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## THE COUNCIL

# COMMITTEE REPORT OF THE HUMAN SERVICES Division

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*Hon. Eric Dinowitz, Chair*

#### November 17, 2021

**Oversight: Mental Health Services for Veterans in Response to COVID-19, and Alternative Treatments for Post-Traumatic Stress Disorder (PTSD)**

**Int. No. 2442-2021:** By Council Member Ayala (by request of the Mayor)

**Title:** A Local Law to amend the New York city charter, in relation to establishing an office of community mental health

**Charter:**  Adds section 20-m

1. **Introduction**

On November 17, 2021, the Committee on Mental Health, Disabilities, and Addiction, chaired by Council Member Farah Louis, and the Committee on Veterans, chaired by Council Member Eric Dinowitz, will hold an oversight hearing entitled “Mental Health Services for Veterans in Response to COVID-19, and Alternative Treatments for Post-Traumatic Stress Disorder (PTSD).” The Committees will also hear Introduction Number 2442 (Int. 2442), sponsored by Council Member Diana Ayala, A Local Law to amend the New York city charter, in relation to establishing an office of community mental health. Among those invited to testify are representatives from the New York City Department of Veterans’ Services (DVS), New York City Department of Health and Mental Hygiene (DOHMH), the Mayor’s Office of Community Mental Health (OCMH), and other interested parties.

1. **Background**
   1. *Veterans’ Mental Health*

Veterans have distinctive health issues related to their military service and are more likely to experience trauma-related injuries and behavioral health challenges than people who have never served in the armed forces.[[1]](#footnote-1) According to a 2008 study conducted by the Rand Center for Military Health Policy Research, roughly one in five veterans experience a mental health condition.[[2]](#footnote-2) Another study shows that veterans who have been deployed are more likely than civilians to experience mental health conditions or cognitive injuries.[[3]](#footnote-3)

Since 2001, approximately 2.4 million active duty and reserve military personnel have been deployed to the wars in Iraq and Afghanistan.[[4]](#footnote-4) Early evidence suggests that the psychological toll of these deployments—many involving multiple deployments per individual service member and prolonged exposure to dangerous threats, such as improvised explosive devices (IEDs)—may be disproportionately high compared with the physical injuries of combat.[[5]](#footnote-5) Estimates based on data from the RAND Corporation suggest that among New York veterans of the wars in Iraq and Afghanistan, “nearly 8,000 suffer from Post-Traumatic Stress Disorder (PTSD), more than 7,000 suffer from Traumatic Brain Injury (TBI), and more than 4,000 suffer from both.”[[6]](#footnote-6)

The primary mental health conditions and cognitive impairments resulting from recent deployment experiences include:

* **Post-Traumatic Stress Disorder (PTSD):** Also known as “shell shock” or “combat fatigue,” PTSD results from witnessing or experiencing (directly or indirectly) a traumatic event such as a natural disaster, a serious accident, a terrorist act, war or combat, rape or other violent personal assault.[[7]](#footnote-7) Although PTSD is not limited to veterans, military personnel experience PTSD at disproportionately higher rates than civilians (8% of non-military men versus 36% of male veterans).[[8]](#footnote-8) One recent study shows that female veterans have a higher prevalence of PTSD (11.40%) compared to their civilian (5.96%) and male (5.19%) counterparts.[[9]](#footnote-9) However, researches have observed mixed findings regarding differences in PTSD prevalence between men and women veterans.[[10]](#footnote-10) Veterans with PTSD may be at increased risk for other conditions or problems such as traumatic brain injury (TBI), military sexual trauma (MST), sleep problems, substance use, pain, and other psychiatric disorders.[[11]](#footnote-11)
* **Depression**: “Depression involves recurrent, severe periods of clear-cut changes in mood, thought processes and motivation lasting for a minimum of two weeks. Changes in thought processes typically include negative thoughts and hopelessness. Depression may also affect sleep, energy, appetite or weight.”[[12]](#footnote-12) Depression remains one of the leading mental health conditions in the military.[[13]](#footnote-13) “The military environment can act as a catalyst for the development and progression of depression. For example, separation from loved ones and support systems, stressors of combat, and seeing oneself and others in harm’s way are all elements that increase the risk of depression in active duty and veteran populations.”[[14]](#footnote-14)
* **Traumatic Brain Injury (TBI):** TBI, is usually the result of a significant blow to the head or body.[[15]](#footnote-15) Symptoms can include headaches, fatigue or drowsiness, memory problems and mood changes and mood swings.[[16]](#footnote-16) Traumatic brain injury is common among military personnel deployed to Iraq and Afghanistan although it is usually mild.[[17]](#footnote-17) A report by the RAND Corporation showed that about 20 percent of veterans that served in Iraq and Afghanistan experienced a probable TBI during deployment.[[18]](#footnote-18)

Unlike physical wounds, these mental health conditions and cognitive injuries affect mood, thoughts, and behavior and often remain invisible to other service members, family members and society in general.[[19]](#footnote-19) “In addition, symptoms of these conditions, especially PTSD and depression, can have a delayed onset.”[[20]](#footnote-20)

Unfortunately, less than half of returning veterans in need of mental health services receive any care.[[21]](#footnote-21) Some of the barriers veterans face to treatment for mental health include personal embarrassment about service-related mental disabilities, long wait times to receive mental health treatment, fear and shame over needing to seek mental health treatment, stigma associated with mental health issues, lack of understanding or lack of awareness about mental health problems and treatment options, logistical problems such as long travel distances in order to receive care and concerns over the mental health treatment offered by the United States Department of Veterans Affairs (VA).[[22]](#footnote-22)

The COVID-19 pandemic has created additional challenges to mental health, physical health, and financial wellness, in particular for veterans.[[23]](#footnote-23) In a recent national survey conducted by the Wounded Warrior Project, veterans reported their mental health issues have worsened since social distancing and stay at home orders went into place, and more than half reported having a mental health appointment canceled or postponed during the pandemic.[[24]](#footnote-24)

* 1. *City Resources and Programs for NYC Veterans*

DVS refers veterans in need of mental health services to providers across the city through their Veteran Resource Centers and the VetConnect service platform. The agency’s mental and behavioral health page promotes support hotlines, coping resources, and connections to respected service providers, including New York Presbyterian Military Family Wellness Center and NYU Steven Cohen Family Wellness Center.[[25]](#footnote-25) Additionally, in the past, the agency partnered with First Lady Chirlane McCray’s mental health initiative, ThriveNYC to launch programming to support and treat veterans battling mental illness.[[26]](#footnote-26)

In ThriveNYC’s initial 2015 report, *ThriveNYC: A Mental Health Roadmap for All,* the administration announced two initiatives designed to reach the City’s veterans:[[27]](#footnote-27) ThriveNYC (1) pledged to invest in and expand the Veterans Services Outreach Team,[[28]](#footnote-28) and (2) to create a Veterans Holistic Treatment Fund to provide grants to community-based organizations that utilize evidence-based restorative practices.[[29]](#footnote-29) In November 2019, DVS and ThriveNYC announced that they would be scaling up their veterans mental health programs through the launch of the following six initiatives:

* increasing mental health providers on VetConnect NYC;
* grants to legal service organizations to help veterans upgrade their discharge status;
* training for mental health professionals;
* support for holistic treatments, funding for a peer support program for veterans with PTSD; and
* coordinating efforts with a federal interagency mental health taskforce.[[30]](#footnote-30)

The City Council has attempted to oversee ThriveNYC’s budget and programing,[[31]](#footnote-31) but due to limited documentation and opaque operations, it is difficult to determine whether the 2015 and 2019 programs under the DVS and ThriveNYC partnership have been fully funded and remain active.[[32]](#footnote-32)

In April 2020, DVS and ThriveNYC launched Mission: VetCheck, a project where volunteers make supportive check-in calls to veterans across New York City. [[33]](#footnote-33) DVS took ownership of the program on July 1st, 2021.[[34]](#footnote-34) The calls aim to decrease social isolation and provide immediate information about essential public services and resources.[[35]](#footnote-35) The most common service requests have been for food assistance, unemployment assistance, information about COVID testing, and healthcare questions.[[36]](#footnote-36) Since the program's launch, Mission: VetCheck has placed over 33,485 calls[[37]](#footnote-37) and referred over 950 veterans[[38]](#footnote-38) to DVS for support and services. Mission: VetCheck trains volunteers from veteran services organizations, including the United War Veterans Council, The Mission Continues, Catholic War Veterans, Travis Manion Foundation, and various American Legion and Veterans of Foreign Wars posts.[[39]](#footnote-39) When the initiative launched, training was delivered by DVS and the Mayor’s Office of ThriveNYC, and volunteer management was overseen and conducted by New York Cares.[[40]](#footnote-40) The New York National Guard helped pilot the initiative by making over 4,000 calls to City veterans.[[41]](#footnote-41) DVS pledges to continue Mission: VetCheck as New York City re-emerges from the COVID-19 crisis.[[42]](#footnote-42)

* 1. *Alternate Treatments for Veterans’ Mental Health Care*

In addition to the traditional approaches and therapies mentioned above, several organizations, cities, and medical providers have begun to look at alternative treatments to address veteran-associated mental health conditions: methylenedioxymethamphetamine (MDMA)-assisted therapy for the treatment of PTSD[[43]](#footnote-43) and the use of psilocybin and ketamine for treatment-resistant depression.[[44]](#footnote-44) Much of the push for such alternative treatments has been borne out of a lack of access to traditional treatment options – long waiting lists, unaffordable costs, lack of enough providers, and lack of resources – at the VA or other veteran providers.[[45]](#footnote-45) This lack of access to traditional therapies, combined with high rates of severe, prolonged mental health challenges has propelled veterans groups and advocates to look outside the scope of traditional therapies, where many feel they are being overlooked or ignored.[[46]](#footnote-46)

Though they are not yet federally approved for treatment, MDMA and psilocybin have shown great potential for use in treatment-resistant mental health conditions.[[47]](#footnote-47) For example, a recent study, which was the first randomized controlled trial to compare psilocybin with a conventional selective serotonin reuptake inhibitor (SSRI) antidepressant, found that psilocybin improved symptoms of depression just as well on an established metric and had fewer side effects than a conventional SSRI.[[48]](#footnote-48) The overall depression scores used in the study did not show a statistically significant difference between the group given psilocybin alone and the one given the SSRI after six weeks.[[49]](#footnote-49) However, the psilocybin group showed significantly larger reductions in suicidality, anhedonia (a lack of the ability to feel pleasure), and standard psychological scores for depression.[[50]](#footnote-50) Additionally, 70 percent of subjects in the psilocybin group responded to the treatment, compared with 48 percent of those in the SSRI group, and the rate of remission in the psilocybin group was 57 percent, and was only 28 percent in the SSRI group.[[51]](#footnote-51)

While this research is extremely promising, the study was very limited (only 59 participants), and scientists and advocates agree that further high-quality studies are needed.[[52]](#footnote-52) Additionally, psilocybin is still designated as a Schedule I substance by the federal government, which means it is considered to have “no currently accepted medical use and a high potential for abuse,” and therefore makes it much more difficult to study.[[53]](#footnote-53) Still, in November 2020, Oregon residents voted to legalize psilocybin therapy for medical purposes,[[54]](#footnote-54) and on May 7, 2019, Denver voters approved Initiative 301 to decriminalize personal possession, cultivation, and storage of psilocybin mushrooms in the City and County of Denver.[[55]](#footnote-55) Additionally, Texas Governor Greg Abbott recently signed into law Texas House Bill 1802, which will allow research on psychedelic therapy as a treatment for veterans struggling with PTSD.[[56]](#footnote-56) Texas is also considering a second study on MDMA treatment.[[57]](#footnote-57)

MDMA was first used in psychotherapy in the 1970s, and today it is being looked at and studied to potentially aid in talk therapy by quieting the part of the brain that is involved in fear processing, which could have huge implications for treatment of PTSD.[[58]](#footnote-58) An organization called the Multidisciplinary Association for Psychedelic Studies (MAPS) conducted a study on MDMA therapy for individuals with severe PTSD, and reported that 67% of participants who received MDMA no longer qualified for a diagnosis of PTSD two months after the treatment.[[59]](#footnote-59) MAPS has been approved to conduct further Phase 3 trials, expected to be complete in 2022, with the hopes that the US Food and Drug Administration (FDA) could approve the treatment as soon as 2023.[[60]](#footnote-60)

By contrast, Esketamine, a relative of the drug ketamine, was approved in 2019 by the FDA to treat patients with treatment-resistant depression, and doctors can now prescribe it for patients experiencing suicidal ideation.[[61]](#footnote-61) Though ketamine itself is not approved for treatment of depression, it is approved for use as an anesthetic and can therefore be used “off label” for depression, if a doctor recommends it, which many do, since medical ketamine clinics have been treating patients since 2014, and there are now dozens of such clinics across the country. [[62]](#footnote-62) Still, ketamine has not been widely utilized for treatment of depression, likely because more research is needed, and potentially because it is not a particularly profitable drug for pharmaceutical companies, and therefore not much effort has been made to commission studies or conduct marketing for its use.[[63]](#footnote-63)

* 1. *Veterans’ Mental Health Budget and Finance*

Much like the programs offered through Thrive NYC, programs and services offered for Veterans’ mental health are challenging to track and understand, particularly from a budgetary perspective. In *Thrive NYC: A Roadmap for Mental Health for All,*  the City pledged to invest $500,000 to create a Veterans Outreach team to “provide additional navigation assistance and care coordination to veterans and their families,” and $1 million Veterans Holistic Treatment Fund to “provide grants to organizations that serve veterans and their families… The grants will allow a variety of community-based settings to host evidence-based restorative practices.”[[64]](#footnote-64) When the Department of Veterans Services was launched in April 2016,[[65]](#footnote-65) it was unclear where the Thrive NYC programs lay within the budget of the agency.

Starting in Fiscal 2020, the Office of Management and Budget (OMB) and the City Council Finance Division had a Term and Condition that required the Mayor’s Office of Thrive NYC to provide Council with an “updated multi-agency ThriveNYC Program Budget reflecting the budgets in each initiative in each year of the financial plan.”[[66]](#footnote-66) Within this budget, the DVS’s Veterans Outreach Program was included for $600,000, and $200,000 was added to the Thrive NYC Program budget in the November plan for Fiscal 2021 for Non-Traditional Mental Health Services.[[67]](#footnote-67) However, in the Thrive NYC Fiscal 2022 Preliminary Budget, the Non-Traditional Mental health Services budget was not considered to be a part of the Thrive NYC budget.[[68]](#footnote-68)

In April 2021, Mayor de Blasio and First Lady McCray announced Mental Health for All and executive order 68 to create the Mayor’s Office of Community Mental Health (OCMH).[[69]](#footnote-69) When the Fiscal 2022 Executive Budget was released, OMB sent the Council’s Finance Division the newly created OCMH Budget. The budget for OCMH did not include any programs for veterans. It is unclear if the veterans programs previously housed under Thrive NYC continue to exist within the Department of Veterans’ Services.

1. **Conclusion**

At today’s hearing, the Committee looks forward to hearing from the Administration, providers, community-based organizations, and advocates about what the City is doing to address veterans’ mental health, how services are coordinated between the federal, state, and city governments, and how the Council can support these efforts.

1. **Legislation**

**Int. 2442**

This legislation requires the Mayor to establish an Office of Community Mental Health (OCMH) within the Executive Office of the Mayor, or as a separate office, or within any other agency or office headed by a mayoral appointee. OCMH would be headed by a director. OCMH would be charged with the following duties and operations: request and receive the assistance of any other agency or office; develop and support the implementation of strategies to close gaps in mental health care; develop interagency policies and practices to promote mental health; decrease any barriers to mental health care that may prevent access among groups identified as being under-served; and perform any other relevant duties as the mayor may assign. Additionally, OCMH would be responsible to ensure interagency coordination with DOHMH or any other office or agency.

This legislation would also require the establishment of a Mental Health Council to advise OCMH on issues relating to mental health and mental health care and facilitate coordination and cooperation among city agencies. Finally, OCMH would be required to annually report to the Mayor and Speaker of the Council, and post to OCMH’s website, a report identifying critical gaps in mental health care that are preventing New Yorkers with mental health needs from accessing and staying connected to care.

The bill would take effect 90 days after it became law.

Int. No. 2442

By Council Member Ayala (by request of the Mayor)

A Local Law to amend the New York city charter, in relation to establishing an office of community mental health

Be it enacted by the Council as follows:

Section 1. Chapter 1 of the New York city charter is amended by adding a new section 20-m to read as follows:

§ 20-m Office of community mental health and mental health council. a. Definition. For the purposes of this section, the term “director” means the director of the office of community mental health.

b. Office of community mental health. The mayor shall establish an office of community mental health. Such office may be established within the executive office of the mayor or as a separate office or within any other agency or office headed by a mayoral appointee as the mayor may determine. Such office shall be headed by a director, who shall be appointed by the mayor or by the head of such other agency or office.

c. Powers and duties. The director shall have the power and duty to:

1. Request and receive the assistance of any other agency or office the director deems necessary to further efforts to:

(a) Reduce substance misuse and promote access to services for substance use disorder;

(b) Promote access to treatment for New Yorkers with mental health needs;

(c) Promote equity in access to treatment;

(d) Reduce any racial and ethnic disparity in reported mental health emergencies in the city; and

(e) Reduce the incidence of mental health emergencies occurring in the city and address individual’s mental health needs before they become crises.

2. Develop and support the implementation of strategies to close gaps in mental health care identified by the office by:

(a) Monitoring the implementation of such proposals; and

(b) Providing data and budgetary information of such programs on the office’s website.

3. Develop interagency policies and practices to promote mental health. Such policies and practices shall include coordination with other agencies to:

(a) Effectively and equitably promote mental health crisis prevention, intervention and stabilization practices;

(b) Promote mental health screening;

(c) Facilitate referrals to mental health care;

(d) Offer training; and

(e) Implement other strategies to promote mental health.

4. Decrease any barriers to mental health care that may prevent access among groups identified as being under-served by such care by:

(a) Developing and implementing strategic partnerships with other agencies and entities to increase access to mental health care; and

(b) Disseminating resources to enhance mental health literacy, promote access to mental health care, and promote equity in access to treatment.

5. Perform such other relevant duties as the mayor may assign.

d. Interagency coordination. In performing their duties, the director shall coordinate with the commissioner of health and mental hygiene, or their designee; and any other agency or office the director deems necessary to further the duties of the office.

e. Mental health council. 1. There shall be established a mental health council to advise the office of community mental health on issues relating to mental health and mental health care and facilitate coordination and cooperation among city agencies. Such council may:

(a) Recommend initiatives and methods to promote mental wellbeing and increase access to high quality mental health care, and address structural determinants of mental health;

(b) Identify methods for advocating for New Yorkers with mental health needs and recommend support programs to remove barriers to mental health treatment and ensure stable and productive lives;

(c) Recommend legislative or regulatory action to improve the lives of people suffering from mental illness and to promote mental health;

(d) Identify methods for such office to support other stakeholders working to provide effective, high quality mental health and care; and

(e) Recommend strategies for such office to educate the public about mental health and available resources.

2. The mental health council shall be convened by the director at least twice each year, and at any other time the director determines.

3. The mental health council shall consist of delegees of any office or agency the director determines the participation of which would aid the office’s efforts.

f. Scope. Nothing in this section shall be construed to affect the powers and duties of the department of health and mental hygiene and the mental hygiene advisory board pursuant to chapter 22 of the charter, article 41 of the mental hygiene law or other applicable law. Powers and duties conferred by this section on the office of community mental health or the mental health council that are within the scope of the powers and duties of such department or board shall be exercised in coordination with such department or board.

g. Reporting. No later than January 31 of each year, the office of community mental health shall submit to the mayor and speaker of the council, and post to the office’s website, a report identifying critical gaps in mental health care that are preventing New Yorkers with mental health needs from accessing and staying connected to care. To identify such gaps, the office may review existing data and research, conduct research as needed, and interview agency staff, community partners, mental health providers and other relevant experts.

§ 2. This local law takes effect 90 days after it becomes law.

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40. *Id.* at 7*.* [↑](#footnote-ref-40)
41. *Id.* at 7. [↑](#footnote-ref-41)
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