Testimony of James Hendon

Commissioner for the New York City Department of Veterans' Services (DVS)

New York City Council Committee on Veterans & Committee on Mental Health, Disabilities and Addictions

Topic: Oversight - Mental Health Services

September 15th, 2023, 10:00 AM

Introduction

Good morning, Chair Holden, Chair Lee, committee members, and advocates. My name is James Hendon, and I'm proud to serve as the Commissioner for the New York City Department of Veterans' Services (DVS). Thank you for holding this hearing on mental health services for Veterans. I am joined today by Dr. Lauren D'Mello, Executive Director of Mental Health and Care Coordination, Ellen Greeley, Assistant Commissioner for Policy and Strategic Partnerships, and Paul Vallone, Deputy Commissioner for External Affairs. I am also joined by Jamie Neckles, Assistant Commissioner for the Bureau of Mental Health at the Department of Health and Mental Hygiene, who is available for Q&A on Intros. 0793, which requires the Health Department to report on referrals to assisted outpatient treatment programs, and Intro 0946, which requires the creation of a mental health coordinator to inform city employees about mental health support and services.

Background & Data

Our Veterans adhere to a military culture that values honor, courage, duty, self-sacrifice, discipline, teamwork, never giving up, holding oneself to a higher standard, and being part of something greater. Yet, many of our Service Members and Veterans suppress the most

acceptable approaches to dealing with physical and emotional pain and often are reluctant to seek professional help.

We at DVS continue to build a military culture competent system responsive to meet the emotional needs of Service Members and Veterans across a spectrum of programs and services as well as work with a multitude of community-based and behavioral health partners to improve their practice when caring for Service Members, Veterans, and Families.

In building this system, we are aware that emotional health is a product of many factors we call social determinants of health. Think of emotional health as the dependent factor based upon a series of independent variables such as socioeconomic status, education, employment, social support networks, access to health care, food insecurity, access to housing and utility services to name a few. We take a holistic approach in addressing these areas as they all impact the emotional wellness of our constituency.

Along our spectrum of services, we spend a significant degree of our partnership work on improving military cultural competence and quality of services for Service Members, Veterans, and Families. This work in conjunction with emotional wellness programming have resulted in the following programs:

- **VetConnectNYC**: A multi-service provider referral platform including connections to the VA Vet Centers, VA Medical Centers, The Steven A. Cohen Military Family Center at NYU Langone, New York-Presbyterian Military Family Wellness Center, Headstrong, Trauma and Resiliency Resources, Stop Soldier Suicide, and other community-based resources. Additionally, we connect constituents to crisis lines including NYC Well, 988, Veterans Crisis Line and others.

- **Transition Assistance Programs & Peer to Peer Connectedness:** Any transition can trigger stressful situations, but this is especially true of Service Members departing from active-duty, student veterans acculturating to college life, and Veterans retiring from employment. These vulnerable Veterans represent the largest group in committing suicide. Onwards Ops, formerly Expiration of Term-Service Program services members departing from military service enroll in program, are assigned a mentor usually in the same geographic area they are returning, and receive assistance in preparing resumes, registering for VA benefits and healthcare, including mental health, and connected to community programs.
- **Big Apple TAPS:** DVS sponsored a virtual and in-person program in collaboration with The Mets at Citi Field. We organized panel discussions on education, job preparation and employment, VA benefits, disability claims, and housing. We plan to conduct a similar program for Women Veterans in the Spring.
- **Joseph P. Dwyer Program:** The DVS Community Survey revealed that about one-quarter of Veterans reported that they feel lonely 3 or more days in a typical week. Social isolation has been found to be a factor in those seeking mental health services. To enhance social engagement, fortify emotional wellness, and encourage health-seeking behavior, DVS began a pilot program with New York State funding for its own PFC Joseph P. Dwyer Program. DVS issued a Request for Information in February/March 2023 and received 21 responses providing a broad selection of in-person arts, music, health and wellness, athletic, culinary, educational, and other community-based programs aimed towards peaking the wide interests of Veterans and Veteran family members of all service eras, genders, race/ethnicities, disability status, ages, and other demographics. To date, four programs are being funded including Yoga at an American

Legion/Veterans of Foreign Wars Post (Gold Post) in Staten Island, Zumba dancing at an American Legion Most in Brooklyn (Dorie Miller), rehabilitating an American Legion Post in Queens (Rosedale-Laurelton), and offering equine therapy with Columbia University's Man O' War Program. In compliance with procurement guidelines, we will be posting a Concept Paper, followed by issuing a Request for Program to distribute the remaining portion of State funds.

- **Crisis Intercept Mapping:** Led by VA/SAMHSA facilitator, DVS curated a group of representatives drawing from medical facilities, mental health providers, city agencies (NYPD, DA offices, DOHMH, Mayor's Office of Community Mental Health), colleges/universities, military chaplains, and nonprofit organizations to help community stakeholders visualize how at-risk Service Members, Veterans, and Family Members flow through the crisis care system. Discussion centers on identifying stakeholders at various intercept points: (First Contact, Acute Care, Care Transitions, and Ongoing Treatment, and Recovery Support).
- **Food Insecurity**: Since July 2020 during the height of the pandemic, DVS has been collaborating with The Campaign Against Hunger and Black Veterans for Social Justice to pack 2,000 food kits for 1,000 Service Members, Veterans, and Families with donated fresh food items from HelloFresh, a food packaging company. Over the three-year period, we have packed more than 312,000 kits translating into 1,248,000 meals.
- **Mission: VetCheck**: Launched in May 2020, we have facilitated over 34,000 total calls with an approximate 25% answer rate, resulting in over 100 calls per week. Of those answered calls, DVS is proud to have been able to serve the over 1,200 requests for service since launching. These requests ranged from food assistance, eviction prevention, mental health, benefits navigation and more.

- **Veterans' Mental Health Coalition**: The Veterans' Mental Health Coalition is group of mental health practitioners, researchers, and organizational leaders that meet once a month and discuss various topics on mental health. The group focuses on a Veterans' mental health concern for each meeting and discusses updated research and data, treatments, organizations, programs and accessibility of these programs and barriers to care.

Additionally, with support from the Mayor's Office of Community Mental Health, DVS began the implementation of two health assessments, known as the Patient Health Questionnaire-9 (PHQ-9) and the Generalized Anxiety Disorder-7 (GAD-7), to screen our clients for depression and anxiety. Since February 2021, DVS staff have conducted over 1,300 health assessments, for which approximately 28% indicated severe anxiety or depression. Since then, DVS has made 529 referrals for mental health services. This is 44 times the number of referrals compared to the period before the implementation of the health screeners. Further enhancing DVS' ability to identify mentth.al health needs of our clients more accurately and connect them quickly to resources.

DVS' Collaborative Approach to Mental Health Services

DVS have also made suicide prevention among service members, veterans, and their families (SMVFs) a top priority through collaboration. DVS has been the beneficiaries of trainings by experts affiliated with the U.S. Substance Abuse and Mental Health Services Administration and the U.S. Department of Veterans Affairs to develop a network of military culturally competent community-based organizations able to tackle the challenges of servicing returning warriors and veterans coping with physical and emotional distress.

DVS also supports the national Department of Defense/Veterans Affairs endorsed Expiration of Term Service Sponsors Program, by identifying community-based organizations which can assist in recruiting and managing veteran and civilian sponsors willing to ease the reintegration of returning warriors to their hometowns or new residential communities in New York City. We have been successful in enlisting the Staten Island Participating Provider System as a lead agency for this network and continue our efforts in reach out to other suitable organizations including leadership of the American Legion and Veterans of Foreign Wars..

DVS participates with New York State agencies on several working committees dedicated to improving health outcomes for Veterans including the VA/SAMHSA's Governor's Challenge Program, the NYS Suicide Prevention Center's Helping Those Who Help Others, and NYS Office of Mental Health's launch of 988.

Conclusion

We thank you for the opportunity to testify on this matter and look forward to any questions you or other Committee members may have.

Brigadier General (Ret.) Loree Sutton, MD
New York City Council Committee on Veterans (Ch. Holden)
Committee on Mental Health, Disabilities & Addiction (Ch. Lee)
Submitted Testimony // September 15, 2023

Chair Holden; Chair Lee; Distinguished Members of the Committee on Mental Health, Disabilities and Addiction & the Committee on Veterans; Honorable Civic Officials; Community Leaders, Advocates, Caregivers, Survivors, Fellow Veterans, Blue & Gold Star Families, Allies & Friends:

Thank you all for being here – and for your leadership and commitment to making New York City a place where there is space and grace for all to live lives of progress, passion, dignity & respect.

Today we gather to address and act on critical issues affecting the most vulnerable and marginalized New Yorkers; to serve as an active and informed voice for those who are afraid or unable to speak; to illuminate places within of darkness and despair; to boldly break through the blockades of bureaucracy to advance vanguard values, social innovation, equitable access, community advocacy, scientific knowledge, clinical practice, and relevant outcomes.

To this end, I heartily endorse adoption of Int 0793-2022, requiring the creation of a mental health coordinator to assist and perform outreach for city employees; and Int 0946-2023, requiring the Department of Health & Mental Hygiene to report referrals, filed petitions and the number of resulting court orders for individuals to assisted outpatient treatment programs under the state law known as Kendra's Law. It's beyond time to make these changes to NYC local law.

Regarding the topic of today's hearing – advancing breakthrough treatments for PTSD, including psychedelics – this truly is work worth doing. As a retired military psychiatrist, finding ways to address PTSD more effectively is my life's work– tackling the tide of suffering, despair, addiction, and suicide – and promoting growth, resilience, initiative, and trust. There is no greater privilege.

Throughout today's hearing, we will collectively:

- witness the trauma tsunami of suffering upon us;
- face the facts;
- listen to stories of strength;
- learn of scientific progress; and
- rally around recollections of recovery

Yet important questions remain:

- Where do we go from here?
- What can we do?
- What should we do?
- What *must* we do?

It's complicated, to be sure. And, given the complex web of dynamics characterizing the PTSD industry, it's daunting. Let's simplify – with ten things to know about PTSD and its treatment:

10. PTSD is not a military-specific affliction stemming only from the horrors of combat. Assault, motor vehicle accidents, rape, torture, incest, natural disasters are a few of the experiences which render psychological trauma a *human* experience and injury which can lead to PTSD.

9. PTSD need *NOT* result in a life sentence of silence, suffering, and shame. Breakthrough treatments offer real hope, fostering the potential to catalyze post-traumatic growth and resilience – with grit, gratitude, and grace.

8. PTSD does not occur in isolation. The trauma of exposure to a terrifying event – experiencing it yourself or knowing that someone close to you is threatened; witnessing atrocities occurring to others; and/or being repeatedly exposed to graphic details of traumatic events – is often accompanied by sleep disruption, pain (physical, emotional and/or spiritual), moral injury, flashbacks, nightmares, and, tragically, deaths of despair, i.e., suicide, drug overdose and alcoholism.

7. Despite the best of intentions and billions of dollars spent since 9/11, the current "gold standard treatments" are failing miserably to meet this moment in which so many are struggling to survive.

6. *Tell me this* -- if Veterans were doing well with treatment as usual, why do suicides and overdoses remain at epidemic levels?

5. *If* treatments as usual were so effective, why are up to 50% of Veterans unable to tolerate them?

4. *If* treatments as usual were acceptable, tolerable, and effective, why would Veterans and their loved ones advocate so passionately for psychedelics?

3. A growing chorus of researchers, clinicians, veterans, family members, survivors, caregivers, and allies are calling for real progress in advancing the innovation of breakthrough PTSD treatments, including psychedelics – novel, brief, lasting, effective, and non-traumatizing. Countless lives depend upon how we respond to this clarion call to action.

2. PTSD is real; breakthrough treatments like Transcendental Meditation (TM), Reconsolidation of Traumatic Memories (RTM) Protocol™ & MDMA-Assisted Psychotherapy (coming soon!) – really do work; early intervention prevents needless suffering – yet trauma healing can occur decades later; and speaking up, reaching out, seeking support, and demanding change – is *real* strength.

1. PTSD treatment is far too important to be left to the doctors, researchers, clinicians, elected officials, philanthropists, and suffering individuals and their families. *ALL* of us must summon the courage, audacity, and outrage to demand better, to harness the fierce urgency of *NOW*.

This concludes my formal testimony. I am honored to engage in an ongoing dialogue – today and going forward – to address the vital need for bringing breakthrough PTSD treatments to NYC.

JUMAANE D. WILLIAMS

STATEMENT OF PUBLIC ADVOCATE JUMAANE D. WILLIAMS
TO THE NEW YORK CITY COUNCIL COMMITTEES ON MENTAL HEALTH, DISABILITIES & ADDICTION AND VETERANS
SEPTEMBER 15, 2023

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 Chairs Lee and Holden and the members of the Committees on Mental Health, Disabilities and Addiction and Veterans for holding this hearing.

Every year, approximately 200,000 people transition out of active-duty service and return to civilian life.[1] Veterans are at increased risk for a variety of physical and mental health problems: in 2020, the most recent year for which complete data is available, the suicide rate among veterans was 57 percent higher than that of non-veteran adults.[2] In 2019, 6,261 veterans died by suicide in 2019, or 17.2 veterans per day.[3] The 2020 National Survey on Drug Use and Health found that 41.9 percent of veteran respondents struggled with drug use, and 70.1 percent struggled with excessive alcohol use.[4]

While serving in the military, many veterans experience traumatic events, including violent combat and sexual assault. About 7 percent of veterans will experience PTSD in their lifetime, compared to 6 percent of non-veterans.[5] Further, data from the US Department of Veterans Affairs ("the VA") national screening program found that 1 in 3 women and 1 in 50 men report having experienced military sexual trauma (the VA's term for sexual harassment and assault experienced while in the military).[6]

Data also suggests that some veterans are unlikely to immediately access the mental health resources and services available to them. In 2022, more than half of veterans experiencing

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[1] https://www.samhsa.gov/blog/supporting-behavioral-health-needs-our-nations-veterans
[2] https://www.mentalhealth.va.gov/docs/data-sheets/2022/2022-National-Veteran-Suicide-Prevention-Annual-Report-FINAL-508.pdf
[3] https://news.va.gov/94358/2021-national-veteran-suicide-prevention-annual-report-shows-decrease-in-veteran-suicides/
[4] https://www.samhsa.gov/data/sites/default/files/reports/rpt37926/2020NSDUHVeteransSlides072222.pdf
[5] https://www.ptsd.va.gov/understand/common/common_veterans.asp#:~:text=At%20some%20point%20in%20their,of%20100%2C%20or%206%25).
[6] https://www.mentalhealth.va.gov/docs/mst_general_factsheet.pdf

mental illness did not receive treatment in the previous year, and more than 90 percent of those with substance use disorder did not receive treatment.[7] Studies have connected this hesitancy to seek support to stigma surrounding trauma and mental health services in the military community.[8][9] Living with untreated mental illness can make it difficult for veterans to find and keep a job as well as stay in stable housing.

Wait times to receive VA benefits can be notoriously long—despite recent publicized efforts to cut them down—exceeding the standard of providing most healthcare appointments within 20 days and half an hour of the patient's home. During the pandemic, Black and Latinx veterans seeking medical care through the VA were more likely to face longer wait times.[10] These barriers can also prevent veterans from seeking care.

Earlier this year, the VA announced that veterans could receive "inpatient or crisis residential care for up to 30 days and outpatient care for up to 90 days," even if they were not enrolled in the VA system.[11] I applaud this program, which was part of Rep. Mark Takano's COMPACT Act. Those who have served our country should not have to worry about treatment costs when in crisis.

Currently, the New York City Department of Veterans' Services connects veterans to a variety of resources and services, including mental health support and treatment. Veterans need services that are tailored specifically to people who have served, not to be lumped into the mental health systems for civilians; further, the unique needs of women veterans must be considered, especially taking into account their disproportionate likelihood of having experienced military sexual trauma. This also applies to housing services for veterans experiencing homelessness, who need support that takes into account their unique needs when returning to civilian life from serving. As veterans are disproportionately likely to experience homelessness, the city should invest in mobile medical units that can deliver treatment and services for veterans' mental and physical health needs.

The city also offers a Veterans Treatment Court, a program run by the state that helps veterans charged with felonies who are struggling with mental illness or substance use or both. This is a resource that is crucial to helping veterans not currently connected to treatment, as many of them end up in contact with the criminal legal system. However, in order to expand the program it is important to know its scope and impact; the Manhattan District Attorney's should track how many cases are referred to the program, how many are accepted and choose to participate, and the outcomes of participating defendants.

Thank you.

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[7] https://www.samhsa.gov/blog/supporting-behavioral-health-needs-our-nations-veterans
[8] https://pubmed.ncbi.nlm.nih.gov/32323576/
[9] https://pubmed.ncbi.nlm.nih.gov/23750758/
[10] https://patientengagementhit.com/news/racial-disparities-in-va-appointment-wait-times-worsened-amid-covid-19
[11] https://ny1.com/nyc/all-boroughs/politics/2023/01/17/veterans-in-suicidal-crisis-to-get-free-help

New York City Council Committee on Veterans

Testimony of Bronx Borough President Vanessa L. Gibson

Friday September 15, 2023

Thank you Chair Holden, Chair Lee, and the members of the Committee on Veterans and Committee on Mental Health, Disabilities, and Addiction for convening this hearing today to discuss mental healthcare and support for veterans.

As Bronx Borough President, I am proud to represent over 20,000 veterans who call our borough home. Those who have served our country in the armed forces have made great sacrifices in order to preserve our safety and freedom. They have often paid the price in wounds – both physical and mental. They deserve and are entitled to all the help that we can give them to aid in their recovery.

Over 6,000 veterans across the country take their own lives every year. In 2020, the adjusted suicide rate for veterans was 57% higher than the rate for non-veterans. The New York City Department of Health and Mental Hygiene reports that one in ten veterans have been diagnosed with a substance use disorder. Further, it was found that 30 percent of suicides among veterans involved drug or alcohol use. These statistics are appalling. Our veterans have experienced traumatic events, and this is a tragic example of how we are not doing enough to care for those who served. That is why it is essential that we as a city do more to ensure that every veteran is able to access the mental healthcare that they need.

The stigma around discussing mental health issues is so strong and those in need of help most often do not know where or how to seek help. There is a critical need to restructure mental healthcare delivery to transition from punitive systems to an equitable treatment model with supportive care for all.

I am proud that my office maintains a Veterans Advisory Council as a forum for veterans in The Bronx to organize and connect with government to make real and lasting change in our communities. The Bronx veterans who serve on this council are an active and engaged group that is fully committed to improving outcomes for all veterans in our city, including in health and mental health. We are unified in our goal of building a strong and successful future for veterans in The Bronx.

We must do more to ensure that veterans are getting all the support that they deserve. While this starts with the federal government fully funding and supporting veterans benefits and Veterans Affairs facilities throughout the country, the effort must include state and local partners as well. Collectively, there is more that needs to be done to ensure necessary resources and treatment are accessible for the most vulnerable.

As the home of the James J. Peters Medical Center, The Bronx is an important hub for veterans' healthcare in our city. This facility provides essential health services to our veterans, and I am proud to work with them to improve access and outcomes. We must be vigilant to preserve the other VA facilities across the city. Closing any of these facilities would prove disastrous for veterans in the other boroughs and add a great strain onto the Bronx's VA hospital.

I am proud to have worked with Councilmember Eric Dinowitz to introduce the resolution under consideration today to recognize November as Veteran Appreciation Month in New York City. We have long celebrated, recognized, and honored our veterans in November, with President Clinton first proclaiming November as National Veterans and Military Families Month in 1996. However, New York City has never recognized a full month for veteran appreciation before. This recognition is the right thing to do, and I hope that the committee will join us in supporting this resolution.

The other two bills under consideration today are also important to advance the cause of mental healthcare for all New Yorkers. Creating a mental health coordinator in each city agency will help the employees and staff who keep our city government running. By ensuring that we are complying with the Americans with Disabilities Act and conducting the proper outreach to city employees, we can ensure that everyone gets the help that they need and is available to them.

The health disparities in our vulnerable communities are a call to action for all public health initiatives and a central focus of my administration. The network of health partners and organizations in the Bronx have amplified their efforts to reach deep into the neediest communities to support better access to nutritious foods, access to mental health resources, and regular preventative health screenings.

In addition to veterans, we must also make sure that other vulnerable populations receive adequate mental healthcare, including LGBTQIA+ people, children, and seniors. Long-term mental health and socialization issues have not been fully accounted for or understood.

On July 16, 2022, the 988-suicide prevention hotline was launched nationwide. The hotline provides 24/7 free and confidential emotional support to those in mental health distress.

There is a critical need to restructure mental healthcare delivery to transition from punitive systems to an equitable treatment model with supportive care for all. I look forward to working with my colleagues in government on these systemic fixes that necessitate mandatory continuity of care and coordinated outpatient and community-based services.

Thank you again to the Chairs and committee members for holding this hearing. The veterans in our communities deserve our support and recognition for their sacrifice. I hope that together we are able to make a positive change for them and their families.

Written Testimony to New York City Council Committee on Mental Health, Disabilities and Addiction: Oversight – Mental Health Services for Veterans

Provided by Services for the UnderServed (S:US)

Perry Perlmutter, CEO & President

September 15, 2023

Founded in 1978, S:US is one of the largest community-based health and human services providers in New York, with a staff of 1,800 serving 37,000 New Yorkers annually throughout the five boroughs and on Long Island. S:US serves a broad and diverse range of individuals and families, including women and children who have experienced domestic violence; veterans who are challenged by homelessness, PTSD, and unemployment; people who have lost their homes and are living in poverty; people with autism and other developmental disabilities; people living with HIV/AIDS; and people with mental health and substance use challenges. By delivering high quality services that address the complex circumstances of each individual, we help transform lives, improve neighborhoods, and break the cycle of poverty for current and future generations of New Yorkers.

Thank you, Chairperson Robert Holden and Council Member Crystal Hudson for allowing S:US to submit written testimony. Thank you for holding this hearing today and your leadership uplifting and protecting services for mental health. S:US fully supports the local law to amend the administrative code of the city of New York, in relation to creating a mental health coordinator to inform city employees about mental health support and services. We know how critical it is to have easily accessible behavioral health care, and that timely access can be the difference between healing and crisis. We also know firsthand how hard the past few years have been on our workforce. It will be essential not just to have available navigators, but also to ensure thoughtful and efficient coordination between those identifying and those connecting individuals to care rapidly.

S:US is in full support of layering a coordinator on top of the existing city workforce EAP, as employees can sometimes struggle to find the willingness or time to engage with their EAP. A coordinator can assist with connecting them, or help them become ready to accept -services they are reticent to access.

We strongly recommend including community partners receiving the city workforce in its care, when building the network through this initiative. Warm handoffs and receptions are effective engagement strategies. In addition, we recommend including supporting and affordable housing agencies in the anticipated network of services. While housing has not historically been included as a mental health support, we all know that stable housing is the first step toward healing. Many individuals are even willing to access housing before they are ready to accept services. Supportive housing agencies like S:US are eager partners in this effort. Pairing coordinators with receiving agencies trained in supporting the needs of the city's workforce will ensure the initiative is successful. While there are myriad existing EAPs

throughout the city, having providers who are knowledgeable in the culture and pressures of municipal workers will ensure better engagement and retention in services.

As a part of our mission, S:US actively supports individuals with behavioral health challenges who are at highest risk for homelessness, unemployment, untreated medical, psychiatric and substance use disorders, and disconnection from family, social and other natural supports. Similar to the proposed legislation, S:US' Care Coordination service assigns a central Care Navigator to help individuals living with mental health issues. The Care Coordinator addresses these mental health complexities by facilitating communication with healthcare providers, greatly reducing reliance on emergency room and inpatient hospital services. S:US strongly believes it is essential to have a designated mental health coordinator at each City agency, and we applaud the Council’s commitment to protecting its employees.

Testimony Before the New York City Council Committee on Mental Health, Disabilities and Addiction jointly with the Committee on Veterans

September 15, 2023

Presented by:
Cal Hedigan, Chief Executive Officer
Community Access, Inc.
chedigan@communityaccess.org

Community Access expands opportunities for people living with mental health concerns to recover from trauma and discrimination through affordable housing, training, advocacy, and healing-focused services. We are built upon the simple truth that people are experts in their own lives.

www.communityaccess.org

Thank you to Chairs Lee and Holden, and the rest of the Mental Health, Disabilities and Addiction Committee as well as the Veterans Committee, for convening this important hearing. I appreciate the opportunity to testify on behalf of Community Access.

I am fortunate to serve as the CEO of Community Access, a nearly fifty-year old organization that is one of the most person-centered supportive housing and mental health agencies in New York City. Each day, I work alongside a team of more than 350 people who devote time and care towards supporting thousands of people living with mental health concerns through housing, training, education, mobile treatment and other healing-focused services. I've seen firsthand the transformative nature of accessible, voluntary, community-based resources.

I testify before you today regarding Intro. 0793, which would require the Department of Health and Mental Hygiene (DOHMH) to report how many times city agencies and hospitals submit referrals for individuals to Assisted Outpatient Treatment (AOT) programs under the state law known as Kendra's Law, including the number of petitions filed for such referrals and the number of resulting court orders.

I would like to begin by noting that Community Access supports efforts taken by the City Council to increase transparency around mental health programs and service utilization. At the same time, we are deeply concerned about how this data could be used to expand the AOT program. AOT, or more accurately Involuntary Outpatient Commitment, is rooted in coercion and mandated services. It is a practice that runs counter to the changes that we must see in our public mental health system if we are to successfully engage people who have been ill-served by existing systems and disconnected from care. According to the State's own accounts, the AOT legislation's stated purpose was to, "enhance the support, supervision and coordination of community-based services for persons with mental illness who are at risk of relapse, violence and/or rehospitalization through court-ordered assisted outpatient treatment and other coordination of care measures."[1] It was also aimed at solving the "revolving door syndrome" of individuals going in and out of involuntary hospitalizations while providing a less restrictive alternative to forced hospitalization.[2]

The truth is that AOT strips people of their rights, and for those people who have first-hand experience under AOT orders, they often report it as being highly coercive. In New York, AOT orders have disproportionately impacted people of color, communities already subject to over-policing and monitoring.

Statewide, 38% of people under AOT orders are Black, 31% are white, 26% are Hispanic, and 4% are Asian. Black and Hispanic New Yorkers are over-represented in the AOT program compared to their proportion of the state population, which is 17.6% Black, 69.6% white, 19.3% Hispanic or Latino, and 9% Asian.[3] A 2005 report from the New York Lawyers for the Public Interest found

[1] https://digitalcollections.archives.nysed.gov/index.php/Detail/objects/19966
[2] https://my.omh.ny.gov/analyticsRes1/files/aot/aot-2009-report.pdf
[3] https://www.census.gov/quickfacts/NY

that Black and Hispanic people were five and two-and-a-half times as likely to be subject to Kendra's Law, respectively.[4] New York City residents were four times as likely. The disproportional impact on communities of color is just one more way that structural racism manifests in our health and mental health care systems.

We are sure that any additional data collected will continue to highlight these facts, but to what end? Many people are under the misapprehension that AOT is needed because those in mental health crisis do not want care. That is simply not true. In fact, Andrew Goldstein, the man diagnosed with schizophrenia who pushed Kendra Webdale into the path of an oncoming subway in 1999, killing her, was not someone who did not want mental health services. He was someone who repeatedly tried to access services and, again and again, was unable to secure the mental health services he needed to stay well.

It is the position of Community Access that those who are disengaged from care are disengaged because the system is failing - unable or unwilling to offer the services and programs that are truly responsive to people's needs. We fail to listen, to understand what people need and want and act quickly to provide it.

Community Access argues that the state should invest more resources into community-based services, including a range of voluntary, rights-based, person-centered supports. Individuals should be offered a plethora of care options and services to choose from, and the spectrum of mental health sector providers should be trained to understand that people living with mental health concerns are the experts in their own lives and must be true partners in the service relationship, with their preferences guiding treatment. Without that, we will continue to fail to reach those who need timely access to the right kind of support to stay well. Our attention should be focused on fixing a broken system instead of better understanding the implementation of a coercive practice that we should move away from.

I am proud of the work Community Access and other providers, advocates and service users have done to ensure that conversations about mental health service delivery reflect the need for voluntary, person-centered, community-based services. With thoughtful policy choices and investments, along with the use of data and statistics, we can create a more just city that meets people's needs, protects them from harm, recognizes human dignity, and supports them to make decisions about their own health and wellness.

Thank you for the opportunity to submit testimony. I look forward to working with Chairs Lee and Holden and the other members of these committees, as well as our agency partners, to advance community-based service options and ensure providers citywide have the resources they need to offer the support our communities rely on. If you and your staff have any questions, or if Community Access can offer direct support to members in your districts, please reach out to me at chedigan@communityaccess.org or 212-780-1400, ext. 7709.

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[4] NYLPI report https://www.nylpi.org/resource/implementation-of-kendras-law-is-severely-biased/

NYU School of Medicine

Testimony for the September 15th Oversight Hearing on Mental Health Services for Veterans
On behalf of the Steven A. Cohen Military Family Center at NYU Langone Health

Good Morning Chairman Holden and Chairwoman Lee, and members of the Committees on Veterans and Mental Health, Disabilities, and Addiction. Thank you for holding this hearing today and for the opportunity to testify.

I am Dr. Linnea Vaurio, Clinical Associate Professor in the Department of Psychiatry at NYU Langone Health, and I am testifying today on behalf of the Cohen Military Family Center at NYU Langone. The Steven A. Cohen Military Family Center was established just over ten years ago to fill a well-documented gap in services available to veterans and their families. Since inception, our Military Family Center has provided mental health treatment to over 3,600 veterans and their family members.

The Center provides free mental health treatment for military families who are experiencing the long-term effects of all phases of military service and other life stresses, including PTSD, traumatic brain injury, anxiety and depression, stress, military sexual trauma, grief and loss, readjustment to civilian life, alcohol and substance abuse, parenting concerns, relationship and family conflict, and children's behavioral or academic problems. The Center's unique services also include treatment for co-occurring substance use and mental health disorders. To reach veterans who are ineligible for care elsewhere or who may be disconnected from mental health services, we have developed strong partnerships with the VA, the Department of Veterans Services, and many other Veteran Service Organizations. The sheer number of veterans and family members served demonstrates the necessity for public-private partnerships in order to meet the needs of the veterans and their families in our community and ensure their access to healthcare.

Literature suggests that 40-60% of veterans who may benefit are not receiving mental health care and that those who are not connected to care die by suicide at a higher rate than those who are connected. Some veterans struggle with connecting to the VA for a variety of reasons including ineligibility and preference. We also know from the 2018 RAND report that there is a dearth of military culturally competent providers in this state. Central to the mission of our Center is decreasing barriers to high quality, evidence-based care for our nation's military families. This is achieved by providing our services completely free of charge; offering our services to veterans regardless of their discharge status, combat exposure, or era served; opening our services to family members of veterans; making appointments available outside of business hours; and offering our services face to face and through a telehealth platform.

Veterans and their family members are seeking mental health services at a higher rate than ever before in the last decade of our operations. This sharp increase in demand for our services has resulted in struggles to meet the demand and ultimately a waitlist for services. While we applaud the Council's effort to improve coordination of mental health services, we see a greater need to create more treatment opportunities through funding direct services. For example, we currently have a waitlist for our City Council-funded Traumatic Brain Injury program. The funding from the Mental Health Services

The Steven A. Cohen Military Family Center at NYU Langone Health
One Park Avenue, 8th Floor, New York, NY 10016 T 646-754-4816 F 646-754-4770 linnea.vaurio@nyulangone.org

NYU School of Medicine

for Veterans Initiative remains the sole source of funding for our Center's Traumatic Brain Injury program, which provides much needed evaluation and rehabilitation services for veterans with TBI, many of whom also struggle with co-occurring substance use disorders.

Our Center is equipped to work together with the community to address the ever-growing needs of veterans and their families. We hope the Council will further invest in the veteran population and we urge the Council to consider further supplementing citywide capacity to meet the ongoing demand for support services for veterans

Thank you again for the Council's past funding for the Center and the opportunity to testify today.

The Steven A. Cohen Military Family Center at NYU Langone Health
One Park Avenue, 8th Floor, New York, NY 10016 T 646-754-4816 F 646-754-4770 linnea.vaurio@nyulangone.org

Good morning councilmembers, my name is Matthew Ryba, I am a Marine Corps combat veteran of Iraq and Afghanistan and Director of community outreach and education the New-York Presbyterian Military Family Wellness Center at Columbia University Irving Medical Center. Thank you for taking my testimony today and a personal thank you to Veterans Committee for their support of our clinic in this year's fiscal budget, and additionally, to council members Holden and Paladino for their additional support on their discretionary budgets.

We know that 15 to 30% of current military veterans likely carry a mental health diagnosis of PTSD or Major Depressive Disorder from combat, military sexual trauma, or other service related experiences. Rates of PTSD diagnosis are higher in veterans then the general population. PTSD is the fourth most common disability reported by the VA, behind Tinnitus, knee issues, and hearing loss. As of 2021 the Bureau of Labor reports that 27% of the veteran population have reported service connected disabilities, although this is likely underreported due to stigma of being labeled with a mental health disorder. Veteran suicide is an everyday occurrence. Newest data suggest that since 2001 over 114,000 veterans have died by suicide. Sixteen times more than killed in Iraq and Afghanistan.

PTSD is curable. Although no one treatment works for everyone.

The Veterans Administration healthcare system provides invaluable resources to the veteran community, however, it is also important to note that nearly half of veterans in New York are not registered for, refuse, or do not qualify for VA services, while their family members are usually excluded from accessing services altogether. Further, only half who are registered use it regularly as a primary healthcare provider. Ultimately, only about 1/4 of the veterans in NY are actually utilizing the VA healthcare system, leaving approximately 75% of veterans seeking treatment from other public or private options.

Since 2016, our clinic, the New York Presbyterian Military Family Wellness Center (MFWC) at Columbia University Irving Medical Center (CUIMC) has sought to bridge this treatment divide for veterans who do not qualify for or are not amenable to VA services by providing cost-free, evidence-based assessment and treatment to local area veterans, active-duty service personnel, and their adult family members and caregivers. Since its inception, the MFWC has prioritized collaborations with regional public and private institutions, seeking to complement existing resources rather than to compete with or replace them. We regularly accept referrals from VA facilities, the DVS offices, metro area universities, and other organizations that serve the veteran community.

There are several reasons that many veterans diagnosed with PTSD struggle to improve. One of them is treatment dropout. A number of scientific publications published between 2013 and 2018 found that rate of veterans who drop out before completing their mental health outpatient treatment ranges between 36%-68%. A mean average of 42% across all settings – more than double the 19.7% dropout rate of the general adult population. Our clinic published a paper in the journal of Psychological Trauma in 2021 with the findings that of the 141 patients treated between 2016 and 2020, the Military Family Wellness Center at Columbia-Presbyterian

had a dropout rate of only 24% – nearly half the rate of the national average of veteran treatment dropout. I believe there are a few factors lead to this success in completing treatment at our clinic.

Some of the chief complaints I hear from treatment seeking veterans I speak to about their negative experiences in accessing care is they "feel like they are just treated like a number", and that they don't want to "just be medicated on pills". At the MFWC we involve the veteran in every step of the decision-making process. Our clinical staff, many of whom are veterans themselves, focus on the individual's needs and let them pick options that are best. While pharmacotherapy consultation is available, it is not the default treatment. Which leads to what I believe is our next reason for treatment success, multiple options of care.

While Prolonged Exposure Therapy tends to be seen as the gold standard treatment for PTSD, many veterans are avoidant, as it can be a very intense therapy modality requiring the veteran to relive their trauma over and over again. At the MFWC we do offer PE, but the majority of our patients choose treatments like Interpersonal Therapy, that focus on the veteran's feelings and relationships in the moment rather than their trauma. We have additional treatments that do not require discussion of trauma, like our equine therapy protocol, the Man o' War Project.

The Man o' War protocol is the only university led, standardized, manualized equine assisted therapy model for PTSD in the country that has been scientifically tested in open trial with veterans and shown to reduce PTSD and depression symptoms. I would invite all the council members to take a look at our three peer reviewed publications on equine therapy available on our website: www.mowproject.org showing decreased symptoms of PTSD multiple clinical assessment instruments, as well as identifiable structural and functional changes in the brain via MRI, post treatment. Further, what is really astonishing, is that during our clinical trials of this treatment modality the veteran treatment dropout rate was only 8%. In a cohort of 71 veterans diagnosed with PTSD only 6 did not complete treatment.

Since the success of our open trial, Columbia has included the Man o' War protocol as one of the many treatment options we offer to veterans free of charge. Thru the generosity of donors, grant makers, and government funding we are able to treat these veterans struggling with mental health issues from their time in service in the way they wish to be treated. I'm proud to mention that our community partners at DVS will be sponsoring our next group of veterans to go through the Man o' War Protocol with the Joseph P. Dwyer Peer to Peer program. The team at Columbia is now in the process of building out our certification training package with the Center for Practice Innovations, which will include our 175-page training manual, training videos, online interactive modules, and more – which will soon be available to equine specialists and veteran support programs nationwide.

Veterans want options. Veterans do not want to have to relive their trauma. A successful mental health program for veterans must include a wide range of alternative modalities in order to treat this population. For this reason, we at Columbia – Presbyterian are constantly researching new alternative treatments for veterans. Columbia is currently leading a six-site randomized controlled trial comparing Transcendental Meditation for PTSD to Present Centered Therapy in

veterans and first responders sponsored by the David Lynch Foundation. Over the next three years, along with our research partners at Northwell Health, Mount Sinai Medical, University of Southern California, UC San Diego and Stanford University nearly 400 veterans and first responders with PTSD throughout New York and California will be studied using standardized psychological batteries, biological assessments, and brain imaging to scientifically test meditation as a viable treatment option for PTSD.

Over the last six years, the Military Family Wellness Center has conducted thousands of screens, and enrolled hundreds veteran and military family member patients into our care. The mental health challenges facing military families are enormous. The health challenges and health disparity of our veteran population are a forefront issue in the veteran community. Through focus on ease of access, privacy, and high-quality care, Columbia-Presbyterian has become a recognized and valued resource in the local military family community. With the help of local government leaders, and our community collaborators, we hope to expand our scope of service and provide vital treatment to this highly-valued but under-served population.

Councilmembers, thank you for your time, and I would be happy to coordinate with your district offices personally to ensure treatment seeking veterans in your districts are taken care of.

USMC Veteran OIF/OEF
Director of Community Outreach and Education
Military Family Wellness Center
PTSD Research and Treatment Team
New York-Presbyterian/Columbia University Medical Center
T 347-949-1193
E **matthew.ryba@columbia.nyspi.edu**
http://www.nyp.org/mfwc
http://www.mowproject.org

My name is Mike. I have always said I am a combat infantryman. I served as a rifleman with the 101st Airborne in the jungles of Vietnam's A Shau Valley in 1969. I say I am a combat infantryman instead of I was a combat infantryman because once you have been in combat, the memories, especially the bad ones, stay with you forever. Shortly after being discharged from the army, I started having nightmares and flashbacks. I became hypervigilant of my surroundings and avoided large gatherings. I trusted no one and withdrew socially from my friends and family members. I never discussed my time in Vietnam with anyone.

It took over twenty years to find out what was causing my life to change so drastically. I had PTSD. For another twenty years, on and off, I have been in PTSD therapy, both with one-on-one counselors and in group sessions. These programs did not work for me. I believe that in the early days of PTSD treatment, an effective therapy protocol was not yet developed and still has not improved much over the years.

Finally, after almost fifty-five years, I have found a therapy that has eliminated the demons I have lived with all these years. It is called RTM (Reconsolidation of Traumatic Memories). RTM has a 90% documented success rate and can be completed in five hours over three weekly sessions.

During my first RTM session, after discussing the PTSD symptoms that were causing me the most grief, I was asked to pick events from my combat experiences that troubled me the most—grading them from one to ten, with ten being the worst. I chose an ambush firefight where my good friend was killed and when I was wounded.

In the second session, we went through several mental exercises where I reenacted the event in the third person. Me looking at myself, watching the event unfold. We did this several times, putting less emphasis on the gory details each time. At the end of this session, I teared up; the event went from a ten to a three.

In the last session, we changed from reenacting the event in the third person to me watching the event unfold from a safe place before the firefight to a safe place after the firefight, looking at the horrible events during the firefight as still images in a fast-running black and white slide show. We did this several times, and by the end of the session, the ambush firefight event that was a ten, then a three, is a zero. The demons were gone. I could talk about this event without the

anxiety I had previously. The most astonishing thing is that the other combat events I experienced have also gone to zero. I cannot explain how this happened in five hours. I do not know how the brain works. I now feel that the heavy burden I lived with for so many years is gone, and I can resume my life without the fear and anxiety I had experienced.

I would like to thank Dr Frank Bourke for developing RTM, Loree Sutton MD for making RTM available to me, and my counselor Florence Maroney for guiding me through my RTM sessions.

For all my Vietnam brothers and sisters, RTM works.

For all my fellow veterans from every era – from World War II to the Korean War through the 1st Gulf War through post-9/11 OIF & OEF veterans, RTM works.

For all our family members, caregivers and survivors of all eras, RTM works.

For all first responders, law officers, or anyone who has experienced a traumatic experience, RTM works.

My name is Mike. I WAS a combat infantryman, and now I am back to becoming a better husband, father, grandfather, and friend. I am home at last.

In solidarity,

Mike Moreno
Vietnam Veteran
VVA Chapter 126
NYC Foundation

March 22, 2023

In Washington Post

Opinion

The best PTSD treatment you've never heard of

By Garry Trudeau
July 10, 2023 at 7:00 a.m. EDT

Garry Trudeau is the creator of Doonesbury, where he has been commenting on wounded warrior issues for more than three decades.

All around the conference room in Atlanta last fall, jaws were dropping. Michael Roy, a physician from the Walter Reed National Military Medical Center, had just revealed to the International Society for Traumatic Stress Studies the preliminary results of a study comparing two treatments for post-traumatic stress disorder: Prolonged Exposure (PE) therapy, long regarded as the "gold standard," and a novel approach called Reconsolidation of Traumatic Memories or RTM.

In such a study, effectiveness is indicated by a complete remission of symptoms, a loss of diagnosis. Roy's trial was ongoing and still double-blinded, so he could report only the outcomes of the two treatments combined. But the success rate was a stunning 60 percent. Every expert present knew that PE's known remission rate hovers at 30 to 40 percent, so the 60 percent combined figure could only mean only one thing: The new RTM treatment was tracking dramatically higher.

From the back of the room, PE researchers glowered at Roy: Way too good to be true, dude.

Except it wasn't. Afterward, the praise from colleagues was effusive, with one top researcher telling RTM's creator, Frank Bourke, that the presentation was a "home run." At the same time, a PTSD researcher from the Department of Veterans Affairs approached one of Bourke's teammates and said coldly, "I don't think it's useful to pick fights" — as though RTM's success had been a provocation.

Given the stakes, this fight is one worth picking. Roy's final, unblinded results are expected later this year, and they will likely mirror those of four previous clinical studies. Many people in the trauma care community aren't waiting: More than 300 therapists from private practices to local health centers to Vet Centers have already adopted the RTM protocol to treat PTSD. It's currently in front-line use in Poland as well as in besieged Ukraine, which has a 160-person waiting list of therapists scheduled for training.

Any promising scientific breakthrough should always be greeted with skepticism and intense scrutiny of its supporting data. But it should never be ignored. Despite the best of intentions and billions of dollars directed to research, training and treatment, the PTSD industry has remained impervious to calls to accelerate innovation and deliver more effective trauma treatments. This must change — and a protocol as effective as RTM is a good place to start.

Bourke, a retired Cornell lecturer and now 80, discovered his treatment almost by accident. In 2001, he was asked to join a team of therapists helping several hundred traumatized survivors of the 9/11 World Trade Center attacks. He had been working with an existing model for treating phobias and he thought that, with some modification, it might work to heal trauma as well.

It did. Over the following year, Bourke successfully treated more than 250 PTSD patients, including one woman who had watched her best friend plunge to her death from one of the trade center towers. These extraordinary outcomes might have been enough to attract the attention of the trauma research community had not Bourke, who'd spent a year in the vicinity of Ground Zero, subsequently developed

cancer.

It was several years before he regained his health and his footing, but he and several colleagues continued to hone the protocol, achieving a 90 percent remission rate for PTSD symptoms and diagnoses, surpassing even his results with the 9/11 patients. In 2010, as the U.S. military was still heavily engaged in Iraq and Afghanistan, Bourke contacted the armed services' top PTSD researchers to present his findings.

It did not go well. After a respectful but futile hearing at the Army Medical Research Institute at Fort Detrick, the lead scientist followed Bourke out to the parking lot for a word. If his team supported a treatment as apparently effective as RTM, he told Bourke, they would jeopardize their own careers; the Defense Department had already invested more than $1 billion to study more conventional PTSD therapies. The message was clear: Bourke was on his own.

The consequences have been tragic. Up to 20 percent of Iraq and Afghanistan veterans still suffer from PTSD in any given year, and the federal government estimates that, since 9/11, more than 30,000 lives have been lost to suicide. Established treatments such as Cognitive Processing Therapy and Prolonged Exposure have limited capacity to achieve symptom remission and loss of diagnosis, require prolonged sessions, and have dropout rates of 50 percent and higher.

In contrast, RTM requires only three to four sessions, totaling about five hours, and involves no drugs or re-traumatization. Therapists can be trained in three days, and treatment can be conducted online. Best of all, the effects last. As one veteran put it, "Who knew that you could retrain your brain in a few hours, without medication, to remove yourself from the traumatic events that have been crushing you and making you wish you would just die?"

How does RTM work? Bourke explains it like this: "The technique is actually a neurological intervention that takes a traumatic memory and restructures it using several exercises like visualizing it as a black-and-white movie. The revised memory updates the original — reconsolidation."

That's pretty much it. But what sounds simple is, in fact, very sophisticated and has been continuously refined over the years. Reconsolidation was initially discovered in the late 1960s by neuroscientists studying the process by which memories are stored and retrieved. What differentiates RTM from previous treatments is that it is not psychotherapy — it is a directed intervention that takes 89 discrete steps, and it has been manualized. This formal sequencing is what makes it so easy to train practitioners.

So, what will it take for a demonstrably successful trauma treatment such as RTM to become standard practice? For starters, Congress needs to hold hearings on the failure of VA and the Pentagon to fully support emerging approaches to treatment, including psychedelics but especially RTM, which has more than demonstrated its efficacy and safety over two decades. Of particular interest to lawmakers should be the tremendous savings in PTSD treatment costs for military populations — over $25,000 in annual costs per individual with traditional therapies versus RTM treatment at $1,000 per individual.

Secondly, Congress should appropriate funding to the Defense Health Agency to stand up comparative effective field studies, train therapists and put them to work relieving the suffering of afflicted active duty service members and veterans. While large-scale, randomized control studies such as the one taking place at Walter Reed are scientifically necessary and should be expanded, there's no reason to deny service personnel the relief they need now.

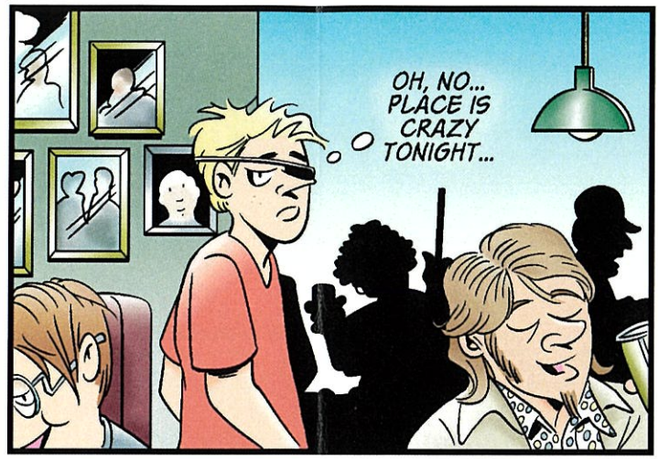
Many voices in the veterans community are now calling for fast-tracking RTM, including retired Navy Rear Adm. Dennis Wisely, retired Lt. Gen. Frank Kearney and retired Vice Adm. David Buss. The American Legion is urging the secretaries of Defense and Veterans Affairs to adopt the protocol as a treatment option.

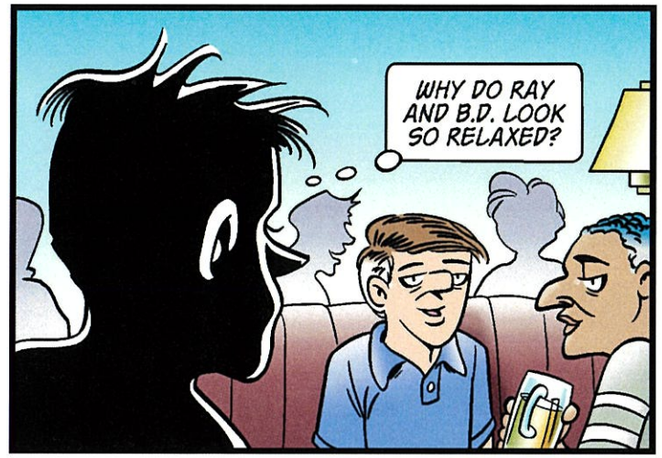
And these prominent advocates are joined by the many veterans who have already been successfully treated with RTM. Listen to Mike Moreno, a Vietnam vet in Queens: "Finally, after almost 55 years, I have found a therapy that has eliminated the demons I have lived with all these years. I am back to becoming a better husband, father, grandfather and friend. I am home at last."

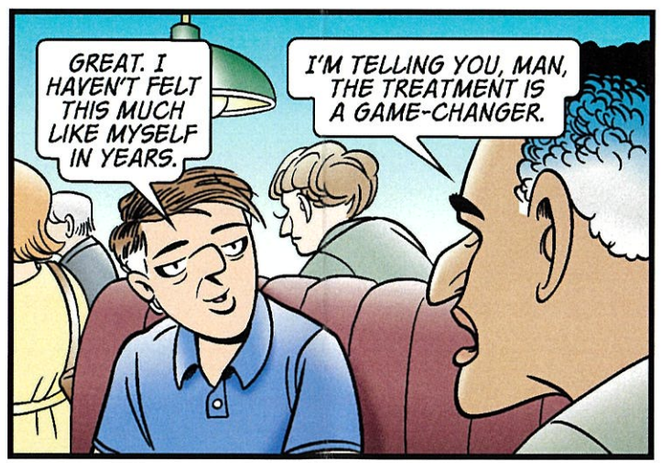
It's time to start bringing all our veterans home.

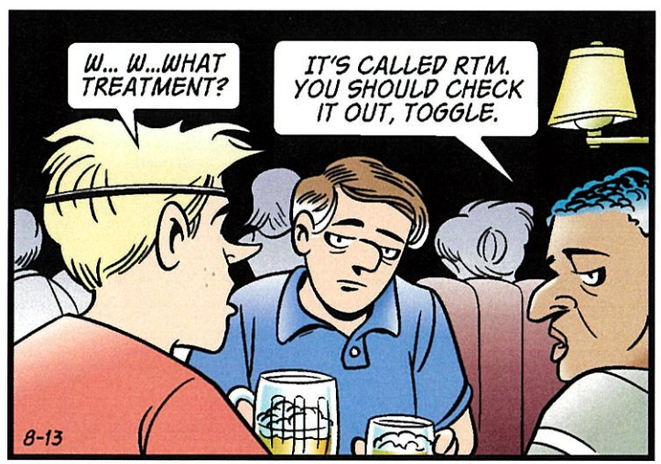
DOONESBURY

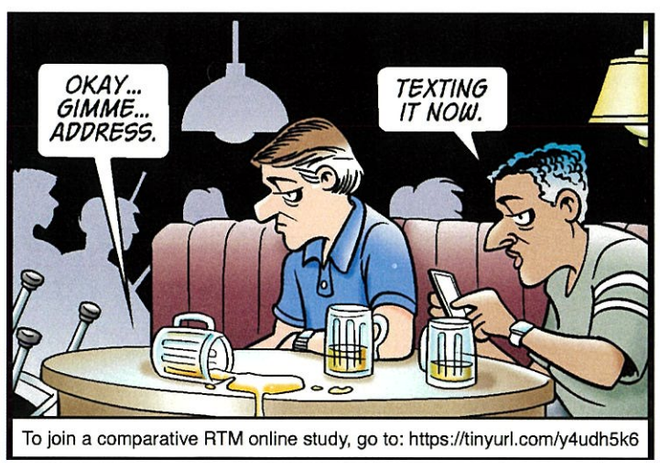
by G.B. Trudeau





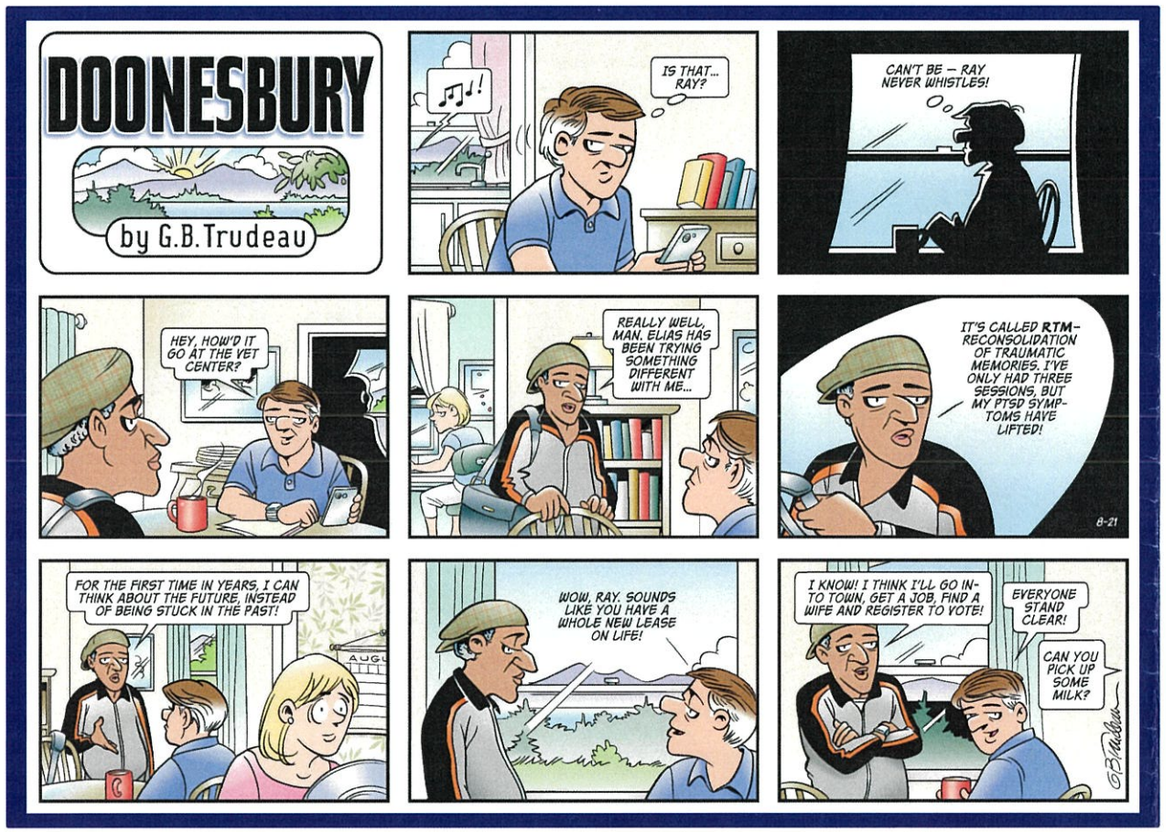




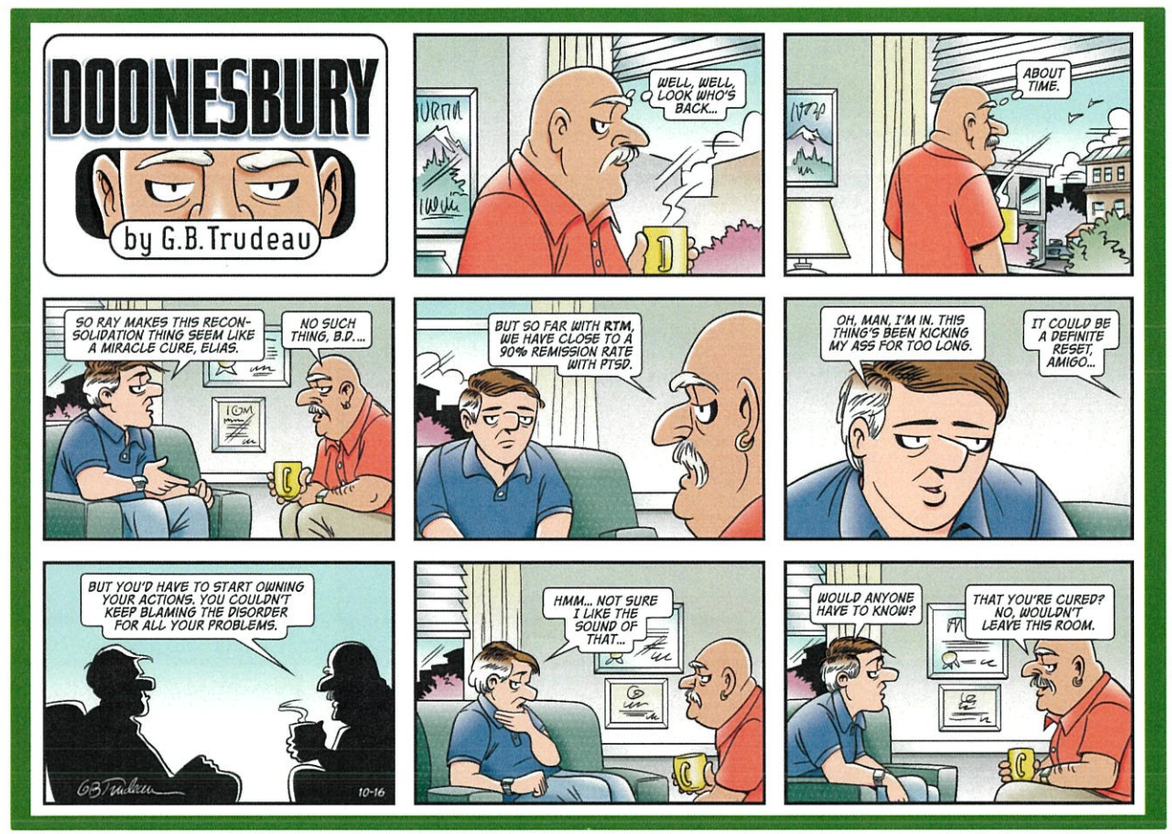


To join a comparative RTM online study, go to: https://tinyurl.com/y4udh5k6

THE RTM PROTOCOL™ IN DOONESBURY



August 21, 2022



October 16, 2022

"Garry Trudeau provides millions of Americans with a gut-level appreciation of the impact of PTSD on soldiers and their families… In so doing he is helping to raise awareness about the importance of PTSD as a national challenge, where investment in treatment and research could have an important and lasting impact." - John Krystal, MD,
Chair, Yale Dept. of Psychiatry

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I represent: Veteran Advocacy Project

Address: 1 Liberty Plaza 10006

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Name: Linnea Vaurio

Address: 1 Park Ave, 8th Floor, NY, NY 10016

I represent: NYU Military Family Center

Address: 1 Park Ave, 8th Floor, NY, NY 10016

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Address: Hall Street

I represent: _____

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