CITY COUNCIL
CITY OF NEW YORK

---------- X

TRANSCRIPT OF THE MINUTES

Of the

COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITY, ALCOHOLISM, SUBSTANCE ABUSE AND DISABILITY SERVICES, JOINTLY WITH THE COMMITTEE ON YOUTH SERVICES

---------- X

April 6, 2017
Start: 1:16 p.m.
Recess: 4:00 p.m.

HELD AT: Council Chambers - City Hall

B E F O R E:
ANDREW COHEN
Chairperson
MATHIEU EUGENE
Co-Chairperson

COUNCIL MEMBERS:
Elizabeth S. Crowley
Ruben Wills
Corey D. Johnson
Paul A. Vallone
Barry S. Grodenchik
Joseph C. Borelli
Annabel Palma
Darlene Mealy
Margaret S. Chin
David G. Greenfield
Andy L. King
Laurie A. Cumbo

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

Roger Platt, MD
Assistant Commissioner
Office of School Health
NYC Department of Health and Mental Hygiene and
Department of Education

Marnie Davidoff
Assistant Commissioner
Bureau of Children, Youth and Families
NYC Department of Health and Mental Hygiene

Lois Herrera
Chief Executive Officer
Office of Safety and Youth Development
NYC Department of Education

Scott Bloom
Director
School Mental Health Services
NYC Department of Health and Mental Hygiene

Nicole Robinson-Etienne
Associate Vice President
Government and Community Relations
Institute for Community Living

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

Peter Karys
Director
Youth Counseling and Support
The Lesbian, Gay, Bisexual & Transgender
Community Center

Rosa Cifre
Chief Program Officer
Comunilife, Inc.

Jennifer Humensky, PhD
Department of Psychiatry
Columbia University

Douglas Berman
Representative
Coalition for Behavioral Health

Fiodhna O'Grady
Representative
Samaritans Suicide Prevention Center

Brett Scudder
Executive Director
Scudder Intervention Services Foundation
The Suicide Institute
Chairman
NYC Suicide Council

Craig Hughes
Policy Analyst
Coalition for Homeless Youth

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

Grant Cowles
Senior Policy Associate for
Youth Services
Citizens' Committee for Youth Services

Skakel McCooey
Co-Founder
Mental Health Matters

[sound check]

[pause]

CO-CHAIRPERSON EUGENE: Thank you very much. Good afternoon. I am Council Member Mathieu Eugene, the Chair of the Youth Services Committee. As you know, today's hearing is a very important topic; it is about youth suicide and because youth suicide may be caused by mental health issues, I'm excited to be joined by Council Member Andy Cohen, the esteemed Chair of the Council Mental Health Committee. Thank you Council Member Cohen for agreeing to have a joint hearing on this important issue which affects many New Yorkers.

Youth suicide is an issue that affects many families across this country. Young people should not have to turn to suicide when dealing with some of their day to day problems of mental health issues that may increase the likelihood of committing suicide. We all agree that mental wellness is extremely important to the **[inaudible]** well and development of youth, whether they are in school, working or they are disconnected from school or work; therefore, early intervention to any problem of mental health issues our young people are

experiencing is the best to address those issues before they lead to a bad outcome.

It is very sad to learn that many of our public school students feel sad or helpless and that some of our high school students committed suicide. The number of students contemplating suicide increase when those students experience bullying.

Students of color who identify as LGBT experience increased stress due to the racism and discrimination.

Homeless students are three times as likely to attempt suicide because of risk factors, such as physical and sexual violence and also because of substance abuse and day to day stress of being homeless. For homeless students, the trauma [sic] of experience is made worse because they do not access to social and emotional support in their school. The suicide rates among homeless youth are also high in comparison of their housed peers.

Research has also shown that communities of color do not have adequate access to mental health treatment. We therefore shouldn't be surprised that these communities experience greater difficulty understanding and addressing mental health issues

within the family and their community. I am also concerned about our young Latino women who attempt suicide at a very, very high rate.

While these findings raise a good deal of concern, our proud First Lady Chirlane McCray, in an effort to not only highlight the importance of recognizing and addressing mental health issues, but for being a champion in this area.

Today's hearing would allow us to know more about ThriveNYC and how well it has been implemented and any challenge we have experienced during the implementation process. Of particular importance, we would like to know more about ThriveNYC's suicide prevention initiative, especially with groups at higher risk of committing suicide and how they have targeted not only students, but also disconnected youth.

I want to thank the Youth Services Committee staff -- Qiwu de Sharu [sp?], Michael Benjamin and Jessica Ackerman, as well as all the members of the Mental Health Committee and who all worked very hard to make this hearing possible.

And at this time I want to turn it over to my Co-Chair, Council Member Andrew Cohen for his opening statement.

CHAIRPERSON COHEN: Thank you very much. Good afternoon. I'm Council Member Andrew Cohen, Chair of the Council's Committee on Mental Health, Developmental Disabilities, Alcoholism, Substance Abuse and Disability Services.

Thank you to Council Member Eugene and the Youth Services Committee for jointly holding this important hearing with us. We are here to discuss how New York City is working to support the mental wellness of young people and prevent suicide. We are also hearing a resolution that I am sponsoring, Resolution 1374, to recognize June 8th annually as Teen Mental Health Awareness Day in the City of New York. This public recognition of mental wellness for adolescents will hopefully work to reduce the stigma associated with mental illness and encourage young people to seek help when they need it.

ThriveNYC: A Mental Health Roadmap for All, released by First Lady Chirlane McCray, represents a significant step toward addressing the issues facing individuals with mental illness,

including young people. According to ThriveNYC, approximately 73,000 New York City students reported feeling sad or hopeless each month. Eight percent of public high school students in the City reported attempting suicide; that percentage doubles if a student has been bullied in school, which 18% of students experience. Gay and lesbian youth experienced nearly twice as much bullying at school as heterosexual youth and are more than twice as likely to attempt suicide. LGBT youth of color may also experience compounded stressors related to racism and discrimination.

Latina teens have the highest rate of suicide among all adolescents.

According to the Institute for Children, Poverty and Homelessness, homeless students experience higher rates of depression and are twice as likely to consider suicide and three times more likely than their housed peers to attempt suicide.

I am particularly interested today in understanding how New York City is meeting the mental health needs of youth and doing so in a way that is culturally competent and takes into account each young person's unique situation.

Many ThriveNYC initiatives are currently or will reach young people, including the training of school staff in youth mental health first aid, mental health clinics in community schools, and mental health consultants in schools.

I would like to understand how these programs are addressing suicide and suicide prevention and how the success of these programs is being measured and how the initiatives are currently functioning.

I would like to acknowledge the members of the Mental Heath Committee who are here with us this afternoon -- Council Member Grodenchik, Council Member Wills and Council Member Vallone.

Lastly, I wanna thank the Committee staff for their work in preparation of this hearing -- Jeanette Merrill, our Finance Analyst; Nicole Abene, our Legislative Counsel; Michael Benjamin, our Policy Analyst; and Kate Theobald, my Leg. Counsel. [background comment] Please.

CO-CHAIRPERSON EUGENE: With your permission, Mr. Chair, let me also acknowledge we have been joined by Council Member Mealy, Council Member Chin and Council Member Annabel Palma, who are

members also of the Youth Committee. Thank you very much for being here.

CHAIRPERSON COHEN: I'll now ask my counsel to administer the oath, or someone's counsel to.

COMMITTEE COUNSEL: Please raise your right hand. Here we go. Do you affirm to tell the truth, the whole truth and nothing but the truth in your testimony before this committee and to respond honestly to the council members' questions?

ROGER PLATT: I do.

COMMITTEE COUNSEL: Please say, I do.

LOIS: I do.

COMMITTEE COUNSEL: Okay, great. [background comment] Haven't heard you. No. Okay, thank you [sic]… [crosstalk]

SCOTT BLOOM: I do.

MARNIE: I do.

CHAIRPERSON COHEN: Please.

ROGER PLATT: Good afternoon Chairpersons Eugene and Cohen and members of the Committees. I am Roger Platt, Assistant Commissioner of the Office of School Health, a joint program of the Department of Health and Mental Hygiene (DOHMH) and the Department

of Education (DOE). I am joined today by colleagues from the Department of Education Office of Safety and Youth Development, the DOHMH Bureau of Children, Youth and Families, and another member of the staff of the Office of School Health. On behalf of Chancellor Farina and Commissioner Bassett, thank you for the opportunity to discuss the serious problem of suicide among our city's youth.

Under ThriveNYC, this Administration has made unprecedented investments to improve the mental health and well-being of all New Yorkers. ThriveNYC builds on and expands the City's existing capacity by changing the culture, acting early, closing treatment gaps, partnering with communities, and using data to strengthen government's ability to lead. I look forward to sharing with you today some of the steps we are taking to promote resilience and emotional well-being among New York City youth and provide public health initiatives in order to prevent suicide.

Nationally, suicide is the second leading cause of death in 15- to 19-year-olds and the third leading cause of death in 10- to 14-year-olds. There are many risk factors that drive suicide among young

people. Young people face an increased risk of suicidal thoughts and behaviors if they have mental illness, substance use, a history of physical or sexual abuse, or a family history of suicide or attempted suicide. Social and environmental factors also increase risk of suicide; these include bullying, homelessness, placement in a correctional facility or group home, social isolation, barriers to health care and stressful life events such as conflicts with parents or romantic partners. Additionally, youth who identify as lesbian, gay, bisexual, transgender, or questioning experience higher rates of suicidal ideation and attempt, which is associated with the social stigma and discrimination they experience.

Just as many different factors influence suicide, there is no single approach to reducing its risk. Therefore, a comprehensive approach is needed. The City provides an array of programs and services to improve the mental and emotional well-being of New York City youth. I will first discuss the prevalence of suicidal ideation and attempts among New York City youth and then describe key interventions offered by the City.

The number of suicides among New York City youth ages 5 to 24 are small, but remain concerning. In 2015, the last year for which we have published data, there were 68 suicides in the 5- to 24-year-old age group -- 21 females and 47 males. While suicide figures are low among young New Yorkers, suicidal self-injurious behavior takes and reflects a wider emotional burden among youth. In 2016, hospital surveillance shows that there were 4,323 emergency department visits associated with a suicide attempt, suicide ideation or self-harm for youth between 5 and 24.

Additionally, data from the biennial Youth Risk Behavior Survey (YRBS) provides important information on the prevalence of health experiences and behaviors among the city's public high school students. In the 2015 survey, 13.7% of respondents reporting having seriously considered attempting suicide, 13.9% reported purposely harming themselves, and 8.3% reported attempting suicide. In line with national prevalence data, the YRBS found that when compared to non-LGBTQ youth, LGBTQ youth reported a higher prevalence of suicidal ideation, self-harm and suicide attempts. In 2015, more than 20% of LGBTQ

youth in New York City reported attempting suicide compared to just over 6% of other youth.

I will now discuss some of what we are doing to address suicide, and more broadly, mental health for New York City youth.

The Office of School Health provides a variety of programs that promote healthy social, emotional and behavioral development for all New York City students. Each of our initiatives aims to reduce known risk factors that contribute to suicidal ideation and attempt. Access to school mental health programs is correlated with significant reductions in high risk behaviors such as suicide attempts, violence and substance use, emergency department visits, absenteeism, referrals to special education, and stigma. These programs also correlate with important increases in academic achievement, staff and community knowledge of mental health issues, and overall child health. Research has shown that these programs also increase parental engagement, improve school climate and build stronger connections to community resources.

Through ThriveNYC, the City has committed to significantly expand and enhance mental health

services and connectivity throughout the school system. To do this, we are using the three-tiered model to assess and address youth mental health needs. This approach delivers serves according to need -- implementing universal programs that promote mental health for all students, more intensive preventive services for students who are at higher risk, and targeted crucial services for students with identified mental health conditions -- all while building mental health competency in school staff.

The range of mental health services offered in DOE schools varies depending on school size and available community health resources. I'll speak more specifically to the many programs within this range momentarily. Some schools are equipped with full service School-Based Mental Health Clinics, where a mental health professional offers services on site. Other schools provide mental health services through their School-Based Health Clinic, which also provides primary care. Some schools contract with a community-based mental health provider to offer counseling, intervention and support services. All of our schools continue to build capacity for screening, counseling and referrals through training

and utilizing existing staff, including school counselors, nurses and teachers.

More specifically, 780 schools have a Mental Health Consultant, a trained Masters level staff member who provides mental health needs assessments and technical assistance. At full scale, 103 consultants will serve 970 schools across the city. The consultants link schools with staff trainings and community-based providers to increase capacity to provide mental health support and services.

Additionally, in order to address particular mental health needs and elevated risk of suicide among LGBTQ youth, we have partnered with the Hetrick-Martin Institute, a City Council initiative, to provide staff of the School-Based Mental Health Clinics and the Mental Health Consultant program with training, capacity building and technical assistance, targeting first those schools identified as having faced challenges with serving LGBTQ youth.

Furthermore, 280 schools have School-Based Mental Health Clinics, which provide on-site mental health services to students and their families, including individual and group therapies,

crisis and psychiatric assessments, case management, school community outreach, and 24-hour crisis coverage for students under clinic care. An additional 251 schools have School-Based Health Clinics that offer primary care with enhanced mental health services.

Through the Community Schools Initiative, 130 Community Schools are now equipped with mental health services. School Mental Health Manager assist schools and partner with community-based mental health providers to assess the mental health service needs at each school. Based on this assessment, schools are outfitted with universal, selective or targeted services.

School Response Teams are present in 40 middle schools, where they offer mental health assessment, crisis intervention, referral and linkage, and training consultation to school staff and families.

And starting in the fall of 2017, the School Mental Health Prevention and Intervention Program will begin providing services in 49 schools with particularly high mental health needs.

All schools with mental health support services can assess a student for suicidal ideation, provide crisis de-escalation and offer or arrange provision of enhanced counseling services for the student body in the case of a suicide. In addition, health professionals, teachers, guidance counselors, and other school staff are offered training that includes instruction on addressing suicide and psychological crisis in schools. These trainings include:

Three evidence-based universal training modules that are available to all school staff through the Universal Prevention Trainings Initiative. These trainings are: Kognito "At-Risk," Making Educators Partners and Youth Mental Health First Aid. These build staff competency for identifying, assessing and referring mental health issues, as well as addressing students in crisis. Staff trained include school nurses, teachers and guidance counselors.

In addition, Screening the At-Risk Students (STARS) training is available for middle school and high school nurses, and enables them to identify children who may need additional mental

health services and support. Nurses are trained how to identify students who are previously undiagnosed or have depression and are at risk for suicide or other harmful behaviors.

The City also provides a suite of behavioral health services and programming for young New Yorkers outside of schools settings. Each of these programs contributes to the emotional well-being and resiliency of this population. I would like to briefly highlight a few of these now.

NYC Well provides all New Yorkers with a single point of access to counseling, support services and treatment referral. It is free, confidential and available 24 hours a day, 7 days a week in over 200 languages. NYC Well clinicians provide an assessment for the needs of clients of all ages who call in. If an individual is in crisis and needs support, clinicians can activate crisis response systems. NYC Well clinicians are trained to respond to youth who experience emotional distress, substance use issues and suicidal ideation. This training also includes specific attention to youth issues, such as bullying and non-suicidal self-harm.

The Children's Rapid Access Mobile Crisis Teams work throughout the five boroughs to provide crisis assessment, stabilization, prevention planning, and caregiver support to children with behavioral crises at home, in the community or in school. These teams provide follow-up services to children and their families to assure that needed mental health services are provided. In 2016, the teams received 1,367 referrals, of which 29% were linked to suicidal ideation and 3% were linked to a suicide attempt.

Children's Crisis Intervention Services provide short-term crisis intervention to youth who present to a hospital, Comprehensive Psychiatric Emergency Program, Emergency Department, or other clinical setting.

Home-based Crisis Intervention and Intensive Crisis Stabilization and Treatment programs provide longer term crisis stabilization in the home and community.

Through the Youth Mental Health First Aid Initiative, community members throughout New York City can receive free training to recognize the signs

and symptoms of mental illness and learn how to help connect people to assistance.

The City provides enhanced mental health services at Runaway and Homeless Youth (RHY) Drop-In Centers, Crisis Shelters and Transitional Independent Living Programs. These services include a range of counseling, therapeutic and support activities, including psychiatric and psychosocial evaluations. This complements the other comprehensive services that are available for RHY, which develop independent living skills and strengthen decision making and communication abilities. These services include food and clothing, health care, prevention and referrals for substance misuse, housing assistance, educational and employment services, recreation, legal assistance, and transportation.

Mental health problems and suicidal behavior among young people in our city is a serious mental health issue and requires intervention along many fronts. The City is working across multiple agencies to improve mental health for our young people. This is as a preventive strategy to reduce risk of suicide by offering a variety of interventions to youth and families through a variety

of school and community-based programs. Together we are building multiple entry points for these needed services.

We are committed to improving the health and mental health of all New Yorkers and will continue to find innovative ways to support our young people so that they can be healthy and successful.

I appreciate the Council's attention to this important issue. We are happy to answer any questions.

CHAIRPERSON COHEN: Thank you for your testimony. You know one of the things at these hearings that I always find challenging is; I really like to show how little I know about some of the subject matter, but that's not going to deter me in this case.

You know one of the things that was particularly striking in your testimony; the number of attempts by young people versus the number of completions. Of the young people that completed suicide, how many of those people had prior attempts; do we know that data? Is an attempt a predictor is I guess what I'm trying to…

ROGER PLATT: Marnie, can you help with that?

MARNIE: Previous suicide attempts are associated with risk of **[inaudible]** suicide, but we do not have the knowledge of those who have completed suicide; how many of those had prior attempts, we don't have that data, the ability to do that.

CHAIRPERSON COHEN: The data doesn't exist or we don't have it today?

MARNIE: We don't have it today and I would have to check back to see if it exists; I suspect that that is not something we can trace back, but I'd be happy to look into it.

CHAIRPERSON COHEN: The 68 suicides figure for 2015, how does that compare to prior years? Is it a trend up; is it a trend down?

MARNIE: Because the data are relatively small year to year, it's not reliable for us to be able to compare, you know in terms of valid comparisons year to year on the trend. So we tend to look at the data in aggregate across several years to make it more reliable.

CHAIRPERSON COHEN: Can you offer a valuable comparison from one period of time to another?

MARNIE: If you wanted the trends with that caveat, I'd have to get back to you on what the trends look like broken down year to year, yeah.

CHAIRPERSON COHEN: I think that that is fundamentally important to know, you know in terms of the City's efforts what the trends are in order to sort of… if we want to treat a problem, you know, as part of the diagnosis, maybe we're doing things right or maybe there's… so it would be I think fundamental if you could report back to us on trend data on this front. And I'm gonna hop around and then I'm gonna turn it over to my colleagues.

You talked about the consultants and the number of schools; what is the student to consultant ratio; do you know?

ROGER PLATT: The program was designed to provide a full-time consultant for 10 schools. We did get a little supplemental funding to deal with the group of schools that have large numbers of students in temporary housing, and recognizing the

special need of those schools, the ratio for those campuses is 1 to 5.

CHAIRPERSON COHEN: Maybe I'm not asking… in your testimony, 780 schools have mental health consultants.

ROGER PLATT: Right and at scale, we will have 103 consultants for all of the schools that are involved in that program.

CHAIRPERSON COHEN: What I'm trying to ask though is; obviously not all schools have equal population; do you have an idea of what the ration is of student to consultant?

ROGER PLATT: Well I can tell you that the average campus, New York City Public School campus, has about 800 students. Now the average consultant probably has fewer than 10 schools with an average of 800 students because the larger campuses tend to have school-based health centers or mental health clinics. But if you want a rough number, that's what it would look like.

CHAIRPERSON COHEN: About 8,000. Okay. I do have more questions, but I'm gonna turn it over to my colleagues and then we'll go around.

CO-CHAIRPERSON EUGENE: Thank you very much, Mr. Co-Chair. Sir, you indicated that the ThriveNYC one-year update indicates that your public awareness campaign reached out to over four million people; what does it mean -- reach out to four million people? Are there people who are being served or have received services? So could you tell us how many people that you reach every year?

ROGER PLATT: We'll have to get back… [crosstalk]

CO-CHAIRPERSON EUGENE: Through the services that you are providing… [crosstalk]

ROGER PLATT: Yeah. I would have to get back to you to give you more information on where that four million number comes from and what it represents.

CO-CHAIRPERSON EUGENE: Let's put it another way. How many people that you provide services to every year through the ThriveNYC? How many people receive services or have been contacted?

ROGER PLATT: From a school perspective, it's too early to make that judgment. We are still in the process of implementing the program. I think we also would need to have a conversation about what

you mean by providing services. For example, our consultant program is not designed to provide direct services to students; it's designed to serve a consultative role to schools and to enhance the ability of the school to care and to refer students who have mental health issues.

CO-CHAIRPERSON EUGENE: So do you know how many students that the schools are able to serve or how many students are receiving services through the school or from the school?

ROGER PLATT: There are lots of different services that different members of the school staff provide to students; I'm not aware that there is a mechanism to collect all that information and to provide an overall number of students who access one or more of these services.

CO-CHAIRPERSON EUGENE: So if you don't have any method to quantify how many young people benefit from the services; how are you going to know if the service or the programs are successful?

ROGER PLATT: Well I think from the schools' perspective, I'm gonna defer some of that answer to Lois, but there are obviously things to follow, such as school attendance rates, emergency

room visits and a variety of other outputs which we will be following over time.

LOIS: Some of the large pieces of Thrive in the Department of Education involve universal training for staff, to enable staff to identify and hold deep conversations, mental health conversations; be aware of warning signs the students present and so at this point we're rolling out the trainings for staff; it would be difficult to measure the impact at this point on students of the universal trainings for staff.

CO-CHAIRPERSON EUGENE: You know that in all schools in New York City the students are from different ethnic backgrounds, you know, there are immigrants, they speak different languages; they have different culture. What do you have in place to efficiently address the diversity of culture or language you know that are part of the culture of those children?

SCOTT BLOOM: Sure. Hi, I'm Scott Bloom, the Director of School Mental Health Services. I can speak to our mental health providers. Our unit oversees the collaborations with community mental health providers and child social services in the

schools. For all the providers that offer school mental health clinics, they are overseen by the State Office of Mental Health and one of the requirements is cultural competency. So they are required to take various trainings, provide resources and supervision that provides culturally competent interventions. The other social service agencies also have various trainings and when these community mental health providers are assigned or go into certain schools and certain areas, they do their best to hire folks that speak -- you know are bilingual, that learn about the populations and understand some of the key factors and dynamics of each of the populations so that they can work in terms of family engagement and school engagement.

LOIS: And of our total 4,043 combined guidance counselors, social workers -- and that number is as of October 31, 2016 -- many of our counselors and social workers reflect the backgrounds of our students, many of whom are bilingual. We have certainly counselors and social workers who are certified as bilingual, but many more who didn't get that additional certification of the bilingual piece.

So I would say our services are culturally competent at the school level.

CO-CHAIRPERSON EUGENE: When we talk about mental health issues affecting our young people, we have to think about their families also, because we know that many of them come from broken families, families with troubles, their parents are facing so many difficulties, especially immigrant people, everybody, not only immigrants, but most likely immigrants, because this is a big challenge for immigrants because they have cultural barriers, language barriers, and it is very difficult for them to navigate through the system. So having said that, do you have anything in place to assist, to support also the family members of the young people? Because by trying to help the young people, we have to make the effort also to address the issues that they are facing in their families. What do you have in place… [crosstalk]

SCOTT BLOOM: Yes, so the…

CO-CHAIRPERSON EUGENE: to provide support to their family members also? I'm sorry.

SCOTT BLOOM: Sure. So again, I'll speak to our school mental health providers in the

community. Any of our school-based mental health clinics that open up, they, again, are required to meet with the families, and typically, within any kind of an assessment or intake you're gonna be working with the parent or parents and start to work with the families, so that's the first thing we do. The second thing we do is offer family-based therapy; many of the agencies provide home-based services as well; some of them are social service-based; some of them are therapeutic, working with the whole family in terms of family systems. In the DOE, we work with the Family, Youth and Engagement Office and we work a lot with the parent coordinators and do some trainings for them; help them in terms of parent engagement. Many of our programs work with the parent individually and certainly if the parent or family needs extra services then they're referred to that community mental health program. Many of our programs where we have mental health services on site, they also offer the workshops; there are a lot of parent workshops and parent trainings on a wide range of topics; could be helping your child with test anxiety; can be how do you work with a child that's got ADHD. So it really is by the needs of

that school, so many of these programs work with the school to focus in on the needs of the parents and the families and then begin to bring in those interventions that are key to them.

The other larger topic and issue that we're trying to do, as you hear; by the end of the school year we'll be in over 1,700 schools with some enhanced mental health service.

One of the main things is to offer de-stigmatized mental health; to make mental health seem as typical or normal, if you will, as somebody going to the dentist or someone going to the doctor. So we work with families to help them see how mental health services can help kids overcome barriers to academic achievement; that's a real goal of ours.

LOIS: And we've focused our training, all our professional development on LGBT support on how to work with families, so that's an essential component of our training for staff.

CO-CHAIRPERSON EUGENE: I agree with you; there is a stigma, you know and I commend the First Lady, and all of you also from your team, who are making the effort to eliminate the stigma and to make

sure that we have enough services to address the mental health issue of the people of New York City.

But before I pass it over to my colleagues for some questions, let me ask you the last one, and I will get back. So we know that in the juvenile system, we have many young people in the juvenile system, they have also the need of mental health assistance or services. So what do you have in place for them and how do you address the situation?

ROGER PLATT: Just to be clear, you're talking about the juvenile justice system?

CO-CHAIRPERSON EUGENE: Yes, the youth, the young people in the juvenile system. Those in jail…

ROGER PLATT: Yeah… [interpose]

CO-CHAIRPERSON EUGENE: those incarcerated…

ROGER PLATT: I… I don't… [crosstalk]

CO-CHAIRPERSON EUGENE: who are suffering also from mental health issues… [crosstalk]

ROGER PLATT: Sure.

CO-CHAIRPERSON EUGENE: Is there any program, you know, designed for them or any approach to… [crosstalk]

ROGER PLATT: Yeah, I… I don't wanna speak for agencies that are not represented at this table; we could certainly get information and get back to you about that.

CO-CHAIRPERSON EUGENE: Alright, thank you very much. Mr. Chair, thank you. Council Member… [crosstalk]

CHAIRPERSON COHEN: Council Member Wills has questions.

COUNCIL MEMBER WILLS: Thank you to the Co-Chairs. So one of the topics I wanted to go into was the cultural competency and you said that OMH is the State agency that has directed that, but then you only went into bilingual when dealing with the cultural competency and bilingual meaning what? I mean is that English and French; English and Urdu, because we have so many different languages, and is that your primary rubric to say that that's how you're culturally competent? Because you can have somebody speak two languages; it has nothing to do

with the actual culture or the dynamic of the community that they'll be serving.

LOIS: I was speaking to counselors and social workers who are on staff and in department of capacity and saying that many of them speak a language other than English. I don't have the breakdown of the languages, but it's multiple languages reflective or our community.

COUNCIL MEMBER WILLS: Right, but what I'm saying is, that doesn't… is that the only rubric or the primary one that you look at to say that this is what equals out to be culturally competent? Just because you can speak multiple languages doesn't mean that you come from the community or the dynamic of the community, you understand it and which you'll be serving. So when the Co-Chair spoke about cultural competence, that's what you spoke about, but that doesn't necessarily mean that it's culturally competent, it just means that they can speak a language. Do you understand what I'm saying? Because you can speak Urdu doesn't mean you're gonna understand that particular population.

SCOTT BLOOM: In terms of the community mental health partners, a lot of that is done through

their offices, and when we partner with mental health providers in the community, one of the things that we do, as best as we can, is to alert them of what are the languages, what are the cultures that go into that school. Those community partners have or do not have the capacity really depends -- the capacity to hire workers, not only about speaking the language, but within those agencies to offer trainings, resources to understand what are those dynamics of the population that goes to the schools.

COUNCIL MEMBER WILLS: So there's really no supervision or oversight from the City that says that we wanna make sure that these people are culturally competent? You're just relying on groups and something that was set by OMH?

SCOTT BLOOM: We recommend strongly and we bring those agencies into the schools, so they have the meetings with the principals and the principal support staff to talk about what those issues are and typically between the mental health provider, the community provider and the schools they work to get the right fit. So when an agency -- and I don't wanna speak for all agencies -- when the agency looks at candidates and hires candidates and

looks at the trainings; they present that to the school so the school and that mental health agency may come to an agreement on who's the right fit for that school.

COUNCIL MEMBER WILLS: From our briefing papers, it looks to be -- and these stats haven't seemed like they've changed since we were doing these hearings under the Bloomberg Administration when we deal with Latino or Latina youths and black youths across the diaspora which the Co-Chair also spoke about, which means African American, Caribbean or anyone else in that diaspora -- when we're dealing with these two groups we have different cultural variables that tend to lend to this, whether they be traditional values or whether they be violence or traumatic stress amongst these young people in the communities and the conditions that they come out of, whether it's abandonment issues because of parents being incarcerated and any other variable. When we're dealing with this, I see that we have mentioned, in your paper and in our briefing paper, LGBTQ youths and I understand the importance of it, 'cause I've sat here and we've gone through these hearings, but what I haven't seen is -- except for

mentioning the rates of suicide amongst black and Latino or Latina youth -- I haven't really seen them mentioned directly as far as what we're doing to deal with their issues. So I wanted to know, am I to take from that that they are in these stats and in these different initiatives in a blanket manner?

LOIS: So one of our initiatives in the DOE is Single Shepherd and it involved District… [interpose]

COUNCIL MEMBER WILLS: Single… Single Shepherd, you said?

LOIS: Yes, it's one of the Equity in Excellence initiatives that served Districts 23 in Brooklyn and District 7 in the Bronx; it involved bringing on about 140 social workers and counselors for those districts, which reduced the student to counselor ratio to roughly 1 to 100. All of the Single Shepherds were trained in working with children of incarcerated parents; they have received training in working with LGBT students. We are fortunate, with the help of Council, to have -- we're in our second year of having an LGBT coordinator who is looking into -- not looking into; bringing training on mental health issues, particularly

looking at suicide prevention for LGBT students, and we also have brought on this year a gender Equity Coordinator. So we're very proud of the work that we've begin to support LGBTQ students.

COUNCIL MEMBER WILLS: The Single Shepherd, this initiative that you just mentioned…

LOIS: Uhm-hm.

COUNCIL MEMBER WILLS: was that in the testimony that was read before us earlier? I didn't see that.

LOIS: No, it's part of the Equity in Excellence initiatives in the Department of **[inaudible]**.

COUNCIL MEMBER WILLS: Can we please have copies of that sent up to the Co-Chairs so that they can distribute that to the members? It would helpful for us to have that and understand that and see how that could be expanded into the other schools, because I don't know any schools in my district or districts similar to mine that have that, besides the districts you just mentioned, and this is the first time we're hearing… I'm hearing of it.

Suicide ideation is something that's pretty broad, it's a broad swath; it covers

everything from the fleeting thought because maybe a relationship that a young person is having is going wrong to almost the serious consideration of suicide, but in that spectrum, do we have stats that say that we can quantify the entire range of that spectrum -- how many young people have had just a fleeting thought; how many of them, besides hospital visits because of them actually attempting it, have had up to that point, creating a plan for suicide and different things like that?

ROGER PLATT: The best information we have about high school students is from the Youth Risk Behavior Survey and I'm going to ask Marnie to provide some additional detail -- Marnie, if you have it here -- otherwise we'll get back to you.

COUNCIL MEMBER WILLS: Okay and I have one other question. We have all of the numbers and everything goes from age 5 and up, and I'm assuming that's because that's the kindergarten age in DOE, but we do have pre-Ks that are controlled by DOE which are 4-year-old children, and if we're talking about the different stresses, especially stresses in the black diaspora where violence and trauma, what I need to know in two parts is; why is ACS not here to

speak to that and having mental health professionals in the pre-Ks; where is that information and what the initiatives are from that and do they derive from ThriveNYC; and what is the rate of translation from these young people from 5 to 15 or 5 to 17 into adulthood that we already have stats on; do we have trackable data for some of these young people going up to adulthood and how they've been handled since then?

MARNIE: Let me address first the question about the Youth Risk Behavior Survey, we refer to as the YRBS, and this is a questionnaire that's administered to New York City public high school and charter school students, so from 9th to 12th grade; it covers a range of topics -- health behaviors, physical activity, mental health -- and it's a joint effort by the New York City Department of Health and Mental Hygiene and Department of Education; it's also a survey that's developed and endorsed by the National Centers for Disease Control and Prevention, so it's replicated in other parts of the country as well.

So the question regarding suicide ideation, essentially it doesn't ask for -- the

survey itself I don't believe gets to the nuances that you just asked for; we'd be happy to get you the exact wording of the question on the survey if you'd like to see exactly how it's worded. But the question is regarding youth who considered attempting suicide during the 12 months prior to the survey, and the survey results are also -- they are reported and broken down by race and ethnicity, so we do have those statistics with suicide ideation; if you wanted to know the rates for 2016, I'd be happy to share those with you.

COUNCIL MEMBER WILLS: Could you please forward those to Chair Cohen, 'cause I'm sure he'll distribute them to all of the members… [crosstalk]

MARNIE: To forward them. Sure, no problem, yes… [crosstalk]

COUNCIL MEMBER WILLS: Thank you very much. So the questions about ACS and the translation from youth to adulthood, those who actually experience this and the services that they receive to adulthood, do we have information on those two things?

LOIS: Our Universal Pre-K program does include social workers, so there are… [crosstalk]

COUNCIL MEMBER WILLS: It doesn't?

LOIS: Does… [crosstalk]

COUNCIL MEMBER WILLS: It does.

LOIS: it does include social workers.

COUNCIL MEMBER WILLS: In which way, because we put legislation in last year asking for every pre-K that had over 40 students to have a social worker, especially those in -- using the terminology that you use; higher mental health needs communities. So explain to me when you say that pre-Ks have social workers; are those social workers attached to the school or are those social workers that are dealing with juvenile issues?

LOIS: No, they're attached to the site, but it's a ratio. I do not believe that it is one per site; I think they have more than one site, but we can certainly get you that information.

COUNCIL MEMBER WILLS: Please do. And would you support that; would you support having social workers attached to the Universal Pre-Ks to deal with these things before they turn into suicide ideation or anything else?

LOIS: I… [crosstalk]

COUNCIL MEMBER WILLS: You can't… you're not in… Okay, no problem; not gonna put you on the spot. Okay. Thank you. Thank you, Chairs.

CO-CHAIRPERSON EUGENE: Thank you very much, Council Member Wills. Council Member Grodenchik.

COUNCIL MEMBER GRODENCHIK: Thank you; I thought I heard my name called. Thank you, Chairs. Thank you all for being here today. I wanna thank you for your work on behalf of the children of the City of New York. Still a painful issue for me; I lost a friend at 19 -- he was 19; I was 18 -- and he had a history of mental illness and unfortunately, he took his own life.

I wanted to follow up a bit on Chair Cohen's questions, in that, it is important for us -- I know that ThriveNYC is a relatively new program -- it is important for us to receive data so that we can make as objective an analysis as we can; we are charged with overseeing a budget that will probably range up to $85 billion this year, there are tremendous needs; I think almost all New Yorkers, if not all New Yorkers, would certainly deem this to be a very high priority in terms of not only the overall

health of the city, but certainly for our children, the mental health, so we do wanna support this program, but we're also gonna need to see data that it's working; we know it's early, but I guess the Chair, if he gets re-elected, will be back next year and maybe we can meet again.

I did wanna ask a couple of questions. It seemed to me -- on top of page three it says, "In a 2015 survey, 13.7% of respondents reported having seriously considered attempting suicide," that's a lot of kids; I mean we have over a million students in the New York City school district, which would translate to over 130,000 children who've considered taking their life. Can you talk about that?

ROGER PLATT: Well first, let me say this is just a high school survey, so… [crosstalk]

COUNCIL MEMBER GRODENCHIK: Okay.

ROGER PLATT: the denominator…

COUNCIL MEMBER GRODENCHIK: Okay.

ROGER PLATT: it's still an enormous number… [crosstalk]

COUNCIL MEMBER GRODENCHIK: Still is an enormous amount of kids.

ROGER PLATT: but the denominator is not a million; it's probably more like 250,000.

COUNCIL MEMBER GRODENCHIK: So that's about 31-32,000 children?

ROGER PLATT: Yes. This is not different than what the… this is a national survey…

COUNCIL MEMBER GRODENCHIK: Okay.

ROGER PLATT: so this data is really not different than the national picture. Marnie, can you provide more detail?

MARNIE: I can, and I agree; it's concerning certainly to… when you see those statistics; it's something that is of concern to all of us. As just the reference point that Roger was mentioning, because the survey is administered nationally, generally when we compare statistics from New York City to the national ones, we see that New York City comes in at lower rates or equivalent rates than the rates nationally, and so for this particularly statistic the national rate for 2015 was 17.7% nationwide, high school youth who had seriously considered attempting suicide during the 12 months prior to the survey versus 13.7% in New York City.

COUNCIL MEMBER GRODENCHIK: Thank you. The services that you provide -- I represent, as most of my colleagues do, extremely diverse communities; my district in eastern Queens is 42% Asian American and growing, the number of languages spoken in my home borough of Queens, the estimates range into the hundreds, it's just an incredible phenomenon really and I'm happy to live there. I do wanna know though; are we getting to people in languages; do we speak all the languages that the Department of Education would normally speak? I'll take it from anybody.

ROGER PLATT: We certainly can't say we speak them all, because… [crosstalk]

COUNCIL MEMBER GRODENCHIK: I understand that.

ROGER PLATT: as you point out, there are hundreds of them, but I think we make every effort to cover the languages that are spoken by large numbers of students.

COUNCIL MEMBER GRODENCHIK: Do you have ability to reach to people that don't speak -- you know in my district, the big languages would be Hindi and Urdu and Mandarin and Korean and others; Spanish and Russian, but…

ROGER PLATT: Right; as I'm sure you know, there is a required set of languages that DOE has that all documents meant for parents have to be translated into, and I can't rattle them all off, but I believe… [interpose]

COUNCIL MEMBER GRODENCHIK: I can't either, to be honest with you.

ROGER PLATT: but I do believe they include Mandarin and Korean and Urdu and Bengali.

COUNCIL MEMBER GRODENCHIK: Okay, because we have, you know, burgeoning communities all over Queens and I think it's something that you need to be cognizant of… [interpose]

ROGER PLATT: Yes.

COUNCIL MEMBER GRODENCHIK: and I know the City provides translation services in many, many different languages. The last thing -- 'cause I know there are other people -- in my district I have the flagship PS 23 school, which is on the Creedmoor campus, and that school has five branches, one of which is Lifeline, which also happens to be on the Creedmoor campus, Doctor, and I would love for you to come out and take a look at the work they're doing; we've been working with some of the DOE people, I've

communicated on many different levels; they're in need of additional funding and I'm not gonna ask you for that funding -- don't worry -- but I would love you to come and take a look at what they're doing; it's a holistic approach; they're even working with yoga now with the children; these are young children; they have a very good track record; it's right at the corner of Winchester and Union Turnpike, so I'm gonna have -- if it's okay with you, Doctor, I'm gonna have my staff follow up with you and we will set a… [interpose]

ROGER PLATT: Sure; happy to do it.

COUNCIL MEMBER GRODENCHIK: set a date. Thank you very much. Thank you, Mr. Chair and Mr. Chair, and thank you for being here today. Yes, oh…

LOIS: May I just add that school district; their staff can access simultaneous translation in 100 languages.

COUNCIL MEMBER GRODENCHIK: Okay. I only speak a few, so that's pretty good. Thank you very much.

CO-CHAIRPERSON EUGENE: Council Member Chin. Thank you very much Council Member. Council Member Chin, please.

COUNCIL MEMBER CHIN: Thank you, Chairs. Good afternoon. Thank you for the testimony. When I was listening and reading along, I was really surprised or shocked or really -- when I saw that the age group, you start with age 5, and then can you share with us some of the statistics, I mean like, what… I guess for children who are that age that they think about, you know, committing suicide? I mean we have statistics to show that?

MARNIE: So the statistic on suicide ideation comes from the YRBS, which is a survey of public high school students, so we don't have surveys of suicide ideation in children that young; it reflects surveys of students between 9th and 12th grades.

COUNCIL MEMBER CHIN: But I'm looking at the testimony, on page two, when you talk about in 2016, the hospitals, so therein shows that there are, you know, over 4,000 emergency department visits and then you still have that range from 5-25. Yeah.

MARNIE: I understand. Right, these were ED visits that were for either suicide attempts, suicide ideation or self-harm, so it's an aggregate of any of those reasons, and I don't have on hand a breakdown by age to 5-year-olds; we can look into the data and get that **[inaudible]**… [crosstalk]

COUNCIL MEMBER CHIN: Yeah, I think… I mean, the question relating to that is that what are we doing in terms of prevention and education in the pre-school level, I mean my colleague asked earlier about Universal Pre-K; if the starting age is at 5, we'd better do something much earlier; right? So in terms of in the nursery schools and also in the pre-K program, do we have mental health personnel in the pre-Ks and also in the day care centers?

LOIS: Yes, we have staff in the Universal Pre-K program; we have social workers, as I testified before. So we have dedicated social workers for Universal Pre-K.

COUNCIL MEMBER CHIN: I guess part of the discussion earlier was like; how do we kinda overcome that stigma; right, at an early age and also get parents to be able to access services. So are there any discussions in terms of how to approach, like for

a child to see a counselor or to have a meeting with them, kinda like in a way that is… it's not labeled, right; it's that they're getting help, that they're getting support to -- are there programs to really do that?

LOIS: Yes, we have the Universal trainings that are part of Thrive; this is to make it so that school staff feel comfortable with mental health issues and to destigmatize mental health issues, and then the hope is; one, that they will be more vigilant and receptive of students if they see signs of mental health issues in our students and also be able to have those difficult conversations with students and also their parents.

SCOTT BLOOM: And just to piggyback, those trainings really help teachers not to become therapists or social workers, but their own anxiety about talking about suicide and stress, because we know that many of the students are dealing with stress and stress is part of destigmatizing mental health; it's something they can identify with right away.

So how to just approach a student that they may see certain signs -- so some of the

trainings include what are the signs that students may be depressed, anxious, dealing with stress; how to just approach them and having a very informal -- hey, I noticed that today you were… or how to have that kind of conversation; then to get them to refer to somebody within the school; it could be guidance counselor, a social worker or if it's one of our community mental health partners who are there. So these universal trainings, making educators partners, the at-risk training, which is an avatar training that's open to all school staff across the City, regardless of elementary, middle or high school, those are the kinds of trainings that we're offering along with workshops so that the idea of destigmatizing mental health, making it part and parcel of our conversation, is available to all teachers so they can work with all the students.

COUNCIL MEMBER CHIN: So is it mandatory that every teacher has to go through that?

SCOTT BLOOM: It's not mandatory, but that's one of the ways that we promote mental health in the schools. And when we sit down and we work with the school administration, we make sure that they know that these trainings are available; we have

to say; in the last few years we've seen rise and indicators that say that more and more teachers are taking these trainings throughout New York City. In fact, I have some numbers, if you would like right now. From March 2016 to February 2017, in high school we had close to 1,800 teachers; middle schools, close to 1,600 teachers, and elementary schools, that you are bringing up, close to 3,500 teachers. So every month we have another, you know, set of teachers that are taking these universal trainings that we're talking about here.

COUNCIL MEMBER CHIN: I mean what about also encouraging the principal to have this as part of their professional development or on their staff meetings… [crosstalk]

SCOTT BLOOM: Sure.

COUNCIL MEMBER CHIN: so that every teacher gets exposed to it… [interpose]

SCOTT BLOOM: That's right.

COUNCIL MEMBER CHIN: that they… 'cause they're the frontline; they're the ones that really should be able to help the students right away.

SCOTT BLOOM: You're absolutely right, you're right on target with our messaging to

teachers. We work with the school so that when they have the professional development days that are required that we make sure that we get in and the schools use those times to promote these mental health trainings or actually to have them, whether we have speakers come in, whether, again, if it's a module that's, you know web-based; they all go to the computer room and do it then and get that information, and that's looked on with our managers, particularly, and the consultants; we promote it and we go in there with the paper: When would you like to start signing up your staff? And it's been very positive; it's something that the teachers in the schools have been looking for.

LOIS: With the Making Educators Partners we have the trainers push into the schools during professional development time; we have the Monday period that's designated every Monday afternoon for professional development for teaching staff, school staff and the Making Educators Partners is something that we've been able to push into staff, so we are rolling it out to schools so that it's easily accessible and part of what the schools do in terms of training staff.

And the other question that you had mentioned about pre-K I wanted to back to -- 1,800 of our pre-K Early Learning Programs have social-emotional learning programs, which address the emotional well-being of students, so we do take that role very seriously.

MARNIE: And if I may just add to that, to also follow up on the young children, concerns about their mental health; tied to that social-emotional learning initiative we have another Thrive initiative called the Early Childhood Mental Health Network and through that we have seven early childhood therapeutic centers that are being specially trained to both treat young children and their families, especially to focus on 0-5, and also do consultation, mental health consultation to the sites that are participating in the SEL initiative to assist with implementation of the SEL initiative and also offer a conduit of referrals if a child does in fact actually need, child and family need a treatment center to assist them with their needs.

COUNCIL MEMBER CHIN: Yeah, that's good to hear, because I think that we've just gotta make sure that the schools and the parents know that the

services are available because all of us need some support on that and we just wanna make sure that our youngest kids get the intervention early on so that they can grow up healthy and strong. 'Kay, thank you. Thank you, Chair.

CO-CHAIRPERSON EUGENE: Mr. Chair.

CHAIRPERSON COHEN: Thank you; just a couple of follow-ups. The correlation between bullying and suicide; the recipe book that you gave us; what strategies do you think are most effective in bullying prevention and I guess, I mean I… again, I have no idea, but I assume we address that from both sides; that we'd wanna offer effective support for victims of bullying as well as trying to prevent bullying in the first place. Could you just talk a little bit about the strategies?

LOIS: Sure. We put our bully prevention work underneath the Respect for All initiative, which is actually in compliance with the State Dignity for all Students Act. We require all our schools to take any allegation of bullying very seriously, investigate and follow up with the students involved and the parents. Having said that, we also look specifically where there have been any sort of

suicidality, so whether it's ideation, behavior or attempt, we read each of those cases centrally and look for elements of whether there was bullying involved or not, and we're able to follow up further and provide support at the school level.

CHAIRPERSON COHEN: Do you have data on how many people report being victims of bullying in the system?

LOIS: I can only speak to material incidents, and if you give me a second, I'll gladly pull that up.

CHAIRPERSON COHEN: What is the difference between a material, I guess versus an allegation or?

LOIS: A material incident is what we're required to report to the State; it's where it effectively affects the student's ability to participate in the educational experience, or it affects their school life and their ability to achieve academically and feel comfortable in school, so it's a higher standard…

CHAIRPERSON COHEN: So it's the perception of the victim that triggers whether or not you have to report?

LOIS: Yeah.

CHAIRPERSON COHEN: Okay.

LOIS: Give me a moment and I'll pull up that data. In 15-16, we had 3,281 material incidents that were reported; they are disaggregated by category, whether it was bullying that had to do with racial or ethnic group or national origin and any of the other protected categories, but the total number of reported cases was 3,281 in 15-16.

CHAIRPERSON COHEN: Do you think it would be helpful though to have data on, you know, someone committed conduct or acted in a way that might be perceived as bullying by one student but not be perceived, for whatever reason, not by another student? Like it would be good if we had both sides of the equation, the bully and the victim, so that we -- you know, if we could do something to also reduce the incidents on the bullying side, or where… again, where the conduct is only bullying because it's the perception of the victim versus maybe like if there was some either objective criteria or, you now where we could identify -- well this student engaged in bullying activity even though the victim didn't feel particularly bullied?

LOIS: I think in the area of bullying perception has a lot to do with it and we do keep incident data on all sorts of incidents, but with bullying there's a difficulty in terms of what a common use of the word is and what we might define it, and so it gets sticky -- is it conflict that we're talking about or are we talking about a pattern of targeted behavior towards a student for a particular reason, whether it's any of the -- height, weight, color -- any of those categories. So it's very difficult to distinguish whether it was a one-time only conflict and not really bullying or whether it was something that was ongoing and targeted. So we do categorize all sorts of incidents, but it's very difficult to disaggregate if it's…

CHAIRPERSON COHEN: And maybe subsequently or offline, I'd like to maybe see some of that data and see if it's, you know useful information in terms of…

MARNIE: May I add just one point about the bullying, is that the YRBS survey -- again, it's also just for the high school students -- does report on rates of students' experiences being bullying at

school, so we can follow up with you with that data, if you are interested in it, but.

CHAIRPERSON COHEN: I am; I appreciate that.

Also, it's been reported widely about a particular concern among Latinas; do we have any reason why we think that is; do we think that there are any factors in the school system that might contribute? What do we think is driving the disproportionate impact on Latinas?

SCOTT BLOOM: So I'm not an expert, but I do… [crosstalk]

CHAIRPERSON COHEN: Me neither.

SCOTT BLOOM: read… a lot of the research has to do with acculturation issues, and sometimes it's family pressure itself. We've had some work -- a number of years ago we had some folks coming in and talking about that and doing some presentations and the research seems to see that part of it has to do with how boys are seen as more machismo and how they're allowed to do certain kinds of behaviors where girls aren't, and so there tends to be acculturation of newly arrived immigrants, and sometimes that causes pressure that causes some pain,

and depending on the individual and the support systems that the families have. So that's a guesstimate of what occurs there.

CHAIRPERSON COHEN: And I guess, just sort of falling back to also the point that Council Member Grodenchik made; it would be helpful I think, and maybe this exists, but like, I'd like to have a better handle on how… like there are particular risk factors that we can identify, how we're targeting those specific risk factors, 'cause it's one thing to have a basket of things that are -- you know, making New Yorkers feel better is I think a worthy and worthwhile goal, but there are specific things that we would like to see where it's quantified that like the effort that we're making is really having an impact on New Yorkers' lives and you know, again, strategies that particularly target Latinas to reduce their susceptibility in this city I think would be something that we would, you know, be particularly proud of and of particular importance with the growth of that population.

Lastly, in terms of accessing the programs, I guess NYC Well is -- I don't know how long NYC Well has actually been up and running in

terms of people accessing it. I should know, but I don't remember. **[inaudible].**

MARNIE: I believe it was November 2016; the data we have is from November 2016, but I can confirm that that was uh… [crosstalk]

CHAIRPERSON COHEN: We believe… Counsel believes it's October of 2016.

MARNIE: Oh October. Okay, maybe my data started in November… [crosstalk]

CHAIRPERSON COHEN: Yeah. Okay.

MARNIE: Okay. Okay.

CHAIRPERSON COHEN: Do we know how many people have called; what's the monthly call; what's the…

MARNIE: We do have data on callers, so one moment; I'll get it for you. Okay. So let's see… So as of January 31st, NYC Well has handled 84,861 calls, texts and chats…

CHAIRPERSON COHEN: 84,000 total so far?

MARNIE: 84,861; combination of calls, texts and chats and we do have some statistics on youth as well. So let's see… and the time period is a little bit different, but we have that 9% of those who called, texted or chatted who reported their age

-- we don't always know the age of the person contacting New York City Well -- but of those who reported their age, 9% were between 10 and 19 years old.

CHAIRPERSON COHEN: Nine percent?

MARNIE: Nine percent, and 23% were between 20 and 29 years old, and that was for the period of November 26th through January 2017.

CHAIRPERSON COHEN: I think that's very encouraging. You know, I also ask this, and I believe the answer is yes, but I'd like to know; you can access NYC Well through 311, I believe that is… uh yes. I would be interested to know how many people are doing it that way, because I think that, you know, for good, New Yorkers are by and large well-trained to call 311 when there's a problem and so I just wanna make sure that there's -- and I should really call it myself and just try to see if it works -- to make sure that that connection is functioning at the way we would like.

And then I'm just curious about accessing the rest of the programs that you mention in your testimony -- the Rapid Access Mobile Unit, the children crisis prevention services or the home-based

services -- how does someone come into contact with those services; how is the connection made?

MARNIE: So it depends in part on the service. The Children's Rapid Access Mobile Crisis Teams are dispatched through NYC Well, so they are set up to dispatch a Mobile Crisis Team. I'm sorry; what were the other programs you were interested in hearing about, the…

CHAIRPERSON COHEN: Children's Crisis Intervention Services and Home-based Crisis Intervention.

MARNIE: Okay. So the Home-based Crisis programs, the referrals are made directly to the -- what we call HBCI directors, but they can come from a variety of places -- emergency rooms, Mobile Crisis can call them, clinics can call them; it can be a community referral, so it goes directly to the program. And the Children's Crisis Intervention Services, those are actually situated in hospital CPEP, excuse me, Comprehensive Psychiatric Emergency Program, or psychiatric walk-in clinics and they're there to provide specialty services to youth, so to conduct crisis interventions, assessments, referral linkage [sic] to sort of determine the triage and

determine what the next step would be for that youth in a variety of hospitals, so the youth would encounter that program upon coming to the ED. Yeah.

CHAIRPERSON COHEN: Thank you. I do wanna just say how enlightened -- you know, upsetting on some levels, but enlightening also on a lot of other levels how the testimony has been, [sic] so I wanna thank you all for your testimony and I'm gonna turn it back over to Chair Eugene.

CO-CHAIRPERSON EUGENE: Thank you very much, Mr. Chair. Again, as I said previously, this is a wonderful effort; a good effort to address this very important and critical mental situation, you know, facing many people in New York, especially our young people, but talking about young people, you know that we have a lot of young people also who are homeless who are in the shelter; are there services designed for them; how do you address their issues?

LOIS: Yes, this year we launched a number of initiatives, but one that I'm particularly proud of is that we identified 30 elementary schools with very large populations of students who are residing in shelter and who otherwise do not have mental health services or counselors on staff, so

we've brought in social workers; we have assigned social workers to those schools; we've hired 30 social workers to work specifically with students who reside in shelter in high-needs elementary schools.

SCOTT BLOOM: In the consultant program we were given additional resources to hire 9 school mental health consultants, so instead of the ratio being 1 consultant to 10 schools, we have 1 to 5 and these 9 consultants are only assigned to schools with high enrollments of students in temporary housing. The additional resources are also towards training and trauma-informed schools, so these consultants are getting specific training and coaching to identify students who may be traumatized so that the teachers then can work in the classrooms, understand some of the behaviors, understand what triggers trauma reactions, and also stress reduction. Many of the teachers and the students in the schools are dealing a lot with stress; you can imagine, with multiple types of problems and issues that these students have, they may get triggered as well and the teachers, so we are doing some stress reduction trainings; mindfulness exercises, so these consultants are also getting training and coaching to

then turnkey that to the administration and the teacher populations to help their students in the classrooms. We are also working with the content experts in the Students in Temporary Housing Unit and the family coordinators in the Students in Temporary Housing Unit as well.

CO-CHAIRPERSON EUGENE: So you know that we have a lot of young people we call "disconnected youth" -- they are not in school, they are not working; they are somewhere -- so what is you method to reach out to them and what do you have available also to address their issues, the mental health issues?

[pause]

ROGER PLATT: I think there are really other agencies that are not represented at the table that have to speak to that issue and if somebody… So I cannot really speak to the out-of-school issues, because they're not the responsibility of either DOE or DOHMH directly. Marnie; is there anything you could say?

MARNIE: Yes, just also that -- thank you for bringing it to my awareness -- that the City Council-funded Hetrick-Martin Institute program that

we fund with City Council dollars is targeting youth who are disconnected from school, etc. within the LGBT community and are expanding, we're expanding our services with the City Council funding, so that's one example of outreach.

CO-CHAIRPERSON EUGENE: Okay. So what about the follow-up method; what type of method do you have to follow up to quantify, to figure out what exactly, you know, what happened to those young people; what are the services that you have providing to them, the counseling? If you have been successful in serving them or providing them with the services that they need, if the need has been met; what type of follow-up method **[inaudible]**… [crosstalk]

ROGER PLATT: I think… I think in terms of the ThriveNYC programs, at least the ones in the school, it's too early to say anything about follow-up and impact in terms of the affect on individual students. I think if there are other programs, we would have to get back to you about who would be prepared to provide that information to you.

CO-CHAIRPERSON EUGENE: And what type of training that are available for those people who serving those young people? What type of training;

what type of certification that they'll receive before they are able to serve the young people?

SCOTT BLOOM: I can only speak, again -- for the community agencies, most of the clinicians are a master's level in the mental health field, so they're either social workers, mental health counselors, they could be psychologists; many of them are licensed clinical social workers and again, if they're doing a mental health clinic, then all the requirements by the State Office of Mental Health must be met.

CO-CHAIRPERSON EUGENE: So I'm talking about staff from the school, like teachers; are there teachers that are involved also in the process? I'm not talking about the mental health professionals; I'm talking about all the -- like teachers and other people involved with the young people; do they receive special training; do they have a certification?

LOIS: Our school counselors and our social workers are State certified and have special training; have master's degree programs, plus, in terms of counseling services in mental health issues. We also have been offering TCIS, which is Therapeutic

Crisis Intervention Services, to school staff and that's a variety of titles that includes teachers, school aides, paraprofessionals, as well as counselors and social workers, and this helps them address when a student is in crisis. So that goes across license areas and it is a certification program and…

CO-CHAIRPERSON EUGENE: So my father usually said that, you know, every time that, my son, you are doing something; you've got to take a moment to reflect on what you are doing; what you have done yesterday; what you do today and what you will do tomorrow and figure out if you have been successful in what you have been doing, and if not; why, and if you have been successful, what can you do to improve what you are doing? If I ask you: Do you believe that your method or your approach to address the mental health issues, you know, affecting the young people, is successful; are you successful in doing and trying to reach your goal; are you successful, 100%? If not; why? And if you are successful, what do you believe you can do to do a better job to better serve those young people?

ROGER PLATT: Well I certainly couldn't agree with you more that it is our obligation to evaluate what we do and to make sure we improve it any way that we can. As we've mentioned, it's early in the implementation phase still, but a very hopeful sign that I would mention is that what we hear from principals and teachers and others in the schools is that the training that we are providing and the services that we are offering are making a difference. It's gonna take at least another year to try to make any sort of assessment in impact on the lives of the students themselves. We do have a large evaluation contract with the Rand Institute and Scott, maybe you can talk about that.

SCOTT BLOOM: Yeah. So the community school model, and mental health is part of that model, has a contract with The Rand Corporation and they're doing a study right now in terms of implementation of the community school model and impact on that model.

MARNIE: And I would also just add that there is actually extensive evaluation that is built into a lot of the Thrive initiatives to answer the exact question you just posed, so I mean, some of it

is initiative by initiative and some of it is broader than that, but I believe there's a hearing coming up in May when we'll be covering in more detail how the various initiatives are going to be evaluated. So that we can do what you said, which is look at the impact we're having and figure out where we need to be, changing strategies and building upon the work we've done.

LOIS: And while we're enormously proud of the initiatives that have rolled out and are currently in place, and while they're in their infancy, any suicide, one single one means we're not 100% effective, so we always strive to reach all our students, and that's a work in progress for sure.

CO-CHAIRPERSON EUGENE: Okay. So on behalf of all the members of the Youth Services Committee and the Mental Health Committee, thank you very much for your testimony and thank you for the effort that you are doing every single day to make a different in the lives of the young people that you are serving, and also to address this very critical issue. Thank you very much. Have a nice day. Thank you.

SCOTT BLOOM: Thank you.

[pause]

[background comments]

CO-CHAIRPERSON EUGENE: So we want to call the members of the next panel: Nicole Robinson-Etienne from Institute for Community Living. Nicole Robinson-Etienne. Jennifer Hunesky [sic], I believe. Jennifer. Thank you. Lisa Furst, Mental Health Association of New York City. I believe this is Diana Christian… [background comment] Okay, thank you very much. Thank you. Peter, is that Peter Karys or… Peter? Thank you, from LGBT Community Center. You may start any time -- Hey, Nicole; how are you?

COMMITTEE COUNSEL: I'm sorry, one minute; let me just swear you in, please. Please put your right hand up. Thank you. Do you affirm to tell the truth, the whole truth and nothing but the truth in your testimony before this committee and to respond honestly to the council members' questions? Great. Please state your name for the record before you begin.

[background comments]

CO-CHAIRPERSON EUGENE: Nicole, can you hold on for a second?

NICOLE ROBINSON-ETIENNE: Thank you. Nicole Robinson-Etienne, Associate Vice…

[background comments]

CO-CHAIRPERSON EUGENE: Okay, for the sake of time, you only have three minutes, so we would love to listen to you, to hear everything that you want to say, but you know, we've gotta go a little bit faster and we appreciate your cooperation. Thank you very much.

NICOLE ROBINSON-ETIENNE: No problem. Thank you. Again, my name is Nicole Robinson-Etienne, Associate Vice President for Government and Community Affairs at Institute for Community Living (ICL).

I'd like to thank the Council Members for providing me with this opportunity to testify.

ICL is a nonprofit human services agency providing trauma-informed, recovery-oriented, integrated, and person-centered care via support of transitional housing, counseling with individual therapies, rehabilitation, and other support services for adults, veterans, children, and families diagnosed with serious mental illness, substance abuse and developmental disabilities. We serve

nearly 10,000 people each year and have 2,300 individuals living under an ICL roof every night.

We serve families with adolescents and transition age youth at our residential services at Livonia, Coney Island and Linden Houses, at our clinics at Highland Park in Brownsville and Rockaway Parkway in Canarsie, and school-based mental health support services at IS 220 in Sunset Park and PS 13 in East New York where we assure access to a full range of mental health and social services.

I just wanna jump ahead really quickly to one quick case study that we had where we had a young woman who was the age of 17 who was referred to us through our partnership with Kings County Hospital after a suicide attempt who was struggling with acculturation issues after recently arriving from the West Indies with a lack of stability being shuttled back and forth between her mother's and her aunt's homes, each of them dealing with their own challenges. She had a serious history of multiple hospitalizations and suicide attempts and other community residences felt they were unqualified to accept her into their programs, but she was placed with our Coney Island Residence and we were able to

help her overcome her deep depression, helplessness and hopelessness stemming from her feelings of loss and rootlessness. She later transitioned into one of our adult residences and graduated to our supportive housing at a much higher level of independence. She has been responsive to our follow-up inquiries and we know that she's now enrolled in college.

And for the sake of time, I just wanna join with the other agencies that are here that also provide adolescent and young adult services in urging the Council to continue to ensure funding and access to these kinds of supports of young New Yorkers in need. And you have the rest of my full testimony for the record.

CO-CHAIRPERSON EUGENE: Thank you very much. Next speaker please.

PETER KARYS: Good afternoon members of the Committees on Youth Services and Mental Health. My name is Peter Karys and I'm the Director of Youth Counseling and Support at The Lesbian, Gay, Bisexual & Transgender Community Center.

The Center provides extensive services to youth and young adults ages 13-22 and has been doing so since 1989. We see over 1,000 unique individuals

a year in our youth programming, with services ranging from drop-in groups to career and academic leadership programs, as well as outpatient substance abuse treatment.

In my role at the Center, I help coordinate a continuum of care for these youth, starting with their initial assessment and intake into our programming, leading to their connecting to comprehensive services such as short-term counseling, psychoeducational support groups and a variety of evidence-based interventions in addition to numerous pro-social recreational activities.

Like many challenges faced by young people, LGBT youth are disproportionately impacted by the issue of youth suicide. Nine out of 10 LGBT young people have experienced harassment at school and many are unfortunately met with similarly unsupportive experiences at home. These factors often lead to despair and isolation which provides insight into why these youth are 190% more likely to abuse substances. A Center for Disease and Control report issue din 2016 revealed that nationwide nearly 43% of LGB students had considered attempting suicide during the 12 months before the survey, illustrating

the prevalence of suicidal ideation for so many of our community's students between the 9th and 12th grade.

These numbers are even higher and more alarming for transgender and gender nonconforming youth. Based on my experience, I would suggest [sic] that the City prioritize access to identity-affirming care and the creation of additional safe and inclusive spaces would be important steps in combating the epidemic within our community through the ThriveNYC.

We believe when an LGBT youth reaches out for support it is paramount that the person they connect with is able to provide affirming and informed care to convey genuine empathy and understanding and to have a positive impact. Those delivering affirmative care can include therapists, guidance counselors, doctors, teachers, and family members in a variety of settings, and the way in which this care is provided is crucial; it can a profound impact on the experience of the youth.

All too often I've heard stories, like that of a 16-year-old gender nonconforming youth struggling with anxiety and depression who was told

by their school counselor that maybe if they didn't dress or act the way they did then perhaps they wouldn't be bullied so much. To combat this kind of harmful response, at the Center we offer cultural competency training to interested providers where we identify how to provide affirming and inclusive care to a diverse LGBT community.

Additionally, I see and hear from our program participants that there is a lack of safe spaces for LGBT youth to engage in around the city. These are environments that promote an understanding and acceptance of all individuals in which sexual orientation and gender identity or gender expression is viewed as a respected and welcomed part of their larger identity.

At the Center we provide a communal adolescent drop-in area in addition to the structured groups and programming to create safe spaces for youth where they can be authentic and feel validated in their identity while seeing their experiences reflected in and understood by their peers.

And I just wanna say; [bell] I just believe that youth should have other spaces where maybe that aren't designated just for LGBT youth, but

that are made inclusive so that youth don't just feel tolerated, but they feel welcomed and celebrated for who they are. So I'll wrap it up there. Thank you very much.

CO-CHAIRPERSON EUGENE: Thank you very much. Next one.

ROSA CIFRE: Good afternoon.

CO-CHAIRPERSON EUGENE: Good afternoon.

ROSA CIFRE: On behalf of Dr. Rosa… [interpose, background comments] Oh okay. Sorry. Good afternoon. On behalf of Dr. Rosa Cifre, Comunilife President and CEO, I would like to thank Council Member Andrew Cohen and Council Member Mathieu Eugene for holding this hearing. We also would like to recognize all Council Members who serve on this Committee.

My name is Rosa Cifre; I'm Chief Program Officer of Comunilife, a Human Services Agency founded in 1989. Comunilife provides culturally competent mental health, social services and supportive/affordable housing for persons living with mental illness, HIV/AIDS and other chronic illnesses. Each year more than 3,500 New Yorkers benefit from our programs throughout the City.

Comunilife, a leading provider of suicide prevention services in the City, has stepped in to address this issue head-on; offering bilingual and culturally competent youth development services to Latina teens and their families through our Life is Precious program. This program is the only one of its kind in the country.

The Problem:

Latina teen suicide has reached epidemic proportions in New York City with suicide the second leading cause of death for Latina teens in New York State.

We know that there are multiple contributing factors that result in young Latina teens attempting suicide including family conflict -- primarily with their mothers -- due to the different levels of acculturation, stress, domestic/sexual abuse, academic failure, and bullying; these, coupled with the stigma with mental illness and the lack of culturally competent mental health services.

I'm not going to go into the statistics of the CDC because we have heard that, but we're very grateful to the City Council for supporting our Life is Precious program for the last six years. Your

investment in this program has saved the lives of 270 Latina teens in Brooklyn, the Bronx and Queens who have received the help they needed and the program has also provided countless outreach activities. Your willingness to raise awareness on this issue and discuss solutions to prevent Latina adolescent suicide is truly appreciated. However, there is a lot of work that needs to be done.

Our Response:

Comunilife's "Life is Precious" program provides nonclinical suicide prevention activities to Latina teens who have seriously considered or attempted suicide. The girls, who range in age from 12 to 17, are immigrants of first generation Americans and live in some of New York City's lowest-income neighborhoods and are all living with depression or diagnosed mental illness. Life is Precious has three locations -- the Bronx, Brooklyn and Queens and the kids, to be enrolled, they need to be receiving mental health services or willing to receive mental health services, be in school; also have their parent's permission, and of course, we work very hard to engage the families to be part of the program as well.

I think at this point we have to 270 Latina teens that have participated in Life is Precious [bell] and Jennifer -- who I've got here -- Dr. Jennifer Humensky from the New York State Psychiatric Institute/Columbia University - New York State Center of Excellence, will provide the evaluation piece and the activities that we have; all the results that we have achieved to the present.

DR. JENNIFER HUMENSKY: So thank you for having me today. I'm Jennifer Humensky from Columbia University, Department of Psychiatry and we've been working with the Center of Excellence for Cultural Competence to evaluate the Life is Precious program for the past three or four years.

We have data dating back to 2008 and 215 Latina teenagers who have participated in Life is Precious. First and foremost, in the past year there have been no reported suicide attempts among program participants in this very high-risk population.

Prior to joining the program, about a third have repeated a grade in school and in the past year all students have been promoted to the next grade; 84% showed academic improvement through a report record review and this year we have 9

participants graduating from high school and making plans for the future of college and vocational training.

Moreover, we've been following trends in suicidal ideation, depressive symptoms and other symptoms over the course of program participation. We're finding that suicidal ideation decreases by about one point per year of enrollment, as measured by the suicidal ideation questionnaire, and we find that participants who report a history of sexual abuse or of tobacco use at program entry have even greater decreases in suicidal ideation. People who report sexual abuse -- that's about a quarter of the population -- report a history of sexual abuse when they enter the program and they experience a decrease of about three points per year in suicidal ideation, as measured by the SIQ, and people who report tobacco use report a decrease of about five points per year in suicidal ideation, as measured by the SIQ.

Likewise, depressive symptoms also decreased, as measured by two different scales -- the RADS, the Reynolds Adolescent Depression Scale and the Trauma Symptom Checklist for Children. The

Trauma Symptom Checklist also measured reductions in anxiety, anger and post-traumatic stress.

And we should also point out a few things: one is that many programs have found tremendous difficulty in demonstrating decreases in suicidal ideation and depressive symptoms in adolescents. A study by the Federal SAMHSA, Substance Abuse and Mental Health Services Administration, they did **[inaudible]** 44 studies of programs serving adolescents nationwide, only three found any statistically significant decreases in ideation or depressive symptoms and none of these particularly targeted the needs of Latina adolescents.

So the effect sizes that we're seeing were significant, we're seeing them relatively stable over time and through multiple assessment tools, so that's what's interesting. We should note we don't have the comparison sample at this time and we only study them while they're enrolled in the program. We are putting in a grant application now to get funding for a comparison site; we have two sites that are onboard to begin that analysis, and we also did a study of people who have left the program -- while we

didn't find valid contact information for about half of the participants, of those that we were able to contact, we did not find any attempted or completed suicides among those that we were able to contact. [bell] Thank you very much for your time… [crosstalk]

CO-CHAIRPERSON EUGENE: Thank you very much. Right on time. Good timing.

Miss Nicole Robinson-Etienne…

NICOLE ROBINSON-ETIENNE: Yes.

CO-CHAIRPERSON EUGENE: Good to see you.

NICOLE ROBINSON-ETIENNE: Good to see you too.

CO-CHAIRPERSON EUGENE: Good to see you. In your testimony, you say that you serve nearly 10,000 people each year, but among the 10,000 people, how many are young people; how many youth do you serve?

NICOLE ROBINSON-ETIENNE: Let's see… I don't have the data on that; I do know that about 63% of them are African American; about 37% are Latina, but I don't have the breakdown between the… with the ages… [crosstalk]

CO-CHAIRPERSON EUGENE: Do you at least have the percentage; I mean is it 20%; 40% approximately?

NICOLE ROBINSON-ETIENNE: Well given the broad… a majority of our programs… [crosstalk]

CO-CHAIRPERSON EUGENE: Or half or less; half?

NICOLE ROBINSON-ETIENNE: It would probably be less than half, because we do have primarily adult-based programs; however, we do have the three residences focused on young adults as well as our Family Resource Center, but a majority of our programs are targeted towards adults, so I would say more than half are adults and probably closer to the 40% or less are for young adults or youth.

CO-CHAIRPERSON EUGENE: Do you provide also services to the young people in shelter and young people who are in the justice system or those who are disconnected; do you have any service available for them also; what type of service are those [sic]…? [crosstalk]

NICOLE ROBINSON-ETIENNE: Yes, absolutely. We have our mental health clinics; the one that's located in Canarsie, as well as in

Brownsville, as well as downtown Brooklyn at the Guidance Center and they all provide those types of services to disconnected youth; families. Those who have been transferred from the justice system, we have a partnership with the Department of Probation and also provide services to people returning home from jail.

CO-CHAIRPERSON EUGENE: So I want to ask the same question to each one of you from the panel. How many young people are you serving and among those young people, are there youth in shelter and the criminal justice system or disconnected youth, and what type of services do you provide to them? Anyone from the panel can answer.

PETER KARYS: I'll say for the Center, so I said that we serve approximately 1,000 unique youth per year, so for the youth program it's 13-22, and we do encounter… you know it's hard to say statistically, but I mean we definitely encounter youth who have had court involvement or who are disconnected in terms of maybe they don't have stable housing, and so for… definitely, like we have -- some of our programming, we have like job readiness or also connection to educational services, like if they

need connection to a vocational program or need help applying to college, like we can assist them with that. We have two internships which are paid internships where again, depending on if they're high school age or older, they can get connected to paid internships in the community and they get support like in terms of creating resumes; things like that. And in terms of housing, we don't provide housing on-site at the Center, but we have a relationship with the Ali Forney Center that provides housing specifically for LGBT young adults and also we've collaborated with Covenant House as well. So if we don't provide a service at the Center, we try to identify community partners that we can work with on those issues.

CO-CHAIRPERSON EUGENE: Anyone else? Anyone want to say something… add something to this question?

ROSA CIFRE: The only thing that I would like to add is the fact that the things that we do in Life is Precious that I think is giving us the results and that includes the tutoring and the homework assistance has been very successful as well as the wellness activities that include nutrition and

the creative arts therapy that are used to work with the kids and engage them and their families.

CO-CHAIRPERSON EUGENE: We know that suicide among young people is a critical situation that affects so many young people in New York City, regardless of ethnicity and also background, or religious background, so based on your experience, what do you believe the most poignant risk factors are, from what you know? Can you say that, you know what, based on your experience, you believe that the majority of young people who are prone to suicide, you know; they are facing these one, two, three biggest challenges in their life that push them to suicide? Is there any way you can identify or get an idea what are the few most, you know, poignant risk factors that can push a young person to suicide? It may be difficult because there are so many.

PETER KARYS: I mean I can speak just from my experience and with the population that I work with… [interpose]

CO-CHAIRPERSON EUGENE: Is it emotional factors, effective [sic] factors, or let's say family issues?

PETER KARYS: Yeah, I was gonna say… I mean I… [interpose]

CO-CHAIRPERSON EUGENE: Again, I know that it is very difficult, very, very difficult; I just want to get some insight, some, you know, comment from you, if you are able or if you are able to identify exactly what are the main, the most powerful risk factors.

PETER KARYS: I mean I think it's a really complex issue, but I… [interpose]

CO-CHAIRPERSON EUGENE: Again, you don't have to, you know, to tell me right away, because… go ahead, you know.

PETER KARYS: Okay. Sorry. No, I think it's a complex issue and I think, for the youth we work with, again, and there's issues such as, you know, family rejection, like a lack of support, so they don't have people that are there for them that they can talk to or they are very isolated, withdrawn; I think that puts them at greater risk, and if they're being harassed or bullied in school, so if they… they don't feel safe in their surroundings, they don't feel in control, I think… you know and that can be again, due to family issues,

due to what's happening in their community around them. I think there are some youth who have just a biological predisposition to certain mental health issues such as depression which also plays a factor. So I think, you know, for people there is kind of a number of variables that can come together. And then again, like a lack of access to services, so you'll have these variables and they're not getting any support for that; it kind of all adds up I think. So it's complicated, but I think there are certain things we… [interpose]

CO-CHAIRPERSON EUGENE: It is.

PETER KARYS: you know that play into it, so sort of risk factors like that, like that isolation or that lack of access to services which create a higher risk, from my perspective.

CO-CHAIRPERSON EUGENE: It is very complicated, but what I want to say is that in order for us to better serve those young people who are facing mental health issues and also to prevent them to be in those situations, we have to know exactly what are the causes, 'cause like in medicine; in anything, in order to be successful in treating any type of disease, we've got to know the cause; not the

symptom, not the signs. So what I would suggest, you know, to all the people who are providing services to the young people facing mental health issues, to dedicate some time or to create some type of programs to identify exactly how many young people -- if I'm serving 100 young people, how many you know are prone to go to suicide because of family issues; how many because of substance abuse, just to have an idea and in this way we can know exactly or get a better idea what type of preventive measures that we can take.

My other question is that; I know… you know, serving young people affected by mental issues or substance abuse is not easy, it is not easy, so many organizations and many dedicated people, they have been working every single day to try to make a difference in the life of those young people; let me ask you; what would be the biggest challenge for you to address you know the need of those young people affected by mental issues? What was the biggest issue for you to meet their needs?

PETER KARYS: I mean I think for us, a big part, when you're working with youth, is pulling in the family members and the parents or the caregivers or whoever -- you know the responsible

adults, because if you're treating a youth in isolation and you're not able to affect their surroundings or the people that are caring for them day to day, then I think you're not really fully addressing what -- you know, the real issue or part of the issue, because you know, they might get support when they come into your office, but if they're leaving your office and going back to an unsupportive home environment, you know, then it's going to keep happening, so… and sometimes it's not always easy to pull the parents into programming or get them engaged. So I think that's one of the challenges that we encounter.

ROSA CIFRE: The same is true for us in terms of engaging families; really trying to address what are the stresses at home that are contributing to the issues with the kid. So I agree with you, that involving the family is crucial in the work that we're doing. I think we do need to find ways of really connecting with the families, which in our case is a lot of single mothers who are dealing with many, many other stressors than the issues that the teenager is presenting. So being able to go and provide support and recognize what are all the issues

that that family is having or their mother is having in order to be able then to address the issue of the adolescent. In our Life is Precious programs, we do provide case management services to the family to ensure that we are aware of what the issues are and find ways of dealing with them so that then we're able to decrease the stress that the family might be in so that we can really begin to address what are the issues with the kid and how can we then bring mother and daughter together, which seems to be one of the biggest concerns that we encounter with the kids that we're serving, and it has a lot to do with the acculturation issues. These are first generation and immigrant families, so there's a lot of conflicting issues with the family and the kid goes to school; there they are taught that you need to be self-sufficient and really think about you as an individual; at home we're teaching them that -- no, your family comes together, so there's a lot of conflicts there that need to… that we try to address. We also try to bring families together to experience themselves in positive ways, not just dealing with the problems always. So we do have what we call family-oriented activities where we bring them in

just to experience themselves, you know positive ways, and that has given us some results.

CO-CHAIRPERSON EUGENE: Thank you.

NICOLE ROBINSON-ETIENNE: I think also the other piece of it is to improve the stability in the home life, so we talked about housing stability and income instability where we provide supportive housing for many of our clients, so where we provide case support as well as supportive services in the home that helps to also improve the life situation and to help the families go through and become healthier mentally and physically.

CO-CHAIRPERSON EUGENE: Thank you very much. I agree with you, because the family values, the family stability is very important in helping the young people grow and stand positive **[inaudible]** and then become positive citizens. And you mention also something about the acculturation; this is very, very important also because as you know, that New York City is home to so many immigrants, they come with their culture, with their belief, with their language; it is very difficult sometimes for them to overcome the challenges that they are facing because of their culture, because of their language, and I

think that in your effort to make a difference in the life of those young people and to address their issues, it is very important that you give to the family members a very important place or role [sic] and I commend you for what you are doing every single day and thank you very much. Thank you. I'm sorry, Council Member Chin; do you have any questions?

COUNCIL MEMBER CHIN: I don't have a question, but I really wanna thank you for the important work that you're doing, and I agree with you about the stability for the family, because without affordable housing, a job, there's so much stress on the parent and sometimes we forget, you know, these young people are still kids and like oftentimes they just don't get the attention, but the stability, if we can help out the family, make sure they have a good-paying job and a good place to live, I think that will be a great help to our kids. And thank you for all the great work.

NICOLE ROBINSON-ETIENNE: I'm sorry; one more statement from me. We also focus on integrated health care, so we focus on the physical as well as the mental in making sure that the primary care doctors take a focus as well as identify mental

health issues that they may see in their primary care physical checkup and making sure that we're all connected, so we're in the process of building an integrated health hub in East New York that incorporates all of those services in one location.

[background comments]

CO-CHAIRPERSON EUGENE: Alright, thank you so very much. Thank you.

NICOLE ROBINSON-ETIENNE: Thank you.

PETER KARYS: Thank you.

CO-CHAIRPERSON EUGENE: Fiodhna O'Grady… I'm sorry; thank you very much. O'Grady? Thank you very much. Rosa Cifre. Douglas Berman, I believe. Bet… Brett Scuddy [sic]. [background comment] Thank you very much. Thank you. [background comments]

COMMITTEE COUNSEL: Please raise your right hand. Thank you. Do you affirm to tell the truth, the whole truth and nothing but the truth in your testimony before this committee and to respond honestly to council members' questions?

[collective affirmation]

COMMITTEE COUNSEL: Alright. Thank you. Please state your name for the record before you begin testifying.

CO-CHAIRPERSON EUGENE: Thank you very much.

DOUGLAS BERMAN: Thank you, Chair… [interpose]

CO-CHAIRPERSON EUGENE: I'm sorry; before you start, each one of you has only three minutes…

DOUGLAS BERMAN: Right.

CO-CHAIRPERSON EUGENE: to do [sic] your presentation. Sorry about that.

DOUGLAS BERMAN: Okay.

CO-CHAIRPERSON EUGENE: Thank you. Bye bye.

DOUGLAS BERMAN: Okay. Thank you Chairman Cohen and Eugene and Committee members for convening this hearing today. My name is Douglas Berman… [interpose]

CO-CHAIRPERSON EUGENE: Could you turn on the mic; your mic is on?

DOUGLAS BERMAN: It's on.

CO-CHAIRPERSON EUGENE: Okay, very good.

DOUGLAS BERMAN: Oh it's just my voice… [crosstalk]

CO-CHAIRPERSON EUGENE: Thank you very much, and state your names, please.

DOUGLAS BERMAN: Douglas Berman.

CO-CHAIRPERSON EUGENE: Okay.

DOUGLAS BERMAN: Coalition for Behavioral Health, which represents 140 mental health agencies in New York City and the surrounding area. We train about 175 providers every month on innovative, clinical and best practices; that's one of our more roles.

We all have heard the statistics and they're appalling, but I think what concerns us most is that the trend is not downward; it's upward. I think our friends at Comunilife told us about the increase in suicides in Latina youth in the Bronx, up an amazing 34% in two years. We've considered that reversing this trend is one of the most important actions we can take to ensure the future of our city.

We are also concerned about the LGBT community and youth and significantly higher rates of suicide and suicide ideation.

We are also concerned about the difficulties of serving the vast numbers of throwaway and runaway youth who gravitate to New York City each year. We regret but are grateful for an increase in shelters that are now serving youth and specifically

LGBT youth. But the impact on the shelter system doesn't compare to the impact on the people in the shelter system.

We urge greater attention to the behavioral health screening and access to mental health services for the people in the family shelters. It's known that about 90% of the mothers in the shelter have experienced violence before getting to the shelter; you add that to the trauma of losing one's home, yet we do nothing about screening people who enter the shelter for their behavioral health needs, and we have very little access to behavioral health services, although there is access to physical health services.

Rather talk a little bit more about what we believe really works. We want proactive programs which identify and reach out to young people at risk before despair escalates. We need act knowing that any attempt is evidence of severe distress and an opportunity to engage. We believe that there need to be as many points of access as possible with as many different modalities so that we can reach the vast diversity of individuals needing mental health services. And we need to explore the vast

opportunities provided by online counseling, supportive counseling, crisis services, especially for youth who are very linked in to the social networking of the web.

We must never forget however that for every youth who does not succumb to suicidal ideation we stand [bell] to regain a resourceful and thriving member of our communities. We urge New York City to use the vehicles of Thrive, Well and Healing to prioritize those at the highest risk and target our young people. Thank you.

CO-CHAIRPERSON EUGENE: Thank you very much.

FIODHNA O'GRADY: Good afternoon, my name is Fiodhna O'Grady and on behalf of Samaritans Suicide Prevention Center of New York City and our Executive Director, Alan Ross, who regrets he was unable to attend today, I'd like to thank the members, the Chairs of the Committee and the staff who worked so hard on this particular hearing.

As you know, suicide is a public health problem that impacts people of every age, sexual identity, race, culture, and socioeconomic standing. So when we address youth suicide, we remind ourselves

it should be in the context of the family and the community -- the young people's parents and grandparents, their siblings, and extended family who are often at high risk, if not higher than they are, which has been brought up all day today.

I'll skip the bit on statistics; however, I would draw your eyes to the packet we gave in which the YRBS for 2013 and 2015, it compares by race and by year and the youth suicide statistics which Dr. Platt had said is the best info out there.

From over 60 years of experience operating suicide prevention and crisis response centers in 42 countries around the world, Samaritans believes much of this is tied to the pervasive social and cultural stigma associated with mental health, concerns about privacy and the fears many people in distress have about accessing help, especially in this political climate.

The military, which as you know, has its own significant concerns about suicide, came to some of the same conclusions and developed, and continues to develop, broad-based, cross-cultural, anti-stigma campaigns to help change that culture.

Recognizing the resistance of soldiers -- active and veterans -- to seek help for emotional distress, they provided messaging, education programs and anti-stigma campaigns to re-shape the conversation.

"I Am Strong!" "It Takes Courage and Strength to Ask for Help!" "Not All Wounds Are Visible!" and "Finding Strength and Hope Together!" are just some of the messaging that has come out of an over 10-year education and awareness campaign designed to impact the perceived image soldiers have about suicide and mental health.

This is an example we can learn from.

Samaritans has worked with the National Council for Suicide Prevention in advancing effective anti-stigma, most notably SAMHSA's "Changing the Conversation" campaigns, education and support programs. We've worked closely with the City Council, and I'll digress to say that we've trained nearly 1,500 student support personnel for the Department of Education, which includes guidance counselors, social workers, psychologists; students in temporary housing from 600 schools every year [bell] for two years and we continue to work in that

direction with your help and applaud the agencies here, our First Lady Chirlane McCray and other efforts and thank you for the opportunity.

CO-CHAIRPERSON EUGENE: Thank you very much.

BRETT SCUDDER: Good afternoon. My name is Brett Scudder; I am the Executive Director of the Scudder Intervention Services Foundation, the Suicide Institute and the Chairman of the New York Suicide Council.

I want to come at this from a different perspective; I noticed that there were a lot of stats and a lot of information thrown out today, but I want to come at this from the personal lived experiences perspective, because I think while we talk about suicide, especially among our youth, we talk about suicide as if it's their problem when it's really our problem.

There is a human condition here that we're not focusing a lot when we talk about suicide and I really brought something that highlights -- and I gave you all a copy of this -- the path from the ideation to completion of suicide. Suicide is not just the end of life, it's a process that people go

through hurting; it is a process that our youth are going through, and many of them have no support; they have no one who listens to them; they have no safe spaces in their community that they can go to for help. We talk about the family dynamics, but the truth of the matter is, sometimes the family is the stressor for a lot of our youth because they're isolated; there are a lot of cultural factors; there are a lot of people who are in different environments; now sometimes you can's better their environment, so how do you help the child who is still struggling with those needs?

So I wanna talk for a few minutes about the experience, right; it's emotional pain; people are hurting and they're hurting deep, our youth are hurting and they're hurting deep. A lot of the services that are being offered are not catering to the hurt and the pain that they're experiencing and sometimes it drives them to this hopeless state; like why even try to get help? Why even talk about what I'm going through, because no one is listening and no one is understanding. So more of our youth are saying that no one is listening and understanding because they don't have safe places or safe spaces or

people who understand the emotional pain that they're going through; as soon as they start talking about certain things, immediately they wanna be medicated or they wanna be put in the emergency room, and those two situations do not enhance or enhance the quality of life for a lot of our youth who are going through these issues; we really have to start looking at suicide from pain -- What is the experience of the pain? I can talk about this from a personal experience and me personally, it is a very hard issue for me to deal with, as someone who has attempted suicide, who has dealt with depression, lived with PTSD. So when I meet with our youth, I meet them on a human basis, humanize the experience of what they're going through, because the truth of the matter is, sometimes the hopelessness is real, it's not like we can tell them -- oh well, you know you can get it; we're gonna improve your housing, we're gonna improve your education, we're gonna give you all these services; we just have to understand on a personal level what the experience of pain is; how can we be of help, and if I can change your circumstance, how can I alleviate the pain that you're going through so you don't have to be taking

drugs; you don't have to be exposed to [bell] at-risk behavior or self-harm, and that's the part in this whole suicide conversation that we really need to pay more attention to; is what is the lived experience of the person in pain who may feel like there is no hope, there is no other reason for me to live. Thank you.

CO-CHAIRPERSON EUGENE: Thank you very much. Thank you. So as we know, the young people who commit suicide, most of the time they are affected by issues that are connected with the situation in the family and you know that; you've mentioned that, so in your organization what type of services that you have designed to assist the family members or the parents, just to support them, just to mentor them, just to provide them with the support that they need… [crosstalk]

BRETT SCUDDER: So apart from the support groups that we offer, we provide in-home services; sometimes we get a lot of youth… [interpose]

CO-CHAIRPERSON EUGENE: Did you say in-home services?

BRETT SCUDDER: In-home services -- people don't come to us; we go to them, wherever they

are, we take our services to them and sometimes when we have a lot of our youths who can't talk with their parents -- they can't tell their parents what they're going through; we have to come in the home and do an intervention in the home where we sit with the family together and explain with the family what the child is going through, the experience the child is going through and how as a family they can build a support system around that child, rather than ostracizing the child or pushing the child out or judging or leaving the child.

CO-CHAIRPERSON EUGENE: Okay. And any member of the panel can answer, if you have some… yes.

FIODHNA O'GRADY: Samaritans does not provide direct services of any sort to individuals. We have three kinds of services; one is the suicide prevention hotline, that is confidential and 24-hour, and that answers about 80,000 calls a year. The second program, which I spoke about, is our professional development program that provides professional development to community-based organization professionals and to school professionals and clinicians in the school. So for

instance, last year, when I think about what Council Member Chin was talking about for younger people who are under 10 who are thinking about suicide who would be younger, we had a Dr. Brian Mishara, who's one of the world's experts in that, to come in and we were in Queens with about 300 clinicians talking about how younger people have a different language; how they look at death; how to speak with them; how, as you go from a certain age to another age and how to speak and to address younger folks' concerns on these communication-level issues, which I think he's talking about too, which is communication is key -- you can have all the tools out there, but unless you know how to use them and establish rapport with young people and have real conversations, then you will… the pain of suicide -- any problem left unattended can have an ultimate painful ending, which is suicide, and sometimes at the end, what you describe for suicide is; suicide is ending pain, so it actually becomes a solution for their problem, whereas if we get back and move the line -- which is crisis intervention -- back into prevention; that's where you want these kinds of discussions that the other agencies are talking about.

DOUGLAS BERMAN: At the Coalition for Behavioral Health, we don't provide direct services, but we provide direct services to the providers who are providing those services. One of our roles, and an important one, is that we try to bring innovative, cutting edge, best practices; clinical practices to organizations who do provide the services who otherwise wouldn't be able to access those educational opportunities.

CO-CHAIRPERSON EUGENE: So do you have a method of evaluation, to evaluate, to quantify the services of the providers that you are serving? How do you know if the services that they're providing are efficient, if they're meeting the need of the people that they are serving; any follow-up method **[inaudible]**… [crosstalk]

DOUGLAS BERMAN: I think most of those quality issues are in the purview of the Medicaid program; most of our providers treat mostly the Medicaid and non-insured population, and when it comes to the quality indicators, most of that information is collected by New York State's Department of Health, through the compliance programs

and through quality assurance programs. We don't have access to that information, but… [interpose]

CO-CHAIRPERSON EUGENE: Yeah, but for your system, do you have a way to follow, to see that, okay, we have been doing good; the technique that we use is great or the technique that we are using needs some improvement? Well just to evaluate yourselves, just to evaluate, you know your output… [crosstalk]

DOUGLAS BERMAN: Yes, we do… After a training, we ask people to evaluate what they've learned and we know that they keep coming to us, our programs are in great demand; we have at least three or four trainings every week to the community, so people need them and I think the fact that they return tells us that we're doing the right thing.

BRETT SCUDDER: Well can I add… Can I answer that… [interpose]

CO-CHAIRPERSON EUGENE: Before that -- you say that your organization doesn't provide direct services… [interpose]

FIODHNA O'GRADY: Correct.

CO-CHAIRPERSON EUGENE: but the client uses the hotline, they call for advice; how many

young people… how many calls that you receive or how many cases that you deal with every year?

FIODHNA O'GRADY: I'm sorry; the question once more?

CO-CHAIRPERSON EUGENE: How many calls that you receive or how many cases you deal with every year?

FIODHNA O'GRADY: We've answered 80,000 calls on average for the last three years and for public education we've trained close to 1,500 and providers in the school system and the University of Rochester has done a study of the training program and the methods that we have used with these populations in the school to do with our education, and they have found that skills, behavior and knowledge were improved in fact around the suicide prevention training that we provide, and that can be provided to you, that study.

CO-CHAIRPERSON EUGENE: Go ahead.

CHAIRPERSON COHEN: Yeah, why don't you count the hotline as direct service?

FIODHNA O'GRADY: Because it's called an indirect service because you don't have the person in front of you, therefore, if they speak and they say

to you that I have a broken leg or I have this or I have that or I am… we cannot verify that because that person is on a call… [crosstalk]

CHAIRPERSON COHEN: I understand that…

FIODHNA O'GRADY: and… no… and so it's referred to as an indirect service. So I just wanna be clear.

CO-CHAIRPERSON EUGENE: When you receive a call; let's say -- help us, you know, navigate or understand what happens -- somebody calls, so what is the procedure…? [crosstalk]

FIODHNA O'GRADY: All calls go through the same process, so we have about 110 volunteers; it takes many months to train them, and every call has log sheets to do with establish rapport -- which is what this lovely gentleman speaks about -- which is giving time to a person -- why did you call and letting the person speak -- active listening is the methodology we use, which is separating the person from the problem and allowing the person to speak after the establishment of rapport. During the call, once we've found out what is the primary presenting problem, we go through a suicide assessment, figuring out: a.) is the person feeling suicidal or not and to

what degree, and so that would go to thoughts, plan, means available, and time set; if the person is doing something to harm them now, we deem that to be a medical emergency; we add an extra team offsite, etc. and that often leads to then calling in 911; we go through a process with the caller where if they need help, etc.; open up the door, put your dog in the thing, make sure you're… you know, if you have medication, etc., we call Poison Control and help is brought to them. That is a very small percentage, 'cause that is crisis intervention, of the number of calls, it's a crisis prevention line, so a lot of our callers may call often during a period of time.

CO-CHAIRPERSON EUGENE: So if there is an urgency, you call 911?

FIODHNA O'GRADY: If there's an urgency we connect persons to help: a.) they can decide themselves to get themselves to hospital; if they need help, then we make sure to stay on the line with the person, but once EMS arrives and once the ambulance arrives, they pick up the call and they say we are here, thank you and it's passed on, absolutely.

CO-CHAIRPERSON EUGENE: But if there is no urgency, so what is the… [crosstalk]

FIODHNA O'GRADY: The urgency -- then we rate the time allotted to the person based on the degree of urgency, so someone who's a low-risk caller who is not showing high-risk factors will be given less time; someone who has a higher risk and has a plan or has means available, will get a longer time and we also track and make sure that if that person calls back that there is continued continuity over the days of that person's situation, as many people, if they're feeling that bad, and we invite people to call back.

CO-CHAIRPERSON EUGENE: So that means if there is no urgency you give counseling to the person, you advise… [crosstalk]

FIODHNA O'GRADY: If there is no urgency, we give a certain amount of time on the call and then we say that we are going to end the call at some point. But every single person who calls the hotline is asked -- Are you feeling suicidal?

CO-CHAIRPERSON EUGENE: Uhm-hm. So that means the person, some of the time, or most of the

time, has to call back, right? You ask the person to call back…? [crosstalk]

FIODHNA O'GRADY: Yes, the person chooses to call us.

CO-CHAIRPERSON EUGENE: But if the person doesn't call; do you have a follow-up method; do you call the person back to find out why you **[inaudible]**… [crosstalk]

FIODHNA O'GRADY: No, the Samaritans hotline is not designed like that…

CO-CHAIRPERSON EUGENE: Ah-huh.

FIODHNA O'GRADY: it's an emotional support line and it assumes that the person takes the responsibility to call us; it doesn't say that we are the panacea of all hotlines, but as we've been pointing out all day, the multiple points of entry and the multiple approaches you have; having a safe, anonymous, confidential hotline is one of the points of entry that are important for a community and that is also how our best evaluation of programs with the U.S. Army Force points that out -- having multiple points of entry, so having a confidential line and to have a follow-up line are both necessary; we happen

to provide the confidential, anonymous suicide prevention hotline.

CO-CHAIRPERSON EUGENE: So I understand what you're saying and I commend you, all of you for what you're doing to make a difference in the life of those people who are suffering from mental health issues. But when somebody is suffering from mental health issues, most of the time the person cannot control him or herself; [background comment] some of them, they don't know what they're doing; if you tell them to call back, they may call back; they may night call back, even if they have an urgency they may not call back; they need help… [interpose]

BRETT SCUDDER: So…

CO-CHAIRPERSON EUGENE: the have a need. So my question is that if this person is not stable, this person is in a moment of shock and tragedy and trauma and I don't know if the person is capable -- some of them; it can happen -- let's assume that the person is not in the mental state to call back, so how do you know what happened to that person? I'm sorry, you know, Miss… through the system do you have… you know, how do you have -- the person calls and you believe, you know, you think that the person,

okay, he'd not in danger; you say, okay, call back again, well probably that… we don't know what's happened to that… [interpose]

FIODHNA O'GRADY: Well all callers are invited to call back and because it is anonymous and confidential, we do not know who is calling back or not calling back; that is not the nature of the service. If you go to the doctor and you're also feeling that way or you're going to a hospital or emergency room, at some point, in all services, people have the right over their health and mental health and can call if they choose; we do not do follow-ups; that's not part of our service.

CO-CHAIRPERSON EUGENE: I do understand this is the way your system is set; that's okay; this is a good effort to service people, but I think that in medical services, and anything in life, we've gotta follow up to find out what is the situation of the person, where if we are successful of helping, you know making a difference in the life of those people, because our goal is to try to prevent suicide; our goal is to provide you know assistance to that person and to prevent that person to hurt himself or herself. So I think that would be a good

compliment, you know, for analysts, if it's a funding resources you know issue, but I think that would be a good addition to your program to add follow-up protocol or service, you know I think… I don't know if it's about resources, but I think that would be great -- you know this is a good service that you are providing, but that would be wonderful if you can add some type of follow-up, to find out exactly what happened to those people. This is just, you know, an advice.

FIODHNA O'GRADY: Thank you.

CO-CHAIRPERSON EUGENE: Yes, sir; I'm sorry; you wanted to say something… [crosstalk]

BRETT SCUDDER: Well… yes, I wanted to add to that. So how our hotline works is when someone calls us, we find where the person is and we try to go to that person; if the person is in an acute state of like, I'm about to kill myself, we have someone physical and meet with that person to try to be an intervention with that person. If we're distance apart from the person, we have difference people across the city who we work with and we train that we can get someone to that person in a very short period of time; we do follow-up with every

call; we do follow-up with every text message; every social media contact that we have we do follow-up. We have a lot of people who we have helped, who we have saved from killing themselves who volunteer to come back into our program to help, to be a voice to other people who are hurting. So in our hotline and how we work with that, we take every call very seriously in terms of building a two-way relationship -- we just don't want you to call and that be it; we want you to call so that we can follow up with you to see how you're doing, and that's how we operate on our hotline, because again, coming from the lived experience, I understand what you're saying and you're right; the person who is in pain may not be able to make that call or may just pick up that phone in an emergency to make that call and just be sitting there for two or three hours not saying anything; that person still is at risk, so how do we measure that risk, and sometimes the way we measure risk sometimes puts people more at risk because we may not think that they're at risk.

CO-CHAIRPERSON EUGENE: Alright.

FIODHNA O'GRADY: And if I might just add that we also have -- we can have the mobile crisis

unit sent as well and we work with the Department of Health and Mental Hygiene services in addition to 911.

CO-CHAIRPERSON EUGENE: Okay, thank you very much. Mr. Chair, do you have any questions? [background comment] Council Member Chin? Alright, thank you very much to each one of you. Thank you. [background comments]

Okay, Shakel [sic] McCooey, I think. Okay. John Timony. Alright. Grant Cowles, Craig… thank you very much. Thank you. [background comment] Yes, good news. Thank you. You need to swear them in?

COMMITTEE COUNSEL: Please raise your right hand. Do you affirm to tell the truth, the whole truth and nothing but the truth in your testimony before this committee and to respond honestly to council members' questions?

CRAIG HUGHES: I do.

COMMITTEE COUNSEL: Before you begin, please make sure you state your name for the record. Thank you.

CRAIG HUGHES: We'll start on this end, I guess.

Hi, I'm Craig Hughes; I'm the Policy Analyst for the Coalition for Homeless Youth. In short, the Coalition for Homeless Youth has advocated in New York City and across the State for the needs of runaway and homeless youth for about the last 40 years. We have 29 members in New York City. I'll be submitting written testimony, so I'll keep this short and quick and just hit some highlights.

It's regrettable that the City's main agency for overseeing homeless youth is not present today; the Department of Youth and Community Development are not here, which is tragic, given the crisis of youth homelessness in New York City. We don't have an accurate count of the number of youth who live on the street of the city, but the last reasonable and accurate count that was funded by the City Council about a decade ago -- before the financial crisis -- was somewhere around 3,800 youth on the street on any given night; there's reason to believe that number has simply grown, as homelessness has grown across the city.

So the City has taken some positive steps in regard to youth mental health for the runaway and homeless youth population -- there's been an

increased prevalence of trauma-informed care and there's been an increased focus on providing LGBTQ services, LGBTQ competent services, particularly the recent expansion, for the first time in the Department of Homeless Services, of 80 beds for LGBTQ youth. However, I just wanna very quickly mention some significant gaps.

First, we don't know how many youth there are that are living on the streets and that's because the City has not committed significant resources to making a count that is actually going to produce an accurate number be completed. The lack of an accurate number of course leads to a lack of significant resources; the City could make different decisions about counting homeless youth; it just doesn't.

Secondly, we know that homeless youth, because of the lack of shelter beds; the lack of access to permanent housing simply go in a circle; they are in youth shelters, they continue in the youth shelters; many of them simply disappear. If we take as a basic premise of health care in regards to mental health that housing is health care; we are systematically failing homeless youth in this city.

Homeless youth have no way out of the shelter system because the City has chosen, to this point, to not give homeless youth resources such as housing subsidies that are available to other homeless populations.

There is a desperate need for low thresholds or low-barrier drop-in centers for homeless youth living on the street; currently the City funds only one 24-hour drop-in center; given that New York City is a hub of the crisis of homeless youth nationally and is a major space where homeless come; only funding one 24-hour drop-in is simply not enough.

And I'll just simply end by saying that there is a need for more supportive housing. Again, if housing is health care, which we believe it is, the need for more supportive housing resources, particularly for youth who experience repeated [bell] mental health crises, is significant and one major issue there is ensuring that the City tracks why landlords and providers of supportive housing reject people who apply, which currently the City does not track. Thank you.

CO-CHAIRPERSON EUGENE: Thank you very much. Next one.

GRANT COWLES: Good afternoon, my name is Grant Cowles and I'm the Senior Policy Associate for Youth Services at Citizens' Community for Children (CCC). CCC is a 73-year-old independent, multi-issue child advocacy organization dedicated to ensuring every New York child is healthy, housed, educated, and safe. Thank you Chairs Cohen and Eugene for holding today's hearing and all the rest of the Committee members and the staff.

We appreciate all the effort that the de Blasio Administration has done to destigmatize teen mental health issues, including the 24/7 New York City Well Mental Health Hotline as well as the ThriveNYC initiatives. Youth mental health and youth suicide are critical issues for the City to pay closer attention to, for the many reasons mentioned that's in the data today. Also in the testimony I provide include more date around the importance of suicide awareness and training, bullying and mental health, and addressing those issues can prevent suicide.

We respectfully submit the following recommendations to help the City address bullying, mental health, suicidal thoughts, and suicide attempts:

1. CCC supports the establishment of an Annual Teen Mental Health Awareness Day in New York City. The resolution would make June 8th the annual day. While CCC fully supports creating this day, the City Council may want to consider choosing a day in May, which is Children's Mental Health Awareness Month, or earlier in the school year when the awareness activities can be better infused into the school curriculum.

2. Continue to invest and baseline the initiatives associated with ThriveNYC, including increasing treatment capacity. In 2012, CCC sought to estimate the gap between the need for mental health treatment slots and the number of treatment slots available for children. We found that an estimated 47,000 children 0-4 have a behavioral health problem and 268,000 children between 5 and 17 are estimated to have a mental health disorder. Through our analysis, in Brooklyn, Bronx and Staten Island, which was all that data was available for,

that only 1% of children 0-4 and 12% of children 5-17, there were slots available for these disorders.

3. Explore ways to enforce the Dignity for All Students Act so that schools are accurately reporting incidents of discrimination and bullying. We include several subrecommendations in the written testimony.

4. Work with the State to ensure a smooth transition into Medicaid Managed Care.

5. Work with the New York State Office of Mental Health Suicide Prevention to support the plans to advance suicide prevention in New York State.

The Suicide Prevention Office was created in 2014 to coordinate State-sponsored suicide prevention activities and we have some recommendations about how that can be done. And finally;

6. Consider investing in the creation of a program targeting self-esteem in adolescents as a preventive method to combat suicide.

And again, more information included in the written testimony. But we want to thank you all again for hosing today's important hearing on suicide prevention.

CO-CHAIRPERSON EUGENE: Next one, please.

SKAKEL MCCOOEY: Good afternoon. My name is Skakel McCooey and I co-founded Mental Health Matters, a teen advocacy group, with John Timony, 15 months ago.

I'd like to thank the two Committees and the two Chairs, especially Chair Cohen for being extremely receptive to our group since our last meeting last fall.

I'd like to preface my testimony by stating the obvious: neither John, my partner, nor I are experts in the field of mental health. Neither of us is a psychiatrist or psychologist. We are simply students going to high school in the 4th District of New York City. Despite our age and our lack of an advanced degree, however, I assert that our voice -- the voice of teenagers -- is fundamental to consider, especially regarding the issue of *teenage* mental health. And I thank you for giving us this opportunity to speak on our own behalf in support of this resolution.

At its core, that is what Mental Health Matters is; a self-advocacy group. We are a group of high school students between grades 10 and 12, who

attend various public, Catholic and private schools who deeply care about advocating for other high school students and, more generally, teenagers suffering from mental health issues in New York City. We have found that this self-advocacy, however, is not as commonplace as one could intuitively expect. More often than not, adults -- not teenagers -- spearhead campaigns to fight for teenage mental health issues. We hope that by creating a Teenage Mental Health Awareness Day on June 8th will prompt difficult conversations and will work to end the debilitating stigma surrounding mental health in our city and across our country.

In order to speak about exactly what type of self-advocacy we practice, I would now like to briefly recount our group's efforts since its inception. We began by speaking to an advising psychiatrist and soon thereafter established a social media presence posting interviews, pertinent news stories and selected quotations for our followers on Facebook and on our website.

More recently, we have begun to survey New Yorkers in a series of impromptu, non-scientific questionnaires. And I'll skip a little bit, but it's

all in the written testimony. The most interesting to our group, and indeed one of the reasons we have encouraged this resolution, is this common theme from our discussions. While everyone, to a person, considers mental health issues "extremely important," very few people were aware of the steps both the City and the State have made in addressing them. An awareness day would start to amend this gap in knowledge. It would allow people to seek out information given by ThriveNYC and a variety of other organizations.

One of my favorite conversations was with a woman we met on the Bridal Path in Central Park who said she had dealt with issues of mental health in her childhood. She said, "Discussing mental health is tough, but it really needs to happen." Simply, these discussions surrounding mental health and teenage mental health are a necessary hardship. I applaud and celebrate the strides made by those at ThriveNYC and indeed in this committee. This resolution is the next stride to take.

I'd like to thank all the Council Members for their time; it is truly my privilege and

responsibility to speak here today. [bell] Thank you.

CO-CHAIRPERSON EUGENE: Thank you very much each one of you for your testimony. I just want to thank you and for the service that you are rendering to the young people in New York City. Thank you for everything that you do every single day to make a difference in the life of all the New Yorkers who are suffering from mental health issues. Thank you very much. I don't have any questions. Mr. Chair.

CHAIRPERSON COHEN: If you don't mind, I have just two quick, I guess. In terms of homeless youth, I'm not clear how the interaction even works with DHS -- if I'm 15 years old and I show up at the shelter system, where am I sent; what takes place?

CRAIG HUGHES: Yeah, if you're 15 years old and show up at the adult shelter systems, so DHS' -- if you're a single person, you're gonna go to -- say you're a young man, you're gonna go to Bellevue or, you know, a 15-year-old, and they're gonna try, in theory, to find you a youth crisis bed or call ACS. Typically, you know, DHS covers 18 and over for singles, and of course families; the runaway and

homeless youth system administered by DYCD goes up to the end of age 20; most homeless youth in New York City are in the DHS and non-DYCD systems; the DYCD shelters unfortunately provide less than -- at last number that I saw -- less than 600 beds for the thousands of homeless youth in New York City.

CHAIRPERSON COHEN: And I do just want to acknowledge the work of Skakel and John really being very advanced advocates in terms of their commitment and really, reaching out to my office -- that's how we came into contact -- and your follow-through and I'm glad that this resolution is moving forward and I look forward to its ultimate passage. Thank you, Chair.

CO-CHAIRPERSON EUGENE: Thank you very much Mr. Chair. Can I adjourn the meeting?

CHAIRPERSON COHEN: This concludes this hearing. Thank you very much.

CO-CHAIRPERSON EUGENE: Thank you.

[gavel]

C E R T I F I C A T E

World Wide Dictation certifies that the foregoing transcript is a true and accurate record of the proceedings. We further certify that there is no relation to any of the parties to this action by blood or marriage, and that there is interest in the outcome of this matter.

Date May 8, 2017