to release people over COVID-19, 45 percent of people jailed had a mental illness. I worry about this as our jails should not be home to people with mental illness, and the City should ensure that this does not continue.

I also emphasize that not all people are dealing with community violence equally. I reiterate as I did last month that we need the Governor and the Mayor to recognize anti-trans violence as a state of crisis, particularly as we approach Trans Day of Remembrance this Friday. In our City alone, two trans women have been murdered and others brutally attacked since the start of this year. The question is how do we change the culture that causes this violence? The answer, which includes mental health, requires all public officials to help trans women, particularly trans women of color. It must be tangible, it must be impactful, and it must stop this crisis from getting worse.

We cannot have violent responses to community violence. Too often this disproportionately affects communities of more color. But this is a moment for leadership, and I am confident we have the moment to help communities suffering from traumatic experiences. I thank the chair for holding today's hearing, and I look forward to today's testimony.

Samaritans
SUICIDE PREVENTION CENTER

November 16, 2020

Oversight - The City's Mental Health Response to Community Violence

My name is Fiodhna O'Grady and on behalf of The Samaritans of New York's Suicide Prevention Center, I want to thank Chair Ayala and all the members of the Committee on Mental Health, Disabilities and Addictions for the opportunity to speak with you in regards to the *City's Mental Health Response to Community Violence*.

As a member of the international organization that created the world's first suicide hotline in 1952--as well as the NYC community-based organization that has operated the City's 24-hour suicide hotline for over 35 years (with ongoing support from the City Council)—Samaritans has spent a lot of time learning the keys to helping people in distress.

The proposed legislation, intro. 1890, requiring the NYPD to notify DOHMH of individuals who are experiencing problems tied to their mental health within 24 hours is a sound step in enhancing crisis responses to those who are potentially suicidal.

But Samaritans would respectfully suggest that those who will implement this legislation consider the research that demonstrates that the more points of access those at risk have in seeking care, support and treatment, the more likely they are to use them.

The fact is: The majority of people do not utilize the referrals they are given; often because they did not select them or they did not reflect their own social and cultural inclinations.

If we have learned anything at Samaritans in our almost 70 years of operating crisis response services in 42 countries it is that--no matter how well-intended, no matter how much evidence-based research goes into program development, people experiencing crises must feel comfortable with the options presented to them. And that means, having choices they can relate to.

Therefore we suggest that the resources provided as a result of this legislation not be limited to the usual network of "City approved providers," but be more expansive. There are countless quality community-based organizations that

have proved effective over the years in serving those most impacted by stigma; use them!

Diverse cultures require diverse choices, whether alternative forms of care, holistic, volunteer-driven, faith and spiritual-based; there are so many people doing good work in this city, their abilities and talents should be better utilized.

For the primary goal is to get that person connected to someone. Someone they can trust and relate to, who makes them feel safe and secure. This will open the door to further forms of care. But you have to start there.

Samaritans completely confidential 24-hour crisis response hotline is a good example of the need for alternatives to clinically based and government-run services. And there are many quality programs just like Samaritans that are not usually included in the City's "approved" referral networks.

This legislation is a good step in assisting more people in crisis in getting the help they need. But to really be effective we suggest you break down the silos and expand the City's helping network.

Thank you.

The Samaritans of New York, Inc. Fiodhna O'Grady (212) 677-3009 fogrady@samaritansnyc.org samaritansnyc.org

The United States Air Force Suicide Prevention Program

The United States Air Force Suicide Prevention Program (AFSPP) is a population-oriented approach to reducing the risk of suicide. The Air Force implemented 11 initiatives aimed at strengthening social support, promoting development of social skills, and changing policies and norms to encourage effective help-seeking behaviors.

Multicomponent Interventions: There is no single cause for suicide. Suicide is a complex act arrived at through multiple pathways, factors and causes. Research shows that suicide prevention interventions employing multiple strategies are particularly effective in reducing suicide rates. The United States Air Forces Suicide Prevention Program, which utilizes the multicomponent intervention model, was shown to be very effective in preventing suicide in the Air Force

AFSPP's 11 initiatives include: 1) Leadership Involvement, 2) Addressing Suicide Prevention in Professional Military Education, 3) Guidelines for Commanders on Use of Mental Health Services, 4) Community Preventive Services, 5) Community Education and Training, 6) Investigative Interview Policy, 7) Trauma Stress Response, 8) Integrated Delivery System (IDS) and Community Action Information Board (CAIB), 9) Limited Privilege Suicide Prevention Program, 10) IDS Consultation Assessment Tool, and 11) Suicide Event Surveillance System

Outcomes: A cohort of active-duty U.S. Air Force personnel exposed to the intervention between 1997 and 2002 was compared to a cohort not exposed between 1990 and 1996.The intervention cohort experienced risk reductions in the following areas when compared to the control cohort (Knox, 2003):

- 33% reduction for suicide
- 51% reduction for homicide
- 18% reduction for accidental death
- 54% reduction for severe family violence
- 30% reduction for moderate family violence

A follow-up study assessed the AFSPP's impact on suicide rates from 1981 through 2008, providing 16 years of data before the program's 1997 launch and 11 years of data after launch. Implementation of program components was measured at 2 points in time: during a 2004 increase in suicide rates, and 2 years afterward. Suicide rates in the Air Force were significantly lower after the AFSPP was launched than before, except during 2004. The study determined that the program was being implemented less rigorously in 2004 (Knox et al., 2010).

For more information, go to: https://www.airforcemedicine.af.mil/SuicidePrevention/

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safehorizon

moving victims of violence from crisis to confidence

Testimony of
Michael Polenberg, Vice President, Government Affairs
Safe Horizon

Committee on Mental Health, Disabilities and Addiction
Hon. Diana Ayala, Chair

The City's Mental Health Response to Community Violence

Nov. 16, 2020

Good morning, and thank you for the opportunity to provide testimony before the Committee on Mental Health, Disabilities and Addiction. My name is Michael Polenberg, and I am the Vice President of Government Affairs at Safe Horizon, the nation's largest non-profit provider of services to victims of violence and abuse.

Last year, our staff responded to 250,000 New Yorkers who experienced harm. Our work is possible thanks to our long-standing partnership with the New York City Council, and we are always eager to respond to your constituents in need of services and counseling and to help shape legislative and budget initiatives that create paths to safety for vulnerable New Yorkers.

This morning I will discuss Safe Horizon's Crime Victim Assistance Program (CVAP) which is a cornerstone of New York City's efforts to improve its response to victims of crime and which last provided services to 50,000 New Yorkers. I will also briefly discuss our Families of Homicide Victims program and how we help families cope with traumatic loss. We believe that both of these programs are in line with the Committee's wishes to provide a more robust mental health response to communities impacted by violent crime.

CVAP

Case Example

The victim, a man in his fifties, was assaulted and robbed by several individuals, two of whom were arrested. The victim's phone, driver's license, and bank cards were taken. He received medical attention on scene. The CVAP advocate reached out to him and addressed his immediate concerns. While he had medical insurance coverage, he was concerned about costs that would not be reimbursed. He was also concerned about the identity theft, as the bank had notified him that someone had tried to withdraw funds from his account.

The Advocate discussed OVS compensation for medical expenses with the client. The Advocate gave the client the phone number for the Detective Squad as the investigation was ongoing for the individuals who hadn't been arrested. The Advocate provided practical assistance by helping the client obtain the form from the DMV to replace his license. The Advocate engaged with the client around his emotional safety and what he might be experiencing in terms of trauma, such as sleeplessness and hypervigilance, as a result of being the victim of a robbery.

The Advocate discussed avoiding the area where the robbery took place and calling the police if he saw the individual who had not been arrested. The Advocate provided the client with concrete steps to address the client's financial safety, especially concerning possible identity theft, by exploring password changes and establishing fraud alerts, as well as checking credit reports.

At its heart, CVAP is about providing a client-centered, trauma-informed response to New Yorkers as quickly as possible after they report a crime. Through CVAP, Safe Horizon advocates can quickly connect with individuals and families and address their safety concerns in a way that addresses their heightened feelings of trauma and fear. Understanding the important role that mental health practitioners can play in the aftermath of a crime, Safe Horizon refers CVAP clients to our licensed mental health clinic as well as those operated by our colleagues at the Crim Victim Treatment Center and other service providers across the city. An important part of our role is linking crime victims to community-based organizations like VIP and other providers who offer a more culturally-specific response.

Funded through ThriveNYC, and available in precincts and Housing Police Service Areas citywide, CVAP has dedicated victim advocates for survivors of domestic violence, community violence, and other categories of crime.

CVAP advocates provide supportive counseling, connections to individual and group therapy, and help navigating the legal and financial challenges that can emerge after a crime has occurred. Advocates follow up with victims who file police reports and those who walk into a precinct seeking help, and assist them in identifying safety concerns and developing a safety plan that meets their needs. Where appropriate, CVAP advocates will also accompany the NYPD on home visits.

We are proud of our work and the of the high client satisfaction rates that we consistently achieve – approximately 90% of the program's 50,000 clients report feeling better as a result of our outreach, and know where to turn to for help, including for mental health assistance. In an anonymous satisfaction survey, one client shared that after her engagement with CVAP, "I feel very safe now, that they have my back if anything was to happen. I have no fear." Another shard "(The advocate) was very patient, listened well and asked me questions that could better help her navigate choices for me."

Families of Homicide Victims

I also want to briefly mention the role Safe Horizon plays in reaching out to family members who have lost a loved one to homicide. We have been doing this important work for decades and have helped provide solace, counseling and tangible assistance to families as they process unimaginable loss and grief. We know that this loss affects not just the impacted family but entire communities, whose sense of safety and order can be in doubt.

Our Families of Homicide Victims Program helps families apply for funds for burial costs. We accompany families to court proceedings. We advocate on the family's behalf with the medical examiner's office, the district attorney's office, and the police department. And we help victims connect to counseling and to others who can share and help them manage their grief. We know every path to healing looks different, and we stay with families as long as they need us.

As the City Council considers how best to bolster the mental health response to communities impacted by violent crime, I hope our work in this space can help inform this process. Thank you for your concerns for the well-being of neighborhoods and for I am happy to answer any questions you may have.

Asian American Federation

Testimony to the New York City Council
Committee on Mental Health, Disabilities and Addictions

November 16, 2020

Written Testimony

I want to thank Committee Chair Ayala and Councilmembers Cabrera, Van Bramer, Ampry-Samuel, and Borelli for holding this important hearing. My name is Ravi Reddi, and I am the Associate Director of Advocacy and Policy at the Asian American Federation (AAF).

By now, it should be no secret that the Asian American community, and communities of color writ-large, have been hit especially hard by this pandemic and its after-effects. While there is plenty of discussion around a potential vaccine, our community can't afford to plan for the future because of myriad challenges in the present. From small businesses grappling with continued collateral damage of the pandemic-related economic shutdown, to unprecedented challenges facing our seniors seeking to secure their basic needs, and continued language and process access issues for our limited-English proficient and otherwise-isolated community members, the pandemic has left many Asian New Yorkers reeling.

We're here to discuss with the Committee a challenge that is specific to our community and the City's mental health response: rising anti-Asian xenophobia and violence. The rise in anti-Asian xenophobia and violence in our City has been palpable since the first news of COVID-19 hit our airwaves, which has been deeply personal to many in our community and layered on top of the practical challenges our community members are facing alongside our fellow New Yorkers.

Our small businesses were hit even earlier and harder, with many feeling the initial impacts of rising xenophobia in January, amidst dramatic falls in business patronage in key ethnic enclaves like Flushing and Chinatown. And one need only look at the almost-daily coverage of anti-Asian violence, like the burning of an 89-year-old Asian woman in Brooklyn in July or the assault of an Asian man in Chelsea last month, for continued reminders of the community violence that Asian New Yorkers are confronting.

Anti-Asian Violence

The impact of anti-Asian xenophobia has citywide implications. Since 2000, the Asian population in New York City increased by 51%, growing from just under 873,000 in 2000 to over 1.3 million in 2019, or 16% of our city's total population. Overwhelmingly, Asian New Yorkers are immigrants, with 2 out of 3 in the city being foreign-born. Of those Asian immigrants, 27.3% arrived in 2010 or after. Additionally, language barriers remain high among Asian New Yorkers. Overall, 44.2% of Asians have limited English proficiency in New York City, compared to a citywide rate of 22.2%.

In the first half of the year, the City's Commission on Human Rights collected more than 100 bias incident reports against Asian Americans just between February and May, while AAF tracked 371 such complaints through its own reporting portal and the Stop AAPI Hate platform in the first half of this year. And these bias incidents are likely significantly underreported, as 70% of Asian New Yorkers are

immigrants and systemic factors like high poverty, high limited English proficiency (LEP), and lack of immigration status deter reporting and reinforce continued systemic inadequacies in making sure justice is served.

A recent survey conducted by AAF of Asian small business owners showed that over 60% of respondents said they were worried about anti-Asian bias and hate crimes for the safety of themselves, their staff, and their business establishment. And while 40% of Asian seniors report experiencing depression and Asian women ages 65 and older have the highest suicide rate across all racial and ethnic groups, community violence is yet another layer to the mental health challenges facing our most vulnerable.

The City's Mental Health Response

We're coming to this conversation well-aware that mental health service delivery in the most diverse community in the city is notoriously difficult. More than 20 Asian ethnic groups are represented within our city, speaking dozens of languages. Aside from the logistics of mental health service delivery in a crisis, cultural stigma around mental health adds an additional layer of service delivery complexity.

Nevertheless, our member and partner agencies are leading the way in innovating service delivery so that we can get our community's mental health challenges addressed while respecting the necessity for cultural competency. While working to reduce the stigma by incorporating mental health concepts into their other services so as to normalize mental health needs, more community members are receiving support services during COVID-19.

But Asian-led, Asian-serving organizations continue to struggle to receive the funding they need to provide services the way our community members best receive them. From Fiscal Year 2002 to 2014, the Asian American community received a mere 1.4% of the total dollar value of New York City's social service contracts. Our analysis showed that over that 12 year period, the Asian American share of DOHMH funding was 0.2% of total contract dollars and 1.6% of the total number of contracts. This was over a 12-year period, representing a trend. While Bill 1890 places the onus on DOHMH to reach out to the community regarding service providers after a traumatic incident, we should also be having a broader discussion about the state of these service providers.

Nonetheless, it's due in large part to our advocacy efforts and that of the community that the City has responded in the ways they have, such as the City coordinating resources to respond to hate crimes and working with us on creating a reporting tool in 7 Asian languages and safety resources to keep our community members safe. But there is still plenty of work that needs to be done.

Recommendations

- We want to recognize Committee Chair Ayala's effort in addressing community violence with the introduction of her bill No. 1890. It validates the need in our community for immediate response to trauma. However, this bill also surfaces a key concern regarding the city's mental health apparatus, very few Asian agencies are funded by DOHMH, which means there are few culturally competent providers who are in DOHMH's network to be able to respond to NYPD's reports of violent incidents against Asian New Yorkers, so there needs to be efforts made to partner with and support Asian groups providing crisis management and trauma support.
- To this end, significant, long-term investment in culturally competent mental health programs is critical. The City should invest in and prioritize Asian-led, Asian-serving community-based organizations that are already doing the work, enabling them to hire culturally competent mental health providers, create community education programs to introduce the concept of mental health

in a linguistically and culturally competent manner, and train mainstream mental health providers to develop their cultural competency.

- Bill 1890 can and should also spur a broader conversation on reporting and the need for greater language and process access for our community when something is traumatic and reportable to the City, especially when law enforcement is involved. There is significant underreporting of anti-Asian bias incidents due to a number of factors, and legislation and policy that is contingent on reporting of such incidents is only as powerful and effective as the community's confidence in, and access to, reporting systems.

On behalf of the AAF, I want to thank you for letting us speak with you about COVID-19's impact on our community and how we can move forward together. This work is critical, these conversations are critical, and the Asian American Federation looks forward to working with all of you in making sure that New Yorkers are safe and secure in their own City.

TESTIMONY OF:

Joyce Kendrick, Attorney-in-Charge,

Mental Health Representation Team

BROOKLYN DEFENDER SERVICES

Presented before New York City Council

Committee on Mental Health, Disabilities and Addiction

Oversight Hearing on the City's Mental Health Response to Community Violence

November 16, 2020

My name is Joyce Kendrick and I am the Attorney-in-Charge of the Mental Health Representation Team of the Criminal Defense Practice at Brooklyn Defender Services (BDS). BDS provides multi-disciplinary and client-centered criminal, family, and immigration defense, as well as civil legal services, social work support and advocacy in nearly 30,000 cases in Brooklyn every year. I want to thank the Committee on Mental Health, Disabilities and Addiction, and in particular Chair Diana Ayala, for holding this important hearing on the City's mental health response to community violence.

BDS' Mental Health Representation Team works to support people living with serious mental illness who have been accused of a crime in Brooklyn so that they may receive the most favorable outcome for their criminal case and receive adequate care and treatment during the pendency of their case and an opportunity to be connected to services that will enable them to gain and maintain stability. Our specialized attorneys represent clients at competency evaluations, hearings and other court appearances during the pendency of their case. In addition, these specialized attorneys regularly consult with others in the criminal defense practice to

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advise on mental health concerns in their cases and provide internal expertise to all of BDS' criminal defense attorneys. We are also very proud of having played an important role in the creation of the Brooklyn Mental Health Court in 2002. The Brooklyn Mental Health Court works with defendants who have serious and persistent mental illnesses, linking them to long-term treatment as an alternative to incarceration. BDS continues to collaborate with this court to advocate for its expansion to meet the needs of more people, including people with intellectual disabilities and people who have previous criminal legal system involvement.

Mental Health, Community Trauma, and COVID-19

The global health emergency due to the COVID-19 pandemic has impacted every aspect of life in New York City. Across the City, people are dealing with economic insecurity, the looming threat of eviction, and dealing with individual and collective illness, loss, and grief. This chronic period of uncertainty has been linked to increased mental health concerns and stress for many people.[1] Black and Latinx communities have been disproportionately impacted by the COVID-19. These communities, too, are at increased risk for mental health concerns due to inequities in healthcare access, systemic racism, and disproportionate rates of poverty.[2]

New York City has seen two decades of decreasing crime rates and is considered one of the safest cities in the United States.[3] While crime rates continue to decline across the City, gun violence continues to be a concern.[4] The same communities that have been most heavily impacted by COVID-19 are also dealing with community violence. For these reasons, we commend the New York City Council for holding this timely hearing on the ways our City can address the mental health impact of community violence and trauma.

Intro 1890-2020

We have worked with many clients who have experienced serious trauma that was the result of direct or indirect community violence. For these reasons, we share the NYC Council's concern that the City dispatch mental health resources directly into communities after a violent incident has occurred.

BDS supports the spirit of Intro 1890-2020, which would require the New York Police Department (NYPD) to contact the Department of Health and Mental Hygiene (DOHMH) to provide mental health outreach following violent or traumatic events in a community. However, we believe there are important components to this outreach that are missing from this bill. We respectfully offer the following recommendations to support meaningful implementation:

Involve community leaders and credible messengers in planning and outreach

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[1] Centers for Disease Control and Prevention, Coronavirus Disease 2019 (COVID-19): Coping with Stress, June 2020, https://www.cdc.gov/coronavirus/2019-ncov/daily-life-coping/managing-stress-anxiety.html.
[2] American Psychological Association, Health Disparities and Stress, 2012, Available online at https://www.apa.org/topics/health-disparities/stress.pdf.
[3] James P. O'Neill, Crime and Enforcement Activity in New York City, https://www1.nyc.gov/assets/nypd/downloads/pdf/analysis_and_planning/year-end-2018-enforcement-report.pdf
[4] Police Department of the City of New York, CompStat Report Covering 10/26/2020 Through 11/1/2020, Available at https://www1.nyc.gov/assets/nypd/downloads/pdf/crime_statistics/cs-en-us-city.pdf

We urge the City Council and the DOHMH to work with community leaders and community based mental health providers to identify credible messengers to conduct outreach. These messengers must be able to build trusting relationships with community members. Outreach workers should be from the community, speak the same language as the people they serve, and have an established rapport in the community.

Ensure clear delineation between NYPD officers and DOHMH providers

After a violent incident, communities are filled with police conducting investigations. People who are seeking mental health services may feel hesitant about speaking to someone who knocks on their door, especially if they are assumed to be NYPD officers or collaborating with NYPD.

Brooklyn is consistently the borough with the most Civilian Complaint Review Board (CCRB) complaints. In order for the program to be successful, clear messaging about the roles of NYPD and DOHMH in the community must be clear.

Take steps to ensure confidentiality of people accessing mental health care

For program success, we caution against the collection of any personal identifying information from community members seeking mental health support following a traumatic event. If referrals from DOHMH workers are tracked, people receiving mental health services must be made aware of the limits of confidentiality and the ability of the court to subpoena medical and mental health records. If there is any chance that case notes from program affiliated mental health providers will be subpoenaed, participants must be informed as a part of informed consent to participate in mental health services.

Recommendations

Additionally, BDS believe that to prevent community violence and to provide communities with the trauma-informed support and resources, the City must invest in the mental health of communities impacted by violence. This investment must include community lead mental health initiatives, increased access to long term mental health care, supportive housing, and programs that seek to minimize community violence and mitigate trauma exposure response. BDS respectfully offers the following recommendations:

Divest from NYPD and invest in communities

Bringing mental health resources to communities impacted by violence or trauma is a crucial service for New York City to provide, but equitable access to proactive, culturally competent and affirming mental healthcare is necessary. Trauma in Black and Latinx communities in the City is not only a response to crime in communities. We know that interactions with the police, community surveillance, racial profiling, and criminal legal system involvement are also traumatizing.

The majority of the 30,000 people we serve each year live in five neighborhoods in Brooklyn: East New York, Brownsville, Crown Heights, Bedford-Stuyvesant and Flatbush. Given the way that the criminal system targets communities of color, it is no coincidence that those are also the

five poorest neighborhoods in Brooklyn. Our clients live in neighborhoods where they are constantly assumed to be dangerous. They are constantly surveilled, stopped-and-frisked outside of their homes, required to walk through metal detectors in their schools, observe vertical patrols in their apartment buildings, and are confronted by armed NYPD who treat them with distrust. Community violence and traumatic events do not happen in a vacuum. Intergenerational trauma, systemic racism and discrimination, adverse childhood experience, the toxic stress of poverty and police violence all contribute to much of the violent or suicidal behavior in our City.

We are in a transformational moment in history—amidst nationwide uprising against racist policing and the unprecedented health and economic crisis that has resulted from COVID-19. The protests in the wake of George Floyd's death have drawn attention to the racial inequities that persist not only in policing but across all institutions. Black and brown people are disproportionately targeted by police, charged with higher-level crimes in courts for the same underlying conduct, and sentenced to longer periods of incarceration.[5] At the same time, Black and Latinx people are infected with and die from COVID-19 at higher rates than their white peers, in part due to health inequities stemming from systemic racism, structural inequities in communities of color, and the impacts of mass criminalization and incarceration.[6]

New York City must start divesting from law enforcement and invest in the needs of people who live here instead, with community resources such as mental health services, housing, healthcare, schools, and jobs.

Fund culturally competent mental health services

Cultural competency is a major barrier to services for many New Yorkers with mental health needs. The existing outpatient mental health programs are not equipped to address the extreme trauma and hardship faced by our clients. Receiving mental health care has cultural barriers and stigma for many of our clients. For people who do not speak English, are LGBTQ, have been incarcerated, or do not see their race or ethnicity reflected by mental healthcare providers, receiving mental healthcare that is affirming and culturally competent can feel impossible. For clients with complex trauma histories, the available low-cost mental health clinics do not have the competency or scope of services needed to treat our clients.

We urge the City to invest in free and low-cost mental health services that are designed for people who have experienced hardship, trauma, or incarceration. These programs must be equipped to meet the needs of people who are newly being introduced to mental health care, to create a familiar, nonthreatening therapeutic environment for those who may be hesitant to engage in treatment. Such programs must employ trained clinicians who are fluent in multiple languages. We must not place the burden on the patient to educate the clinician about the realities of incarceration, gun violence, or racism.

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[5] The Sentencing Project, Report to the United Nations on Racial Disparities in the U.S. Criminal Justice System, April 2019, https://www.sentencingproject.org/publications/un-report-on-racial-disparities/.

[6] Rashawn Ray, Why are Blacks dying at higher rates from COVID-19?, The Brookings Institution, April 2020, https://www.brookings.edu/blog/fixgov/2020/04/09/why-are-blacks-dying-at-higher-rates-from-covid-19/.

Increase number of mobile crisis units citywide

BDS was pleased to hear the Mayor's announcement on November 10th that the City will pilot a NYC Mental Health Team program to dispatch emergency medical technicians and mental health providers to 911 calls for mental health support. We are hopeful that this program will be successful and remove the burden from caretakers who have too often struggled to access mental health support and care for their loved ones due to fear of police escalation during a crisis.

Families and caretakers of people living with mental illness often feel that they have nowhere to turn when their loved ones are in the midst of a mental health crisis. They recognize the sad reality that in New York City, calling 911 to report a mental health crisis will likely trigger a response by NYPD. Our clients and their families are fearful that, instead of a trained mental health provider or emergency medical technician, armed officers may respond to a call and that may lead to someone being shot by police.[7]

Mobile crisis teams are an essential resource for New Yorkers, yet in a moment of crisis a caller must decide if they can wait 48 hours for a crisis team to arrive. In most mental health crisis, people need immediate care and cannot wait 2 days for an intervention. The current mobile crisis model requires that people remain at home or a fixed address while awaiting response. For clients experiencing homelessness or those who must appear in court, this intervention is not able to meet them where they are. BDS calls for the expansion of the mobile crisis teams so that individuals can receive crisis intervention in real time, just as EMS responds to medical emergencies.

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BDS is grateful to the Committee on Mental Health, Disabilities and Addiction for hosting this critical hearing and shining a spotlight this issue. Thank you for your time and consideration of our comments. We look forward to further discussing these and other issues that impact our clients.

If you have any questions, please feel free to reach out to Kathleen McKenna, Senior Policy Social Worker at 718-254-0700 x210 or kmckenna@bds.org.

[7]Leah Asmelash, Philadelphia shooting is just the latest case in a long history of mental health crisis calls that turned deadly in the US, CNN, October 29, 2020, Available online at https://www.cnn.com/2020/10/29/us/mental-health-crisis-police-trnd/index.html.

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NASW NEW YORK CITY CHAPTER
National Association of Social Workers

NATIONAL ASSOCIATION OF SOCIAL WORKERS (NASW-NYC)
New York City Chapter
Executive Director: Dr. Claire Green-Forde, LCSW
President, Board of Directors: Ms. Erica Sandoval, LCSW

NEW YORK CITY COUNCIL:

COMMITTEE ON MENTAL HEALTH, DISABILITY, AND ADDICTION OVERSIGHT HEARING

November 16th, 2020

Thank you for allowing the National Association of Social Workers-New York City Chapter (NASW-NYC), to present testimony regarding **The City's Mental Health Response to Community Violence** and Introduction 1890, which relates to required reporting of incidents of community violence and trauma, and subsequent community outreach by DOHMH regarding access to mental health services for those impacted.

My name is Dr. Claire Green-Forde and I currently serve as the Executive Director for the National Association of Social Workers, NYC Chapter. I am honored to be joined by Ms. Erica Sandoval, President of our Board of Directors. The National Association of Social Workers- NYC Chapter represents over 5,000 social work members in the New York metropolitan area. As part of a national organization with over 110,000 social workers across the country, we are honored to represent our profession for such an important and timely discussion today. Social workers are uniquely positioned and trained to address a wide range of biopsychosocial needs impacting individuals, families, and communities. Among many specialty and practice areas, social workers are trained in advocacy, community organizing, and mental health. On any given day, social workers support thousands of individuals and families in addressing a myriad of needs, including trauma. We appreciate this opportunity to speak about the need for a comprehensive mental health response to address community violence and trauma. We would be remiss if we didn't begin by acknowledge and offering our heartfelt condolences to the many New Yorkers who have lost loved ones and have been profoundly impacted by personal trauma, community violence, racial trauma, and COVID-19.

Historically, the field of mental health has played a vital role in responding to, and supporting the healing process for survivors of harm. Individuals and families impacted by intimate partner violence, sexual assault, war, poverty, forced migration, homelessness, and other traumatic experiences have benefited from mental health treatment if they have been able to access programs offering these services.

As social workers, we are charged by our professional Code of Ethics to uplift oppressed and marginalized communities and so, we ask, what about survivors of community violence who don't have an opportunity to access those services? What about those who live in communities where services are few and far between? What happens to those children, parents, and community members who experience compounded trauma as they grapple with the social, mental, economic, and personal impact of years of divestment and systemic oppression? Research shows that high levels of community violence are often associated with experiences of divestment and inequality within communities. It also shows that lived experiences of community violence can often be traced to a need to survive while facing the realities of community pain, trauma, inadequate support and resources, and poverty (Blanco, et al., 2016).

Moreover, what happens to individuals who reside in neighborhoods that are over-policed and under resourced? Those communities that have a justified mistrust of the helping professions, because that help typically comes with a condition? Whether you're mandated to a program or otherwise must comply with services to avoid punitive sanctions, it's undeniable that people living in communities most impacted by community violence and trauma, are predominately Black, Brown, and Indigenous People of Color. It is also understandable that after years of systematic violence and limited support, many in these communities have a general mistrust of social services: mistrust is a protective factor when experience suggests that these systems don't make people feel safe or secure.

There are far-reaching implications for access to critical mental health services for NYC residents: 41% of adult New Yorkers living with serious mental health illness report that they needed mental health services in the last year but did not receive, or delayed treatment. Black, Latinx, and Asian American NYC residents are disproportionately less likely to be connected to the mental health care services they need. Despite this mistrust, with sensitivity and care given to the experiences of communities impacted by violence, the mental health system is uniquely positioned to make an impact in the space of community violence. Depression, anxiety, and PTSD have all been linked to exposure to community violence, and this pattern is most prevalent in communities already disproportionately affected by COVID-19.

Throughout the city, some organizations are providing socioemotional support to communities impacted by violence. The Crisis Management System (CMS) is uniquely positioned to support in this effort, due to their proximity and credibility in these communities, as well as their effectiveness which is reflected in the numbers. Across all CMS sites, shooting victimizations fell by 28% over the first 24 months after a site launched and gun injuries decreased by 33%. Programs led by community members enjoy public support and 68 percent of likely voters support funding programs to train community leaders to de-escalate potentially violent situations. Programs such as S.O.S., LifeCamp, and Man Up are connecting with survivors who are otherwise not going to the Family Justice Center for example. These projects are leading with the notion of providing support with no strings attached and also work to engage and uplift those they serve in ways that go beyond traditional approaches.

Effectively addressing the simultaneous public health crises of community violence, COVID-19, and systemic racism requires an approach that is community-oriented and community-led. It requires that *experts* partner with, and learn from impacted communities. It necessitates that trust is built between communities and helping professionals so that appropriate and timely hand-offs to those who have the ability to provide in-depth mental health and trauma response services are made. Our values should be rooted in the notion that all people deserve support without being tethered to conditions or punishment. We must also look outside of traditional talk therapy interventions in communities and include mentorship and convene peer support spaces which can also provide healing for communities.

We sincerely applaud the City Council for taking steps to address the mental health needs of individuals and communities impacted by violence and trauma. At the same time, we recognize the importance of addressing violence and harm through a lens that both acknowledges systemic racism and brings voice to the impact of racial and ethno-racial trauma. As such, we implore the Council to respond to the needs of the community through a holistic and culturally humble lens that is built upon the foundation of collaboration, trust, and the importance of human relationships.

The National Association of Social Workers-NYC Chapter overwhelmingly supports efforts to address the mental health needs and trauma response services for New Yorkers impacted by community violence. We stand ready to be a partner and resource to City Council, NYPD, DOHMH, other Community Based Providers, and those directly impacted by community violence and trauma. We are happy to assist in developing models of care and educational resources grounded in our professional expertise in mental health, advocacy, community organizing, and cultural humility. Fortunately, there are examples of community-organized interventions to look to and partner with in creating greater accessibility of mental health services.

Thank you for this incredible opportunity to advocate for mental health services on behalf of the many individuals and families impacted by community violence and trauma. We leave you with the words Lilla Watson, Aboriginal Educator and Activist from Australia who stated “If you’ve come to help me, you are wasting your time. But, if you’ve come because your liberation is bound up with mine, then let us work together”. We agree and believe that the way forward is built upon respect, partnership, understanding our interconnectedness, and creating equitable and culturally humble access to mental health and trauma response services in NYC.

In partnership,

Dr. Claire Green-Forde, LCSW
Executive Director, NASW-NYC

Ms. Erica Sandoval, LCSW
President-Board of Directors, NASW-NYC

CACF
Coalition For Asian American Children+Families

Testimony of Hallie Yee, MPH, Policy Coordinator
Coalition for Asian American Children and Families (CACF)

Committee on Mental Health, Disabilities, and Addictions Remote Hearing
November 16, 2020 at 10:00AM

Good afternoon. My name is Hallie Yee, and I am a Policy Coordinator at the Coalition for Asian American Children and Families (CACF). Thank you, Chair Ayala and members of the Committee for giving us this opportunity to testify.

Since 1986, CACF is the nation's only pan-Asian children and families' advocacy organization and leads the fight for improved and equitable policies, systems, funding, and services to support those in need. The Asian Pacific American (APA) population comprises over 15% of New York City, over 1.3 million people. Many in our diverse communities face high levels of poverty, overcrowding, uninsurance, and linguistic isolation. Yet, the needs of the APA community are consistently overlooked, misunderstood, and uncounted. We are constantly fighting the harmful impacts of the model minority myth, which prevents our needs from being recognized and understood. Our communities, as well as the organizations that serve the community, too often lack the resources to provide critical services to the most marginalized APAs. Working with over 70 member and partner organizations across the City to identify and speak out on the many common challenges our community faces, CACF is building a community too powerful to ignore.

We must think about more than the 3% Citywide AVERAGE transmission rate threshold that the City is focused on. On behalf our 70+ organizational members and partners serving the diverse Asian Pacific American, or APA, communities across New York City, we are asking City Council today to hold our public health system accountable to our communities' needs. Mental Health has not been a key concern in the City's COVID response despite the fact that this has been and is continuing to be a time of deep collective trauma.

- **First, we demand the City provide accurate data collection & disaggregation of data on infection rates, hospitalizations, and deaths in the APA community.** In order to best respond to this pandemic and reopen safely, we must at least be able to track race/ethnicity and languages spoken for those who are tested, so we can appropriately trace and take care of families. We are not doing this now, and our APA communities and our struggles are being erased.
- **Second, we demand that the City's health system, can ensure that critical information gets to students and families in the language they need.** It is only recently that the Health+ Hospitals was able to translate health outreach documents into the City's top 11 languages required by local law. This was too late, and still not enough. The City MUST be prepared to reach and support students and families who are limited English proficient.
- **And third, we demand that the City address the mental health needs of students and families, especially those who are East-Asian presenting who have been targeted during this pandemic.** The health system must be prepared to help our community members—who have faced loss, isolation, discrimination, xenophobia, and more—as they return to everyday life.

- **Mental Health has not been a key concern in the City's COVID response despite the fact that this has been and is continuing to be a time of deep collective trauma.**

This pandemic has exacerbated long-standing and interconnected crises in socioeconomically disadvantaged communities. While unfortunate and heartbreaking, this was not entirely unexpected. Our APA communities are historically overlooked and our needs misunderstood or entirely uncounted. We are constantly fighting the harmful impacts of the model minority myth, which prevents the community's needs from being acknowledged and understood. This means our communities often lack the resources to provide critical services for those in need. Never has this been more apparent than right now.

While the City has touted the advancements that have been made in testing capacity recently, there is still inadequate testing in low income neighborhoods, which have been hit especially hard by the pandemic.

We've heard from community members and organizations that severe shortages of testing resources remain in their neighborhoods, with results taking anywhere from 2 days to 2 weeks to be reported back to them. We have also heard unfortunate testimony from our communities that testing centers and resources have been pulled out or heavily reduced in some of the most hard hit areas--such as Elmhurst and Corona, both heavily APA community populations. We need to bring the testing sites into these neighborhoods, and we need to increase rapid on-site testing and local outreach to make sure these communities are no longer left behind.

Ensuring best practices around COVID-19 testing is key to NYC's recovery. It's critical in making it safe for our children to learn in person and for our communities' revitalization efforts.

To do so, the City must address the following.

<u>Accurate Data Collection & Disaggregation of infection rates, hospitalizations, and deaths in the APA community:</u>

- **Track disportionality.** The City and State use seven measures to reopen. We need a key 8th measure that tracks disportationality. Not all neighborhoods or communities are improving at the same rate, and averaged or aggregated data creates a false sense of recovery and security.
- **Specific and granular disaggregated data on infection rates, hospitalizations, and deaths:** Disaggregate existing data collection around race/ethnicity, sex, and age. Expand data to include collecting information on primary written and spoken language, disability status, sexual orientation, gender identity, and socioeconomic status of participants. Data collection should also be carried out in nursing homes, residential facilities, homeless shelters and detention centers. Deaths at home or in the streets must be counted.

- As of May 13, 2020–which is unfortunately the most recent publicly reported data on race/ethnicity—there were 1,532 deaths from COVID-19 associated with individuals identifying as Asian American. At the same time, some 1,951 COVID-19-related deaths were relegated to the "other" or "unknown" race categories, which represents about 10% of the nearly 20,406 city deaths that had been logged by the NYC Department of Health and Mental Hygiene through that date. The City relies on lab reports and medical records to identify the race or ethnicity of those who died of the virus. When the information is missing, victims are categorized as "unknown." Additionally, when it comes to data of those not hospitalized for COVID, 64% of racial demographic data is incomplete. And while the information regarding COVID-related deaths are available each day, the breakdown by race is sporadic and by ethnicity non-existent. Before anything can properly be addressed, that data is crucial in determining which zip codes and neighborhoods receive the resources they need.

<u>The Impact of COVID-19 Related Anti-Asian Discrimination:</u> The pandemic has fostered an environment of fear and uncertainty that are resulting in targeted acts of racism towards APAs. In NY, APAs, specifically East-Asian presenting individuals have been subjected to violent racist attacks and xenophobic representations of the virus in the media. The City needs to **ensure support of targeted communities of color during this crisis and moving forward.**

- We all know communities of color and immigrant communities are often scapegoated in times of crisis-- for the APA community, due to the stigmatizing nature of the virus compounded by the anti-Asian racism, this means that individuals are less likely to seek treatment and when they do, they may be afraid to even identify as 'Asian,' potentially leading to negative health outcomes and an underrepresentation of the pandemic's impact on the community.
- This pandemic has fostered an environment of fear and uncertainty that are resulting in targeted acts of racism towards APAs. Specifically, East-Asian presenting individuals, have been subjected to violent racist attacks and xenophobic representations of the virus by political leaders and in the media. We demand an investment in community-led efforts towards data collection on incidents, inter-community healing, and positive mental health.
- Below is a quote from a member of our student program which highlights the needs of proper mental health services for youth even prior to the COVID-19 pandemic, and it has only become truer for more and more students as these months have dragged on:

  "I'm Edison, a youth leader from ASAP and a senior at the Bronx High School of Science. I myself experience isolation. Like many other teenagers, I was alone in a large high school with no middle school friends to accompany me, and I kept feeling that I failed to live up to the expectations of my family and culture. At my school, my guidance counselor is responsible for 80 students and we only have 1 social worker. So I didn't bother to go. For four years I held everything in. My choice was to bear it all and laugh it off. The choice I made brought me countless sleepless nights where I literally suffocated over my thoughts, lack of motivation in the morning where I risked being late, and lifelessness throughout parts of my day.

CACF
Coalition For Asian American Children+Families

> Thankfully, I was able to vent to my best friend. And I am reassured by the presence of my new Asian American counselor, who constantly vouched for me and assisted me whenever I needed it. But other students are not so lucky, which is why I ask City Council to make sure that the City maintains or even increases the funding for more guidance counselors and social workers to address student mental health barriers and students' discomfort in asking for help."

Language Access: The COVID-19 has highlighted the barriers the most marginalized APAs face to language access. The mere availability of languages is not enough without effective outreach and implementation of language access policies, preventing vital communication about school decisions and the pandemic from reaching the community.

- The delay of disseminating and general lack of in-language information about the pandemic, including the social distancing guidelines has led to a higher risk of exposure to the virus for the most vulnerable in the APA community.
- This egregious gap in language access has led to our communities to rely once again upon the community-based organizations (CBOs) who serve them in the absence of proper resources by the City as CBOs act as interpreters and crowdsource translated materials regarding even the most basic of information on the pandemic.
- **Outreach to the most marginalized pockets of the community must be prioritized--without it, their health and very lives are endangered if they are unable to communicate with their schools and healthcare providers.**

Our communities are consistently overlooked in the distribution of resources, which is harmful to us as well as other communities of color who are denied the same resources due to the perceived "success" of APAs. This pandemic has highlighted a myriad of holes in our City's safety net systems, and the City's response must address root problems in addition to immediate needs. Our community will continue to suffer every day we allow these flaws in the system to exist. As always, CACF will continue to be available as a resource and partner to address these concerns and look forward to working with you to better address our communities' needs.

July 15, 2020

OFFICE OF ADMINISTRATIVE LAW,
FAIR HEARING FOR TEMPORARY DISABILITY ASSISTANCE

P.O. Box 1930 Albany, NY 12201

Sworn Statement of New York State of Office Administrative Hearings.

I declare that, to the best of my knowledge and belief, the information herein is true and complete. I understand this statement is made for use as evidence in court and is subject to penalty for perjury. See. Article S.210.50

My name is Bobby Felicie, I am [34] years old and am working as a part-time vendor for the Joint Commission's Office on Public Ethics as a lobbyist where as oath taking uphold the responsibilities and protection of law as a compliance consultant specialist. I currently reside at [3205 Oxford Ave 10, Bronx NY 1463].This matter has made unforeseen delays and has frustrated pursuit to(28 U.S.C. § 1404(a)'s intent to "prevent the waste of time, energy, and money and to protect litigants, witnesses and the public against unnecessary inconvenience and expense).

This following statement is to the request in reference to the case matter for Public Assistance requesting grant allowance for utility arrears be paid as proof "s.351.26-Good Cause", related to other matters that recoupment have force other cash assistance services that was in good payment to the benefit card I have where an offset cash assistance was in recoupment status unaware . On instant process a transaction withdrawal simultaneously for this it resorted my funds in-house to other responsibilities unsatisfied for payment to ConEdison having the installment plan defaulted. As urgent this may seem it is to no fault of my own that's agency " Department of Social Services" dba as (HRA) Human resource Administration, lack personal jurisdiction due to a recent order by family court judge to an ongoing domestic violence issue final relief granted for a protective order causing emotional stress and anxiety and other health factors where I was unable to pay anything to utility bill for reason my ex partner access my accounts and email causing financial burden , however I conveyed this matter to police and DOSS. I have undergone duress affect where I have currently in treatment for my mental health; pursuant to (s.393.2- Administration), and pursuant to (s.387.12- Income Deductions) that I am inquiring full service equally entitled for the lack of circumstances that involved allowance and grants by the department state of social services dba HRA, as continues to violate a rule that restricted without policy performance as to(s.2549- Due process) no written request made upon my case to have a initial option request for other vendors to assist me with this case for applying for special grant of HEAP. The agency of HRA knowingly and granted previous allowances waiver for reduction did not assess my case properly, taking action including while in extreme circumstance to ensure that there are no foreseeable risk factors and other causes regarding my wellbeing protecting in interest to secure the financial burdens or changes.

Furthermore, with only to pay a one time transaction to ConEdison, when in receipt of a Shut off notice by the utility provider ConEdison, when the agency is well aware of the asthma and have no windows to ventilations or bring fresh air into the unit of my residence . On their evidentiary packet, you see plainly that the guarantor or the agency in providing public assistance , SNAP benefits ensure monthly ongoing installment plan to satisfy the electric arrears bill honoring a payment as agreed. However, due to the corona-virus pandemic, agency lack due diligence in providing services when knowingly I sustain a illness such as HIV, Asthma and Anxiety carrying a medical machine prescribed in home for treating my asthma. This is emotionally stress, mental anguish on me by the agency causing more high risk factors to my longterm health condition. Where agency forgets the months and timing of their action decisions to my case the matter of other in home issues were still ongoing.Playing catch up with the provider or agency from previous and current recoupments. All I've done since the recoupment as previous orders directed to verse, since my moving to the above location as mentioned since my residency of living.The Agency till this day have NOT reimbursed past recouping orders to allow me to maintain other services providers by forcing my hands to reluctant of any opportunity with dealing to other responsibilities I have outside of the agency's commitment.

Therefore, I requested this hearing as it is my responsibility to take unending continuing services as lacking of my medical assistance , wherefore, for good case I will sustained irreparably harm to my health and future issues related to my health (see. Title 42 C.F.R. s.40.371 – Suspension offset and recoupment of Medicare Providers). And to (see. Title 4 C.F.R. s.260.58-What Penalty relief is available to meet) if the agency does not take protection in assessment to satisfy my areas and other financial issues for the ongoing. History of its department reducing and or restricted funding to satisfy in home utility or items for emergency bases as I am entitled to for their past mistakes. Affirming, to codes and regulations (see.s.8-1.13(l) health providers- Assurance of access) arranging and address the wellbeing of a management care enrollee, is priority to assist and reducing tax payers expense for future government protocols to case hearing or conferences be preventive of damages to not be reoccurring issuing.

SINCERELY,

YOUR NAME
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Testimony of Irving Campbell, RN –New York State Nurses Association
Oversight- The City's response to Community Violence Intro 1890–Virtual Hearing

November 16, 2020

My name is Irving Campbell, I am an RN at NY Presbyterian Brooklyn Methodist Hospital. I represent our Local Bargaining Unit for New York State Nurses Association representing more than 42,000 nurses. Thank you Chair Ayala for bringing attention to this very important matter.

I was a behavioral health nurse NY Presbyterian Behavioral Mental Health before NYP decided that the best way to deal with the worse pandemic and all the psychological distress everyone is experiencing is to close our inpatient behavioral health units which accounted for 50 beds. Now myself and my colleagues are working in non mental health units throughout the hospital.

Some may say you should be thankful to have a job and while I am thankful, I am deeply saddened as those with mental health disorders are being ignored by the institution and the people of Park Slope and neighboring communities have no access to inpatient MH care here at Methodist at a time when it is needed the most.

Covid 19 has led to many being isolated from friends and family, which has led to an astronomical increase in depressive and anxiety symptoms as well as substance abuse, PTSD, domestic violence and grief. Suicidality levels have increased during this time as well. I was informed that one of our patients passed away during this time from an overdose and it effected me because I truly feel that had we been open he would still be with us.

Many patients and family members has expressed that the closure has been difficult and they choose to not go anywhere else as this means literally starting all over. They have built trust and confidence in us and at a time when they needed us the most we were NOWHERE TO BE FOUND.

We know so many are suffering in silence and are experiencing negative thoughts daily. We know many of our frontline workers including myself has lost colleagues, family members and friends and we have been unable to properly grieve or process these losses. Those with behavioral health disorders are going through this at a greater level and they need to be cared by people like my colleagues and I. The community demands these beds reopen NOW.

Many people in our community are jobless, homeless, hopeless and helpless. Food insecurity is real, many are still fighting for their lives and their families can not help them and in many cases not see them. The trauma is real, and we must address this need. I know we must prepare for a potential second wave, but eliminating psychiatry beds should NOT be the way to prepare. It is evident that our patients are being forgotten by hospital organizations like NYP, Northwell, HHC and others, because reimbursements rates are lower for mental health care compared to other services such as the O.R. and labor & delivery. NYP has a checkered history of attempting to close mental health beds (Allen Pavillion). There is a push for Telepsychiatry as reimbursements for this service is bigger, but again you can not put a dollar figure on what we do here.

We find it disrespectful that our patients, many who are from the community and neighboring underserved communities are being transported from our emergency rooms to Gracie Square and Westchester and can not receive services here at their local hospital where they have built trust and confidence with the healthcare team.

It is sad that at a time when frontline workers were going through the fire literally, NYP was looking for ways to maximize on this pandemic.

We can not stand by and allow this to happen and let me be clear this is an attack on access to mental health care in New York at a time when we need it the most.

At a time when More than 1.6 million New Yorkers live with serious psychological or mental distress, nearly half of Americans reported mental health strain since the Covid- 19 pandemic began and 12% of people in NY have experienced a substance use disorder, more than 11% have expressed suicidality. Increased number of suicidal and homicidal attempts by adolescents and teens, our peds unit has been inundated with these patients as there is nowhere for them to go.

About 2 million people with mental illness are booked into jails every year, many because they didn't get the treatment they needed. This has to stop.

Last week the city introduced a pilot program that will have a mental health emergency team that consist of a SW and EMT to address Mental health calls instead of NYPD. I have been disappointed due to disregard for the bed closures here. This is may be a good first step, but it is missing a lot and is not enough to address the needs of the mental health community. Consulting with NAMI and frontline workers who have expertise dealing with this population is key for success. The fact that our leadership does not realize that there needs to be inpatient beds for those in mental health crisis shows the disconnect. The fact that patients are being sent over an hour away isn't addressed.

The spokesperson for NYP stated that in order to care for covid patients we needed to close the entire two units here at Methodist, these are the only two units that remains closed. The system has turned it's back on those with behavioral health issues and their support system and place staff who are not trained to care for those with behavioral health disorders in unsafe situations. Too many employees have been assaulted since the closures and it is not fair and its only a matter of time before a patient or visitor is assaulted.

Lastly OMH, states "there's still plenty of room and every psychiatric patient is getting cared for". This statement disregards the cries of family members, mental health advocates, and even our elected officials.

Let me make this clear: we are demanding that entities such as New York Presbyterian, Northwell, Westchester Medical System- Health Alliance and HHC do the right thing and not use the pandemic to close these inpatient units and put our patients before profits.

NY State Nurses Association does support Intro 1890 in relation to community outreach regarding the availability of mental health counseling. We also ask for transparency for how inpatient and outpatient services are delivered.