NYC Commission on Human Rights

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Testimony of Dana Sussman
Deputy Commissioner for Policy and Intergovernmental Affairs
New York City Commission on Human Rights
Before the Committee on Civil and Human Rights and the Committee on Mental Health, Disabilities, and Addiction
December 12, 2018

Good morning Chair Eugene, Chair Ayala, and members of the Committee on Civil and Human Rights and the Committee on Mental Health, Disabilities, and Addiction. I am Dana Sussman, Deputy Commissioner for Intergovernmental Affairs and Policy, at the New York City Commission on Human Rights. Thank you for convening today's hearing on the important topic of the negative mental health consequences of discrimination and bias incidents.

As you are aware, and as my previous testimony before this Committee highlighted, the Commission surveyed over 3,100 Muslim, Arab, South Asian, Jewish, and Sikh (MASAJS) New Yorkers about their experiences with discrimination and harassment. The survey results were published in a report earlier this year. The report found high levels of bias harassment, discrimination, and physical assaults experienced by MASAJS communities leading up to and following the 2016 presidential election. The report also revealed that victims of such acts are reporting them at low rates.

The survey included two screening questions about depression associated with the survey takers' experiences with discrimination and harassment. The findings of the survey show that half of those who had been fired because of race, ethnicity, or religion selected answers that indicated depression (51.3%) compared to just 16.2% of those who did not. Those who experienced employment discrimination of any kind were more likely to screen positive for probable depression (33.8% vs. 15.1% compared to those who had not). Experiences of verbal harassment were also associated with increased odds of depression, with over one quarter of those who had been verbally harassed screening positive for probable depression compared to less than one in six of those who had not been harassed (26.2% vs. 14.4%) and with physical assault (36.7% vs. 17.0% compared to those who had not experienced physical assault). Discrimination in public accommodations (37.9% vs. 15.9%) and experiences of bias harassment and discrimination such as experiencing vandalism or property damage targeted at your race, ethnicity, or religion (37.1% vs. 17.0%) were also associated with depression. Among those who wore religious clothing, having it forcibly removed was associated with depression (36.6% vs. 21.1%).

As a result of these findings, the Commission has been collaborating with our colleagues at Thrive NYC to share the information we gathered from the report and to cross train staff. Commission staff trained Thrive NYC's Mental Health First Aid outreach team this past September, and we are currently working with Thrive NYC to plan an event with MASA leaders to discuss intersections of discrimination and depression as highlighted in our report. And the Commission is working with Thrive NYC to arrange a Thrive training for Commission staff. The City Human Rights Law allows for complainants to receive compensatory damages, including for emotional distress, for harm that they've experienced. In Fiscal Year 2018, 125 cases at the

Commission involved an award of compensatory damages, totaling $3,785,312 with an average compensatory award of $30,282, higher than any prior year.

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Thank you for convening this hearing today on this important issue. I look forward to your questions.

Testimony

of

Gary Belkin, MD, PhD, MPH
Executive Deputy Commissioner, Division of Mental Hygiene of the

New York City Department of Health and Mental Hygiene

before the

New York City Council Committees on Mental Health, Developmental Disability, Alcoholism, Drug Abuse & Disability Services and Civil and Human Rights

on

Negative Mental Health Consequences of Discrimination and Bias Incidents

December 12th, 2017
250 Broadway, 14th Floor Committee Room
New York, NY

Good morning Chairs Ayala and Eugene, and members of the Committees on Mental Health and Civil and Human Rights. I am Dr. Gary Belkin, Executive Deputy Commissioner for Mental Hygiene, at the New York City Department of Health and Mental Hygiene. I am joined by Dr. Aletha Maybank, Deputy Commissioner for the Center for Health Equity. On behalf of Acting Commissioner Barbot, we thank you for the opportunity to testify today on the mental health consequences of discrimination and bias.

For decades, discrimination and bias have eroded our ability to fully value and treat people fairly so that they reach life's full potential. Bias, harassment, and discrimination based on race, ethnicity, gender, sexual orientation, religion, and disability come in varying degrees of subtleness and violence. But even at their most subtle, these forces can shame, deny, traumatize, and by doing so ultimately threaten health and mental health.

Due to recent advances in research, we have begun to learn about the consequences of discrimination and, in the field of science, can explain their links to health over the life of an individual. A body of work now describes the weathering hypothesis, the process by which the cumulative burden of discrimination on the body and adverse childhood experiences, can have lasting physical harms that can lead to early disease and death.

Groups who have been discriminated against have historically been treated in ways that set values on who is deserving or not and in turn create limits for participation and opportunities in all aspects of society. Beliefs and practices reinforced by discriminatory behaviors, rooted in both explicit and implicit bias, work to negatively impact our understanding, actions, and decisions. The ongoing experienced objective reality of not being valued by our institutions, laws, and society affects individuals and communities alike and can be expressed in subjective reactions such as diminished self-worth, self-harm or violence against others, depression, impulsive and disrupted emotional coping and stress.

At the Health Department, we have begun researching how explicit and implicit bias affects the mental health of New Yorkers, including fielding our first survey to understand the impact of discrimination and harassment. This survey asked New Yorkers a series of questions including how often they experience racism, how often they were treated with less courtesy or respect than other people and how often they were threatened or harassed. We are still analyzing the results of this data, but preliminary review show that Serious Psychological Distress was more likely among adults who experienced racism, discrimination and harassment.

Additional data also supports the hypothesis that discrimination poses significant impacts on mental health outcomes. In New York City, LGBTQ youth are more likely than their non-LGBTQ peers to experience bullying and homelessness, placing them at greater risk of depression (twice as likely) and suicide attempts (more than three times as likely). Adults show similar trends. Nationally, nearly a third of LGB and half of TGNC adults show increased rates of depression – two to three times the rate of the general population.

We also must remember that individuals do not experience only one identity. People at intersections of multiple oppressions who most often experience high rates of health inequities

include LGBTQ people of color, especially persons of TGNC experience, and persons with justice involvement, report a greater incidence of mental health issues.

And when these New Yorkers seek mental health care, discrimination and bias also affect the care they receive. For example, studies have shown Blacks are five times more likely to be diagnosed with schizophrenia compared to Whites in state psychiatric hospitals even with the same symptoms. Similarly, LGBTQ individuals experience implicit bias when accessing mental health care, with surveys finding heterosexual providers' implicit preferences favor heterosexual people. Mental health services and systems play an important role in undoing structural racism and other discriminations. I am a psychiatrist, but I will readily admit my profession and much of mental health care has been slow to grapple with a history of racism and gender-and gender-identity bias and discrimination.

To begin addressing this history we must redesign how care is accessed and delivered and change our institutions. This work is happening across the Health Department, coordinated by the Center for Health Equity, and it is central to the Administration's mental health agenda as well. Through ThriveNYC we are challenging how mental health prevention and treatment can be done, by finding new pathways for care that are participatory, inclusive, and accessible.

One key approach used across many ThriveNYC initiatives is called task-sharing, which provides non-specialized community members with the skills to be part of the care pathways of mental health treatment and prevention that extend beyond the traditional treatment settings, into more familiar community settings and ways of thinking.

For example, ThriveNYC is partnering with local organizations and community members that are best positioned to understand and implement mental health solutions for their communities. Through the Health Department's Neighborhood Health Action Centers, sister agencies, community based organizations and faith leaders, we are focusing mental health initiatives and activities in communities that have been traditionally disinvested. The First Lady has been instrumental in launching Brothers, Sisters, and Latinx Thrive, which are volunteer efforts, working to promote mental health literacy in Black and Brown communities, and to empower and develop a more diverse and culturally relevant mental health workforce.

In schools, ThriveNYC in partnership with the Department of Education, has expanded training and coaching support for teachers and staff to help students and support healthy socio-emotional development and interpersonal resilience. Part of this work is training for school safety agents in Collaborative Problem Solving, De-escalation, and Restorative Justice Practices to make schools more welcoming and avoid unnecessary punitive practices such as suspensions and arrests that disproportionally affect students of color.

And in partnership with the New York Police Department, we have trained over 10,000 officers in Crisis Intervention Team training. We have also partnered with our public safety colleagues to develop teams that respond to behavioral health emergencies with clinicians, as part of a range of efforts to change the relationship between policing and communities.

ThriveNYC efforts have also focused on reaching communities experiencing bias based on gender identity and sexual orientation. This summer, the City released the LGBTQ Behavioral Health Roadmap. The report includes recommendations from health care providers, community groups, advocates, and public health experts. We are now working with our partners to implement these recommendations.

Finally, it isn't enough to change how mental health services are designed, institutional change is also needed to address the impacts of structural racism and gender-based biased. In 2016, the Health Department launched Race to Justice. This initiative engages staff in conversations about race, power, and privilege, facilitating trainings to improve staff capacity to undo racism and gender bias, and to recognize how explicit and implicit bias affects the decisions we make as a City agency. By applying a racial and social justice lens to all the work that we do, we can better prevent discriminatory actions or perpetuations. To date, the health department has trained over 80% of its staff on gender and LGBTQ equity, health equity, or racial equity and implicit bias.

Similar work is happening at several other city agencies thanks to the work of City Council who passed Local Laws 174 and 175 last year. These laws mandate that the Departments of Health and Social Services, and the Administration of Children's Services assess internal procedures as well as programs and services to better understand their impact on racial and gender equity. These laws also ensure that agency employees receive vital training in these areas.

We look forward to continuing our work of reform, both internally and in the larger mental health care system, to mitigate the effects and address the root causes of discrimination. Doing so has to be considered a part of any effort to improve the mental health of New Yorkers. Thank you again for the opportunity to testify.

We are happy to take questions.

URBAN JUSTICE CENTER

MENTAL HEALTH PROJECT

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

Oversight Hearing on the Negative Mental Health Consequences of Discrimination and Bias Incidents

Wednesday, December 12, 2018
250 Broadway, 14th Floor Committee Room
New York, NY

Testimony of
Urban Justice Center / Mental Health Project
40 Rector Street, 9th floor
New York, NY 10006

The Urban Justice Center Mental Health Project (MHP) is a non-profit organization based in New York City that works to enforce the rights of low-income New Yorkers with mental health concerns, with the belief that people with mental health concerns are entitled to live stable and full lives, free from discrimination. As advocates focused on serving low-income individuals with severe mental health challenges, MHP submits these comments to underscore our concern about the impact of discrimination and bias on mental health.

Our clients regularly experience discrimination based on their mental health conditions when seeking services from public agencies, such as HRA job centers and SSA field offices. These are places with which they must interact to address their basic needs. The discrimination they face exacerbates their experiences of anxiety and isolation, perpetuating a cycle of adverse mental health effects. For example, clients with "invisible disabilities" who have difficulty in cognitive processing are often met with callousness and impatience from HRA staff, who often use a condescending and disrespectful tone of voice. Rather than recognizing that there may be legitimate reasons why someone may need extra time to process information and respond, staff members are often short and dismissive, and fail to meet the needs of the individual.

Our transgender clients report experiencing adverse mental health effects due to the discriminatory and biased treatment they have faced when out in public. In a number of cases, our LGBTQ clients have been hospitalized due to psychological and physical trauma and mental illness incurred from physical abuse, both at a young age at the hands of family members, and later in life due to hate crimes. One client subjected to a brutal hate crime not only experienced cognitive impairments but psychological and emotional harm as well.

The Mental Health Project also advocates for people who are receiving mental health services while incarcerated in city jails. The impact of incarceration on the mental health of an individual is incalculable. Living in a New York City jail means living day and night under the constant threat of violence. It means separation from work, home, and loved ones in the community. For those who have survived trauma in their lives, which is the majority of our clients, incarceration means a return to fear, vulnerability, and the experience of victimization. Our clients report severe depression, anxiety, mood swings and, at times, psychosis as a result of being incarcerated, among other diagnoses and symptoms. This matters on a human level, but it also matters on a policy level, when we consider that the vast majority of people incarcerated in city jails are black, brown and low-income. In those terms, we can see that in the city jails, there occurs a daily mental health catastrophe which has discrimination, racism, and inequality at its roots.

Thank you for inviting us to testify on this important subject. We look forward to finding out how the City Council will address this issue.

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Testimony of Arab-American Family Support Center Before the New York City Council Committee Civil and Human Rights and Mental Health, Disabilities, and Addiction
Wednesday, December 12, 2018
Ghadeer Ady, Director of Family and Child-Well-Being, AAFSC

I want to begin by thanking the Committee on Civil and Human Rights, the Committee on Mental Health, Disabilities and Addiction, and the entire New York City Council for inviting community-based organizations to comment on the negative consequences discrimination and bias incidents have on our community members. My name is Ghadeer Ady and I am the Director of Child and Family Well-Being at the Arab-American Family Support Center (AAFSC). As such, I work directly with individuals experiencing stress, anxiety, and depression within targeted immigrant and refugee communities. I am honored to testify today on behalf of marginalized families throughout New York City.

At the Arab-American Family Support Center, we have strengthened immigrant and refugee families since 1994. We promote physical, mental, and community well-being; prevent violence; prepare families to learn, work, and succeed; and amplify the voices of marginalized populations. Our organization serves all who are in need, but over nearly 25 years of experience, we have gained cultural and linguistic competency serving New York's growing Arab, Middle Eastern, Muslim, and South Asian communities.

Arab, Middle Eastern, Muslim, and South Asian communities are under attack. This past May, AAFSC hosted the launch of the NYC Commission on Human Rights' report on discrimination against vulnerable communities in New York City leading up to and following the 2016 presidential elections. Many of our community members contributed to the findings in the report, sharing their personal experiences as victims of acts of hate and the results are disturbing. Nearly 40% of those surveyed reported being the victim of physical assault. One in four Muslim women who wear hijabs reported being intentionally pushed or shoved on a subway platform. Nearly 71% of those surveyed said they did not report the crime for fear of retaliation. Over a quarter of those verbally harassed also screened positive for depression. Even with these disturbing statistics, we know that the numbers are being underreported. We hear from community members every day about physical and verbal attacks made against them in a particularly xenophobic climate. We recently supported a young woman who was afraid to leave her home after someone on the street forcibly removed her hijab. Another community member experienced vandalism – the tires on his car were deflated and racial slurs were spray-painted across the vehicle. These community members are experiencing depression and anxiety and are being treated at our center.

In addition to a heightened risk for experiencing depression, immigrant community members face multiple challenges in accessing services, including language barriers, limited education and resources, and difficulty navigating an unfamiliar social service and health care system.

Understanding these compounded issues, AAFSC developed a Mental Health Initiative. We now have two mental health clinicians and three mental health specialists on site to offer services to youth, adults, and staff in a culturally and linguistically competent manner. Each case requires a high-touch point of service, with clients meeting clinicians regularly over a period of 9-12 months. Youth are particularly impacted by the rising levels of discrimination and hate.

Simultaneously, AAFSC partnered with the New York City Department of Health and Mental Hygiene (DOHMH) and Maimonides Hospital in Brooklyn to build community partnerships that will reduce stigma around mental health issues, expand access to treatment for vulnerable populations, and build a strong referral network for community members in need.

We can attest that the need remains great for additional mental health support in conjunction with a comprehensive response to the rise in rates of discrimination, bias incidents, and acts of hate.

In light of these observations, AAFSC:

- **Welcomes measures by New York City to ensure that all residents—regardless of race, ethnicity, religious background, or other status— are welcomed and treated with respect and that acts of discrimination and hate are not tolerated.**
- **Encourages efforts to lower health costs associated with accessing mental health services and supports further action to simplify the maze of health insurance regulations that leave so many families confused and under-resourced.**
- **Invites the City Council to join in partnership with AAFSC, NYC Department of Mental Health and Hygiene, Maimonides Medical Center Community Care of Brooklyn, and over 60 community stakeholders to reduce stigma, expand access to treatment for vulnerable populations, and build a strong referral network for community members in need.**
- **Respectfully requests that the City continue to include culturally and linguistically competent service providers like the Arab-American Family Support Center in conversations around community health, to ensure proposed solutions are fully inclusive and optimally designed.**

Thank you for your attention. As always, the Arab-American Family Support Center stands ready to work with you in ensuring the most vulnerable among us thrive.

The Committee on Civil and Human Rights and
The Committee on Mental Health, Disabilities and Addiction

Negative Mental Health Consequences of Discrimination and Bias Incidents

Testimony of The Center for HIV Law and Policy

Catherine Hanssens, Founder/Executive Director
Wednesday, December 12, 2018

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I thank the Committees for the opportunity to testify today. I also want to thank the Governmental Affairs Division, the Committees and their staff for the excellent briefing paper provided to frame this hearing. I am the Founder and Executive Director of The Center for HIV Law and Policy and have been working in the field of HIV law and discrimination for nearly 35 years. My comments reflect the experiences of people living with HIV who are on the margins and who, because they are low income, either rely on are disproportionately ensnared in the criminal, detention, foster care and publicly funded health care systems.

There is bountiful evidence of the impact of discrimination. We know that refusing someone a job, denying them access to a service, treating them differently in the criminal legal system or in the level of respect afforded them in the delivery of essential health care on the basis of their identity or disability does far-reaching damage beyond the already profoundly disturbing immediate one.[1]

Even if it weren't self-evident, the evidence of discrimination's impact on an individual's mental health also is well-established.[2] Studies show that perceptions of discrimination among Black, Latino and Mexican Americans not only have a measurable impact on mental health, but appear to be worse for immigrants the longer they are in the country, and the full weight of discrimination in this country hits them.[3] Experiences that teach and reinforce the self-perception that one is "less-than" is strong fertilizer for feelings

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[1] Patterson SE et al. The impact of criminalization of HIV non-disclosure on the healthcare engagement of women living with HIV in Canada: a comprehensive review of the evidence
Journal of the International AIDS Society 2015, 18:20572 http://www.jiasociety.org/index.php/jias/article/view/20572 | http://dx.doi.org/10.7448/IAS.18.1.20572

[2] R. Kessler, K. Mickelson, D. Williams, *The Prevalence, Distribution, and Mental Health Correlates of Perceived Discrimination in the United States,*40 J. OF HEALTH AND SOCIAL BEHAVIOR 208-239 (1999).

[3] *Self-Reported Discrimination and Mental Health Status Among African Descendants, Mexican Americans, and Other Latinos in the New Hampshire REACH 2010 Initiative: The Added Dimension of Immigration,* Gilbert C. Gee, PhD, Andrew Ryan, MA, David J. Laflamme, PhD, MPH, and Jeanie Holt, MS, RN.,96 Am J Public Health, 1821–1828 (Oct. 2006)

of self-loathing. For people living with HIV, that also translates into a disinclination to get into care or to stay in care after diagnosis.[4] For people with complicated lives and few resources to manage those complications, people who overwhelmingly are poor, Black, Brown, female or living with a host of other disabilities and issues, the anticipation of discrimination is enough to cause stress and the understandable decision to avoid yet another source of judgment and trauma.[5]

You already know that this is the case; as the briefing paper acknowledges, unconscious or implicit bias in healthcare is well documented, [6] and nearly 70% of individuals diagnosed with a chronic illness report that their ability to access health care has a great deal with who they are.[7]

The unconscious stereotyping of people's association to a group rather than as an individual is primarily a failure of the clinician to try and understand the patient based upon their own merits. Implicit bias has been shown to adversely influence medical and clinical outcomes and may manifest itself in everything from medication non-adherence on the part of the patient to missed diagnosis on the part of the clinician.[8] Just in the past year, I have done trainings and had discussions with medical and dental students who believe they have a right to refuse to treat a person living with HIV if they have a high viral load, and physicians who believe that a couple of missed appointments and a suspicion that a

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[4] *Perceptions and Impact of HIV Stigma among High Risk Populations in the US Deep South, Susan Reif, Elena Wilson & Carolyn McAllaster, Journal of HIV and AIDS (2018)*

[5] American Psychological Association "Stress in America: The impact of discrimination", March 10, 2016, available at: https://www.apa.org/news/press/releases/stress/2015/impact-of-discrimination.pdf, p. 8

[6] Blair, I.V.Ph.D., Steiner, J.F. MD, MPH and Havarnek, E.P. MD. (2011). Unconscious (Implicit) Bias and Health Disparities: Where Do We Go From Here? Permanente Journal, 2012, Spring; 15(2): 71-78. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3140753/

[7] Id.
[8] Id.

mother is breast feeding is enough to remove her children from her custody. Yet in every discussion I have ever attended about reducing disparities in treatment access, engagement and outcomes, I have never heard serious discussion of treating health care providers as part of the problem to be solved. To the contrary, and to an unfortunate degree right here in New York City, a number of prominent health care administrators and physicians continue to argue that the best way to get more of the poor and people of color in this city in HIV care is to reduce the amount of communication and patient engagement employed at the diagnosis stage. In view of the minimal nature of the requirement in the case of HIV testing, the objections to the inconvenience of speaking with patients ignore the other issues at play – a discomfort with talking about sex, a lack of trust in the capacity of disadvantaged patients to understand and make choices that work for them, and an inability to understand the extent to which distrust of providers affects decisions to access care.

I am heartened that the Briefing Paper concludes its discussion with observations about discrimination in the health care setting. As the authors of the Briefing Paper state, "Victims of discrimination, bias and harassment often internalize and normalize the behavior so that they come to believe that the are less worthy because of their characteristics."[9] Many people at risk, and even those who have been diagnosed, assume that they will not be treated with respect and that "the system" does not prioritize their best interests, and avoid health care as a consequence.

A basic but frequently ignored fact of life is that for individuals to do those things that require them to stay healthy, they need to believe that they have a life worth living.

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[9] Council of the City of New York, Briefing Paper of the Governmental Affairs Division, OVERSIGHT: NEGATIVE MENTAL HEALTH CONSEQUENCES OF DISCRIMINATION AND BIAS INCIDENTS (Dec. 12, 2018)

The persistent failure to recognize this in the field of HIV testing and care may be one of the most important contributors to ongoing racial and economic disparities in HIV care. While advocates typically advance proposals for reducing and now eliminating patient engagement and consent in testing decisions as a "stigma reduction" measure, the fact is that it is not the test, but the consequences of the test and the enduring distrust of health care professionals that drives the avoidance of testing and care. For example, a recent study in New York City, which arguably has one of the best arrays of competent LGBTQ-friendly service providers of any city in the U.S., found that a third of a cohort of sexually active gay men and transgender women had not tested for HIV and that expectations of stigma that accompany a positive test was a major reason for that avoidance.[10]

Recognizing discrimination's damage to mental health is important, as are services to address that damage. However, I hope that our primary goal here today is to make those services less necessary by focusing on new ways to identify and stop the daily onslaught of discrimination and indignities that people of color, women, seniors, people with disabilities including HIV and the poor experience. Despite the fact that racism in its many forms contributes to poor health outcomes, health professionals and policymakers have yet to employ concrete anti-racism measures to address persistent health inequities in the United States.

It is my hope that this hearing will inspire the creation of programs and policies that effectively reduce the human suffering, both in terms of new HIV infections and the quality of life, that is the direct result of unrelenting discrimination. We can start by considering

[10] The Impact of Anticipated HIV Stigma on Delays in HIV Testing Behaviors: Findings from a Community-Based Sample of Men Who Have Sex with Men and Transgender Women in New York City, Sarit A. Golub and Kristi E. Gamarel, AIDS Patient Care and STDs (2013).

the extent to which we have policies or laws that disadvantage these communities or treat them with the assumption that they are less than: less able to make their own decisions, less worthy of autonomy, less capable of understanding what's best for them in terms of health care and other life decisions.

A disturbing example of this is the proposal of health care providers and large ASO's who also provide health care to eliminate even personal notice that an HIV test is going to be administered, eliminating the very minimal requirement of telling a patient they will be tested and asking them if that's okay or if they would like to opt out. This small piece of communication, which is no more than what is provided before testing anyone for any significant disease, has been described by providers at places such as Montefiore Medical Center as a "significant barrier" to getting people tested. As one legal services provider told me recently, "the real reason that most people aren't getting tested is because medical providers are bad at talking about HIV/sex/drugs and just don't do it, so people don't get tested. The doctors and hospitals are failing to convince people to get tested so the solution is to just let the medical world off the hook and test everyone without their consent."

Even just a few specific, concrete commitments to action that can reduce the mental cruelty of discrimination could have a real impact. Examples are:

- Requiring regular trainings in cultural humility and capacity and patient engagement skills for all staff in hospital and clinical settings

- Universalizing patient feedback systems to rate systems and provider quality of services and provider's communication with/treatment of patient

- Incorporating ethics training in the treatment of patients with disabilities, including infectious diseases, as part of provider education, certification and CME requirements
- Increasing the role, and funding, of peer navigators and counselors to support patient engagement and monitor the cultural capacity of primary and ER care providers.

Thank you for your consideration of these comments.

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Testimony on the Negative Effects of Bias and Discrimination/City Hall/ 12-12-18

I am Jean Ryan, President of Disabled In Action. I am somewhat surprised, no very surprised that this hearing is being held because isn't it obvious that in many cases, maybe all, there are negative effects of bias and discrimination? I think the general public most likely thinks that bias and discrimination is acceptable in many cases. After all, people are bullied and discriminated against and thought of as lower class or dumb or someone to be left out in matters of appearance, race, religion, ethnicity, and, most definitely, disability whether it is visible or invisible.

I'm here to testify that people with disabilities are very negatively affected by bias and discrimination. It is so ingrained in our society that people with disabilities aren't capable of what everyone else is except for the people who are featured as being an "inspiration" and "overcoming" their disability like if you try hard enough, you can get rid of it! Most people with disabilities are trying very hard, but we face big odds. Our unemployment rate is high. It is hard to get hired if someone knows you have a disability. Employers are afraid they will have to make accommodations. Like I was told when I taught at Hunter College in the 90's: "If we do it for you, we'll have to do it for everyone." You're right you have to make needed accommodations and when you do, you get a very hard worker who is afraid of being fired just for being disabled. And most of the accommodations are cheap.

- In school, we have to do what is feasible because of access. I changed my major from teaching children to adults because the student teaching was not accessible. I couldn't do extra teaching because the janitor did not feel like turning on the elevators. Stories like this are legion. Often we have to use freight elevators to get to a doctor or other office. We're not freight!

- People with disabilities are judged by co-workers as well as by employers at work. We're seen as catching a break that no one else gets and unable to do a good job. But accommodations just level the playing field. We have to try to be perfect employees. Then when a nondisabled person becomes permanently or temporarily disabled, they feel like they have to downplay their problem or they'll join the club and be ill thought of, and they probably will be ill thought of and maybe let go. That's discrimination and bias.

- Meetings and fun events are held in inaccessible places with inaccessible restrooms. Oh, it's just one step, we'll hear. I spent most of my time during my 10 years on my community board talking about accessibility because I couldn't even get into some meetings, and forget about an accessible restroom.

- Try going to the annual holiday party and getting there and you're the only one who cannot enter!

- People with low-vision or who are blind are not given computers they can use at work or are not given special training to use the special equipment or software. Someone was threatened

with firing because of needing special computer training which would certainly make him a better worker.

- Blind people and people with developmental disabilities are evidently thought not to need money so they are paid very little at so-called sheltered workshops. That's discrimination and exploitation.

- People with mental illness are not tolerated or integrated and do not receive necessary treatment and accommodations.

- Strangers make comments about us speeding or riding on our laps and people think it is funny.

- Complaints are made about us getting on express buses because people think they'll be late to work because the bus lifts are complicated and not maintained well and the drivers don't know how to operate them. How is that our fault? We need to get places, too!

- We fought for years to get into City Hall not through the basement and have an accessible restroom.

- We fought to get the cobblestones filled in so we could get to City Hall. We are going to push for a safer City Hall area by the steps because after I have seen 2 scooter/wheelchair users fall off the ledge on a sunny day, it is clear that something needs to be done.

- It is apparently acceptable to think that because the subway system is old, people with mobility disabilities don't need to use the subway. And if it is brought up, excuses are always made about it costing too much money. After all these years, that is discrimination.

Do these things have a negative effect on the person it happens to and their friends and colleagues who are also disabled and their families? Of course. We want change, and that's why our organization has been around since 1970.

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NYLPI
40 YEARS OF JUSTICE

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December 12, 2018

Testimony of Lauren Quijano

On behalf of New York Lawyers for the Public Interest

Before the New York City Council's Committee on Civil and Human Rights and Committee on Mental Health, Disabilities and Addiction

Greetings. My name is Lauren Quijano. I am the Community Organizer for the Health Justice Program at the New York Lawyers for the Public Interest (NYLPI).

On behalf of NYLPI, I thank Councilmembers for conducting this hearing.

NYLPI is a non-profit organization which advocates for civil rights. We aim to address systemic issues communities face and emphasize the active role members of those communities play in addressing such issues. For the past 40 years, NYLPI has been a leading civil rights and legal advocate for New Yorkers marginalized by race, poverty, disability and immigration status. NYLPI's Health Justice Program brings a racial justice and immigrant rights focus to health care advocacy in New York City and State. We provide expertise through our Immigrant Health Initiative, utilizing individual and systemic advocacy to improve immigrant access to healthcare, including for those in immigration detention facilities who should not be in detention centers in the first place. We also are looking to work ahead in addressing mental health crisis and

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supporting community organizations long fight to implement alternatives to policing including having health workers be first responders to 911 calls as opposed to the police being dispatched.

Discrimination and bias through a racial-justice lens is recognizing a system that is inherently set up to disproportionately target and negatively impact Black and Latino communities and immigrant communities of color. Policing in these communities, including the community where I live, is a major problem. Even as I reflect on the work that we do in immigration detention advocacy, we cannot say that we are for ending detention without addressing the increasing levels of policing in communities that put people in contact with the criminal system in the first place. Discrimination and bias in housing, healthcare, access to counsel, education, and employment are all issues that the advocates and community organizers of my organization see our clients having to face every day.

Mental health services are trying to address issues that people have human rights to. These human rights not being realized is what are causing the ever-increasing need for more mental health services in the first place. The human right to healthcare, education, stable employment, food and water. All these necessities for human life is required, at NYLPI we try to address some of the issues having a huge impact on communities, including issues of transportation, lead in water, mold and asthma, among many other issues. A huge function of that is mental health.

When I see lack of access to healthcare for our clients, I see a lack of prioritizing human life. I see more efforts being made to privatize everything from housing to healthcare. Then once

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everyday people draw attention to this matter in a public way, they are faced with policing. Policing in their neighborhoods, in schools, in healthcare settings, even in their own homes.

The priorities are so blatant when the advocates are calling for training the police and funding is routed towards training the police as opposed to providing mental health services for those who need them the most. As opposed to having community members and health workers who understand the community members and identify with the stresses of not having basic human rights realized responding to people experiencing mental health crisis, the police are still responding. A few months ago, NYLPI filed a FOIA to access full body camera footage from the police in the shooting of a man in his own home, a man who had a mental illness. Whether the police are trained or not has been both a political and fiscal priority of the city, and not enough attention has been going to what community needs including mental health support. This affects Black and Latino communities, for those who are undocumented and those who are documented. As a community organizer, it leaves myself and my community confused as to why we are having to fight and advocate for people's rights in a system that is inherently racist. This is what I experience outside my workplace and there is fluidity in my work where this also affects particular workforce that I support and advocate for. We cannot leave things outside of work, regardless of our best ability to do so.

For example, at NYLPI we are mindful of when photo identification is going to be required for a client to have access to a building where a meeting will be taking place. The requirement for photo identification can cause nervousness for a client prior to a likely very important legal

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meeting regarding their case. This is especially important for any meetings pertaining to someone's individual immigration case, along with other needs such as access to healthcare and mental health services. The same issue goes for language access for clients who are Limited English proficient or need other accommodations to communicate needs and demands. Yet when I am hearing about immigrants' rights to healthcare and other human rights as being too ambitious to pursue, that makes me question the very existence of my family and myself being in this country, in this state, in this city as an advocate for its citizens.

Through our work at the intersection of immigrant and health justice we have witnessed firsthand the negative impact on the ability of marginalized communities to access services, including vital healthcare, that have been a direct result of policies that target and undermine Black and Latino and immigrant communities from thriving. The immigration detention centers and county jails where ICE contracts at the end of the day are the same jails, arrests facilitated by the same police force, and the bodies that fill them are our community members who have always had difficulty accessing services that are supposed to secure their basic human rights. Our work acknowledges this harsh reality and we look forward to advancing the advocacy efforts of communities who have been demanding change to survive. I look forward to answering any questions that you may have about NYLPI's work.

Testimony

I am here today to talk about the internal discrimination and isolation that members of Orthodox Judaism experience by members of their own tribe when they publicly do not conform to their standards. These biases create conditions that are conducive to declined mental health. The lack of formal complaints does not reflect the actual number of these discriminatory instances because many do not speak out due to fear.

My mother is a licensed psychologist and is one of the directors of the Mental Health Counseling Program at Brooklyn College. From a young age, I have heard her talk about certain buzzwords like therapy, catharsis, growth, culture, identity, self-expression, authenticity, etc.... From a young age, I was extremely aware that psychological health was as important as physical health.

Being a member of the Jewish Orthodox community has many advantages. We are close-knit tribe that looks out for one another. There are hundreds of organizations that are set up to ensure that the community continues to thrive and has all the necessary resources to be helped from within the community, rather than having to seek it outside, from a world that does not understand the Jewish mindset and conditions and sensitivities.

But in this space of wonderful connection amongst brothers and sisters exists a significant faction that struggles with unaddressed mental health issues due to the constraints of conformity.

What some males experience as elation from joining a congregation to engage in prayer, others experience as a feeling of pressure to put aside some aspects of their individuality for the sake of camouflaging within the greater whole.
What some girls experience as a feeling of belonging in a classroom of girls who dress and act all within a similar manner, others feel as though their identity is being determined for them, before they had a chance to choose an identity for themselves.
What some parents experience as a feeling of gratitude for having children in a school system that instills the values of Judaism, others feel as though they have to undo some of the messaging that their children come home repeating.
What some women experience as pride for being in a community that values modesty to the point that it excludes female representation in printed media, others feel objectified and sexualized and are uncomfortable with their sons and daughters picking up on those signals.

If you find yourself on the former side of these previously stated situations, you will experience the most magnificent and enchanting life full of meaning and belonging. But if you find yourself on the latter side, even in one area, you are unquestionably going to experience feelings of isolation, shame, and guilt. The community thrives on conformity and requiring members to fit into a box. There is no space for someone

to color outside the lines. Those people who do are often shunned by their teachers, families, and clergy.

There are some supportive spaces like a small wreck room for kids who might be a little lost, to play pool with their friends, and there might be a school that is more accepting of girls who are experimenting with their sexuality or with drugs, but none of these spaces are considered sanctimonious. It is perceived by the former parts of the community as a place for rejects and misfits who couldn't handle it. Who couldn't recognize the beauty. Who are sick in the head. Who are the products of dysfunctional homes. And very often these individuals leave the community completely and are not rehabilitated to the impossible standard of the community.

There are concepts ingrained from a young age called Chillul Hashem, Mesira, Lashon Hara. The stated explanations for these philosophies is to not invite anti-semitism into the community, but it's actually used as a way to gag and control and keep a lid on internal problems. This tactic has been used to protect pedophiles and criminals and not enable positive change within the community by keeping abuse of power from becoming public. The Jewish community needs a network of support so that they can file complaints regarding gender and sexual discrimination without the risk of them being ostracized by their own community.

Many Orthodox Jews have a personal story to share of how they sacrificed their identity or how their identity was judged to the point of it challenging their mental health, but most will never do so under the fears of rejection and isolation. You will never hear most of these stories because of the internal pressure that is exerted from a very young age. We know it's impossible to quash the human spirit, so the only thing that is accomplished by the discrimination tactics is that people end up leading double lives. They are closed off from the support systems that are needed.

I am a lone public crusader who deals with hate and threat, just because my heart goes out to those who need someone to make them feel like they're not so crazy. And that they're not alone. I run an Instagram account under the name FlatbushGirl and I have 45K followers, 90% of whom live in New York. Their user activity is completely inactive on Saturdays, indicating that they are Orthodox and Sabbath Observant. These are people who love Judaism and its practices, but are frustrated. The message of frustration within the community resonates with them.

Over the last few years I have received thousands of personal, gut-wrenching stories. Many were shared anonymously, out of fear of the word getting out in our small, tight-knit community:

"I grew up my entire life being forced to dress and act and do things that I didn't connect with. I grew up hearing the Jews around me say horrible things about anyone who didn't fit into their idea of what a Jew should look like. I never felt like I fit in. As I got a bit older I started doing what I wanted but I was so sickened and turned off by what I went through as a child that it ruined religion for me and in addition my mental health. I went through so much trauma growing up, in the religious school system and religious neighborhoods. What I went through ruined every part of me.

I now suffer from anorexia, I'm pretty sure I'm asexual although I wasn't always such, and I have automatic negative feelings towards religious Jews that I can't control even when they haven't done anything wrong to me, all because of the kinds of things you've described that go on in the Jewishy kinds of communities"

"Hi adina! I really appreciate it that you are speaking out ! I would like to bring something to your attention i live in Monsey and in the chasidisha world women are not allowed to drive i feel i am in prison my husband doesn't mind that i drive its the schools that don't accept your kids if you drive i personally am afraid to drive becuase then my kids won't have a school the more litvish won't accept me if i left the "system" so i am stuck ! I do take taxis but what's the limit i cant go far or just run away for a few hrs ....."

There are thousands of ways in which the Jewish community can experience discrimination and bias from external sources i.e. non-Jewish offenders. But my experience and testimony is mostly focused on the ways in which this group can be discriminated against from within. These discriminations are incurred by Jewish establishments with religious standards and rules. Some of these include synagogues, schools, newspapers, and even restaurants.

In Synagogues:

- Warning letters are sent to female congregation members who are violating the length of wig, skirts, and other specifications of modesty.

In Schools:

- Children are removed from schools in situations when
    1. students are engaging in unsupervised conversation with the opposite gender
    2. students went to a westernized establishment like a movie theater
    3. students are experimenting with recreational drugs off of school grounds

In Newspapers:

- Editors will reject any advertisements that feature the face or silhouette of a female, even a young girl.

In restaurants:

- As I have just experienced first hand, restaurant owners are threatened by kosher certifiers that they will lose their kosher stamp of approval if they
    1. have TVs playing in the restaurant
    2. have radio playing in the restaurant
    3. host events that are led by anyone who might be gay

4. allow mixed seating in non-family oriented events

I ask that you please consider ways in which such reporting can be done safely and anonymously for members of the Orthodox Community so that the fear tactics instilled in us from a young age can be combatted. With your support and resources, those suffering from mental health issues as a result of discrimination from within the community can come forward to ask for help to hold these institutions accountable without the fear of being ostracized forever.

Thank you for your time.

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STATEMENT OF
ALBERT FOX CAHN, ESQ.
LEGAL DIRECTOR
COUNCIL ON AMERICAN-ISLAMIC RELATIONS, NEW YORK, INC.

BEFORE THE COMMITTEE ON CIVIL AND HUMAN RIGHTS AND THE COMMITTEE ON MENTAL HEALTH, DISABILITIES AND ADDICTION
NEW YORK CITY COUNCIL

FOR A HEARING CONCERNING
OVERSIGHT – NEGATIVE MENTAL HEALTH CONSEQUENCES OF DISCRIMINATION AND BIAS INCIDENTS

PRESENTED
WEDNESDAY, DECEMBER 12, 2018

Good morning, my name is Albert Fox Cahn, and I serve as the Legal Director for the New York Chapter of the Council on American-Islamic Relations ("CAIR-NY"). CAIR-NY is a leading civil rights advocacy organization for the Muslim community here in New York City and across New York State. Today, I am proud to testify in continued support of our colleagues at the New York City Commission on Human Rights (the "Commission") and their indispensable work to counter discrimination, harassment and bias, and to call attention to the widespread and troubling negative mental health consequences of these incidents. I also thank and applaud Chairs Eugene and Ayala for calling today`s hearing on this vital topic.

New York City faces few tasks as urgent as countering the surge in ethnic and religious discrimination that CAIR-NY battles each and every day. The reality is stark. According to CAIR-NY's data, from 2015 to 2017, anti-Muslim harassment, discrimination, and hate crimes increased a staggering 974%.[1] Behind each of these statistics is a heartbreaking story; lives forever changed by hate. New Yorkers who are fired for simply asking for a place to pray during their breaks, or who have to endure abuse and degradation for wearing a beard or head-covering.

But that nearly ten-fold increase fails to capture the stories of so many who continue to suffer in silence. According to the Commission's June report documenting bias harassment and acts of hate against Muslim, Arab, South Asian, Jewish, and Sikh New Yorkers, 71% of targeted New Yorkers never report harassment or discrimination. This sort of survey is an indispensable tool for advocates, helping us document the landscape of harassment and discrimination; helping show the scale of the problems we face. The Commission's landmark survey also found that nearly one in five Muslim women report being intentionally shoved on subway platforms, and one in ten Muslim New Yorkers are blocked from practicing their faith in the workplace, as the law allows.

This climate is truly unprecedented, as we witness elected officials at the highest levels of the federal government normalize anti-Muslim bigotry. Tellingly, half of the hate crimes we recorded in New York in 2016 took place in just the final seven and a half weeks of the year, immediately following the Presidential election. Additionally, the last years saw the growth of anti-Muslim hate groups, which nearly tripled in 2016 according to the Southern Poverty Law Center (SPLC), and have continued to increase another 13% through 2017 to a total of 114 hate groups.[2]

President Trump's anti-Muslim and anti-immigrant rhetoric has driven countless New Yorkers into the shadows. Discriminatory policies like the Muslim Bans and repeal of the Deferred Action for Childhood Arrivals ("DACA") make many undocumented Muslim victims unwilling to report their crimes. More directly, the fact that U.S. Immigration and Customs Enforcement's ("ICE's") have expanded enforcement in sensitive locations, such as schools, hospitals, and even courthouses, has made it much harder for community-based organizations to convince clients to pursue justice by reporting their incidents to law enforcement or the Commission. Even though we can reassure clients

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[1] The 974% figure is obtained by combining the 2016 and 2017 data reporting 560% and 74% increases in anti-Muslim bias incidents. *See* CAIR-NY Press Release, dated May 9, 2017, available at http://www.cair-ny.org/news/2017/5/10/press-release-civil-rights-report-2017 [2017 CAIR Civil Rights Report]; CAIR-NY Press Release, dated March 5, 2018, *"CAIR-NY Reports 74% Increase in Anti-Muslim Hate Crimes Since Trump's Election"*, available at http://www.cair-ny.org/news/2018/3/5/cair-ny-reports-74-increase-in-anti-muslim-hate-crimes-since-trumps-election [2018 CAIR-NY Hate Crimes Report].

[2] Southern Poverty Law Center, Anti-Muslim Groups 2010-2017, available at https://www.splcenter.org/fighting-hate/extremist-files/ideology/anti-muslim.

that city officials won't ask about immigration status, we must admit that ICE has targeted witnesses and victims before.

This new enforcement paradigm creates opportunities for criminals and harassers to target immigrant communities. We've seen reports of merchants who refuse to deliver merchandise and threaten to report their victims to immigration officials. While we assist some of these victims with reporting their experience to city officials, all too often the victims are too scared to do anything, fearful that the person who targeted them will make good on their threat to call ICE.[3] Such immigration concerns are only relevant to a small subset of the Muslim community, but it is the same subset that is disproportionately the victim of hate crimes and harassment.

These facts, together, have a substantial chilling effect on the reporting of discrimination and bias incidents. Victims fear that they might be deported simply for reporting a crime that has been perpetrated against them. We are deeply concerned by the lasting mental health impacts on victims. Not only will victims continue to live in fear of further discriminatory treatment or harassment, given that the perpetrators of these crimes face no consequences, but they feel helpless and revictimized by the inability to secure justice.

Even when people do report these incidents, they are often turned away. At CAIR-NY we often hear from people who, after having made the brave decision to report a crime perpetrated against them, have been turned away with little explanation. This minimizes their experiences and trivializes their pain. A consequence of such discriminatory treatment is a feeling of hopelessness and exclusion. These victims are made to feel that their pain does not matter, simply because of who they are, their ethnicity or religion. This heartbreaking truth is exceedingly demeaning for the victims involved. It will necessarily have negative consequences for the mental health of those whom, at great personal risk, come forward to seek the vindication of their rights – rights that our Constitution guarantees, without exception, to every person.

It's impossible to discuss the experience of Muslim hate crime victims without discussing the reality of widespread and discriminatory surveillance. For years, NYPD targeted majority Muslim communities and Muslim families with unlawful and unconstitutional surveillance.[4] It spied on entire mosques[5] and labeled some local businesses as "place[s] of concern" just because they had customers of middle-eastern descent.[6] As a result, many Muslim New Yorkers have felt the need to self-censor their religious practices. This ongoing legacy of surveillance has made many survivors of harassment and hate crimes unwilling to come forward to the same authorities that systematically target their communities.

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[3] Jennifer Medina, Too Scared to Report Sexual Abuse. The Fear: Deporation, N.Y. TIMES, April 30, 2017, *available at* https://www.nytimes.com/2017/04/30/us/immigrants-deportation-sexual-abuse.html

[4] Matt Apuzzo & Joseph Goldstein, New York Drops Unit That Spied on Muslims, N.Y. TIMES, Apr. 15, 2014, https://www.nytimes.com/2014/04/16/nyregion/police-unit-that-spied-on-muslims-is-disbanded.html?_r=0; see also DIALA SHAMAS & NERMEEN ARASTU, MUSLIM AM. CIVIL LIBERTIES COAL., CREATING LAW ENF'T ACCOUNTABILITY & RESPONSIBILITY & ASIAN AM. LEGAL DEF. & EDUC. FUND, MAPPING MUSLIMS: NYPD SPYING AND ITS IMPACT ON AMERICAN MUSLIMS 10 (2013), *available at* https://www.law.cuny.edu/academics/clinics/immigration/clear/Mapping-Muslims.pdf.

[5] Apuzzo & Goldstein, *supra* note 8

[6] Adam Goldman & Matt Apuzzo, NYPD: Muslim Spying Led to No Leads, Terror Cases, ASSOCIATED PRESS, Aug. 21, 2012, *available at* https://www.ap.org/ap-in-the-news/2012/nypd-muslim-spying-led-to-no-leads-terror-cases

Not even children have been exempted from the dragnet. New York's Muslim Student Associations have been targeted with informants and undercover officers for as little as organizing a rafting trip,[7] or having members deemed "politically active."[8] This chilling surveillance causes self-censorship and disengagement by many students. According to a Muslim student at Hunter College, many feared that they would be spied upon for political engagement.[9] A CUNY student said that she did not know who to trust anymore.[10] At Brooklyn College, following disclosure of on-campus surveillance by NYPD, attendance of Islam Awareness Week events plummeted.[11] One CUNY student withdrew from Muslim Student Association events after police came to his home to question him about his political opinions.[12]

While the worst documented abuses may reportedly-ceased with the disbandment of the NYPD's "Demographics Unit," many Muslim students still fear to speak in class about political issues, worried that they will be misinterpreted and investigated.[13] Younger students have not been immune to this. Some educators have sought Know-Your-Rights workshops to quell student fears of surveillance for children as young as eleven.[14] The NYPD's surveillance practices remains a structural barrier for Muslim New Yorkers who wish to vindicate their rights against discriminatory harassment. All this even though many of the most invasive NYPD programs never produced a single lead, let alone have stopped a terrorist act.[15]

We know that government surveillance heightens stress, fatigue, and anxiety; fosters distrust; and reduces our sense of personal control.[16] As illustrated by the experiences of Muslim college students across the city, being subject to a surveillance regime can impact a one's ability to form healthy and meaningful relationships with other people. Limiting open social interaction will inevitably erode mental health.

Perceived and actual surveillance is deeply detrimental to a person's mental health. It curtails where they go, whom they interact with, and what they say, robbing New Yorkers of the autonomy to make everyday choices without fear of adverse repercussions. In addition, surveillance impacts a victim's self-perception, breeding a sense of otherness; "Why am *I* being watched"?

Thank you for giving me the opportunity to address these urgent issues. I look forward to working with the Council to combat the discrimination and structural biases that Muslim New Yorkers face.

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[7]Chris Hawley, NYPD Monitored Muslim Student All over Northeast, ASSOCIATED PRESS, Feb 8. 2012, *available at* https:// www.ap.org/ap-in-the-news/2012/nypd-monitored-muslim-students-all-over-northeast.

[8] 6 N.Y. POLICE DEP'T, NYPD INTELLIGENCE DIVISION: STRATEGIC POSTURE 2006 17 (2006), *available at* https://www.nyclu.org/sites/default/files/releases/Handschu_Exhibit7b_%28StrategicPostureredacted%29_2.4.13.pdf.

[9] Shamas & Arastu, *supra* note 8, at 23

[10] *Id.* at 42.

[11] *Id.*

[12] *Id.* at 43.

[13] *Id.* at 44-45.

[14] Id. at 43.

[15] Goldman & Apuzzo, *supra* note 10

[16] Chris Chambers, *NSA and GCHQ: the flawed psychology of government mass surveillance*, THE GUARDIAN (Aug. 26, 2013), *available at* https://www.theguardian.com/science/head-quarters/2013/aug/26/nsa-gchq-psychology-government-mass-surveillance

The New York City Council
Committee on Civil and Human Rights

Re: Discrimination and Mental Health

Testimony presented by Dr. Marisa Franco, Professor of Psychology

Hello to members of the committee and others who are joining us today. My name is Dr. Marisa Franco and I am a professor of psychology. My research program focuses on racial discrimination and its negative impact on mental health and I am here to present information on this topic. I appreciate the opportunity to speak at this hearing and want to thank the New York City Council Committee on Civil and Human Rights.

I would like to start by defining racial discrimination. Racial discrimination is defined as negative or unfair treatment based on race but it comes in various forms. A leading research on racism and its health effects, Shelley Harrell (2000) indicates that there are six different forms of racism that affect mental health: racism-related life events, vicarious racism experiences (i.e., racism experienced by other individuals in one's racial community), daily racism microstressors (or microaggressions—subtle slights that convey devaluing, such as being ignored), chronic contextual experiences of racism (or what's known as institutional racism—unequal distribution of resources and limited opportunities due to a history of racial injustice), collective experiences of racism (or experiences that convey that one's group has a lack of power in larger society, as evinced by stereotypical portrayal of one's group in the media, and lack of political representation), and last, transgenerational transmission of group traumas (stories of trauma such as slavery and intermittent that are passed down by generations). Thus, Harrell outlines that discrimination can be both subtle and blatant and also occur at different tiers: interpersonally and institutionally. I outline each of the ways that discrimination manifests to encourage the council to consider addressing discrimination in multiple forms.

I would now like to present a short overview of major studies that link discrimination to mental health. A study with over 3000 racial minorities found that racial discrimination related to a number of mental health issues, including major depression, panic disorder with agoraphobia, agoraphobia with history of panic disorder, post traumatic stress, and substance use (Chou et al., 2012). A meta analysis is a study that integrates findings across multiple studies. A meta analysis combining findings from over 18,000 Black people found links between discrimination and anxiety, depression, and psychiatric symptoms (Pieterse, Tood, Neville, & Carter, 2012). Another meta analysis combined findings from 32 studies on racial discrimination and found that both subtle and blatant forms of discrimination negatively affect mental health and to similar degrees (Jones, Peddie, Gilrane, King, & Grey, 2016).

To understand why discrimination affects mental health, I would like to refer to minority stress theory, developed by Ilan Meyer in 2006. This theory has been supported by multiple research studies. According to this theory, discrimination provokes a certain state of mind in the stigmatized. First, as Shelly Harrell (2000) indicates "the stress of racism lies not only in the specific incident, but also in the resistance of others believing and validating the reality or significance of one's personal experience (Harrell, 2000, p. 45). Thus, constant rumination as to

the discriminatory experience along with invalidation as to the weight of the discriminatory experience is one of the ways discrimination's effect on health lingers. Discrimination can also lead individuals to be "hypervigilant"—that is, chronically weary of rejection in the future. This finding is supported by my research that finds that Multiracial individuals experiencing more discrimination had fewer White friends, and also less satisfaction with their friendships and community. When minorities are discriminated against, they may avoid further interactions with the dominant group because of fear of experiencing further discrimination. Discrimination is, at its core, exclusion, and thus leads to a sense of loneliness and alienation. Minority stress theory also indicates that negative experiences become internalized wherein the individual begins to see themselves more negatively as a byproduct of negative reactions from others: perceptions from society are incorporated into how the individual sees themselves. Last, individuals undergoing discrimination may expend ongoing mental effort in monitoring themselves as to not provoke further discrimination. For example, a Hispanic individual may no longer speak Spanish in order to avoid harassment from others for using their native tongue. All of these examples are pathways through which discrimination affects mental health, and also these pathways explain why just a single instance of discrimination can provoke ongoing mental health struggles.

I want to call for research-based intervention programs that address the impact of discrimination on mental health. Generally research supports that having pride in one's racial identity is protective against discriminatory experiences (Brown & Tylka, 2011; Neblett et al., 2008). Thus, interventions should focus on instilling pride in minority group members regarding their racial group status. This can be done by emphasizing the historical contributions, uniqueness, and resilience of the group. Secondly, given that racism contributes to a sense of loneliness and alienation, it is important for individuals undergoing discrimination to be able to seek out community. Research supports that individuals from marginalized groups benefit from cohesiveness and close connections with other individuals undergoing similar experiences of discrimination (Branscombe, Schmitt, & Harvey, 1999).

Ultimately, however, solutions that mitigate the impact of discrimination on mental health will be most effective if they focus on the individuals perpetrating discrimination so that discrimination does not occur in the first place. Given that discrimination is often subtle and the perpetrators are unaware that they are acting in a racially biased manner, implicit bias training—which encourages awareness of subtle racial biases— may be helpful. Researchers Emerson and Murphy (2014) outline a number of "situational cues" that demonstrate safety for individuals from marginalized groups. These cues include having a critical mass of individuals from minority backgrounds who are also in high status positions, diversity statements that emphasize valuing difference among employees, and a collaborative racially diverse workgroups wherein each individual within the group has equal power. Last, policy that addresses continuing institutional racism and grants minorities equitable access to healthcare, education, and housing is critical for sustainable change.

Thank you again for the opportunity to testify. I will also be sharing a toolkit created by psychologists that includes tips for people of color coping with discrimination.

Dr. Marisa Franco

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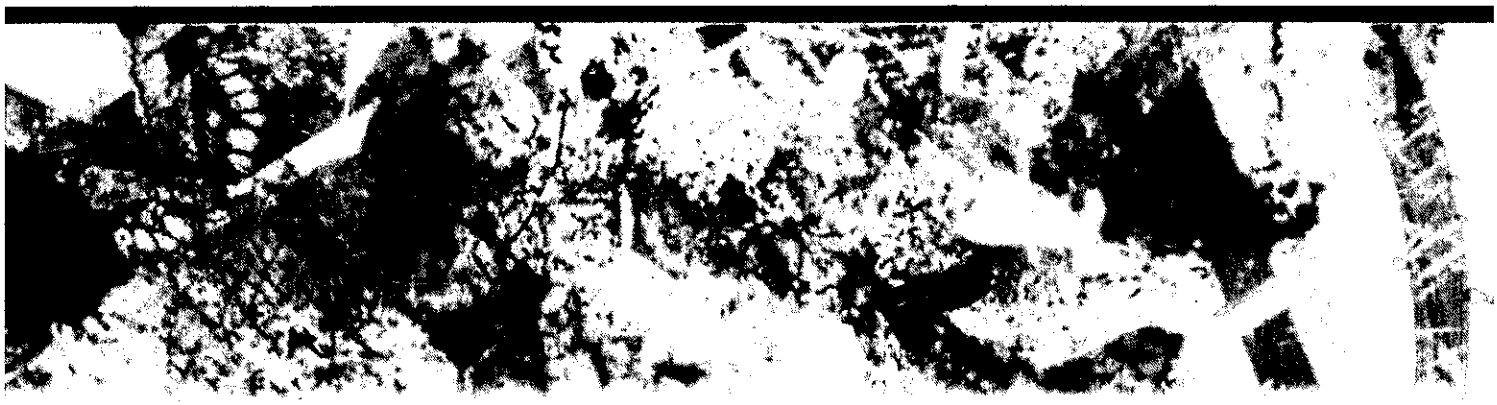

Surviving & Resisting Hate:

A Toolkit For People of Color

#ICRaceLab

Dr. Hector Y. Adames & Dr. Nayeli Y. Chavez-Dueñas

1. Stay physically and psychologically healthy, by eating healthy, sleeping (7-8 hours a night), taking breaks from social media, and staying physically active.
2. Stay connected to individuals, communities, and organizations that affirm your humanity.
3. Listen to your gut and remember that a healthy cultural suspicion (suspicion of white supremacy, people and systems they created) has allowed People of Color to survive during the darkest times of our history.
4. Focus on your goals. Finish your projects, do the best you can at work, school, and home. Being successful in whatever you do is in and of itself an act of liberation and resistance.
5. Focus on change and organizing with the people closest to you including family circle of friends, neighborhood, and place of employment. Focusing on the big-macro picture may feel paralyzing.
6. Give yourself permission to experience what injustice naturally evokes in you. All feelings are acceptable including anger, honor it; anger has led to positive change.
7. Listen and validate the experiences of People of Color with different backgrounds from your own.
8. The burden of oppression and injustice is too heavy to carry on your own. Do what it takes to keep yourself going while remaining committed to racial and social justice.
9. Focus on one breath and one step at a time while knowing and always keeping in mind that our ancestors never gave up; their resistance and fight led to the changes we enjoy today.
10. Remember that the system does not get to determine your worth, dignity, and humanity. Never forget that you matter!

Committee on Civil and Human Rights jointly with the Committee on Mental Health, Disabilities and Addiction hearing on **Wednesday, December 12, 2018 at 10:00 A.M. in the 14th Floor Hearing Room, 250 Broadway, New York, NY** regarding the **Oversight - Negative Mental Health Consequences of Discrimination and Bias Incidents.**

Thank you for the opportunity to testify before this committee.

My name is Katherine Bouton and I am President of the New York City Chapter of the Hearing Loss Association of America. Our organization represents the thousands of New Yorkers who have a hearing loss, many of them elderly. Our constituents are not the ASL-speaking Deaf community, but, rather, those who lost their hearing after they had acquired language. Many, even those who have hearing aids or cochlear implants, as I do, rely on accommodations like CART captions, on LED displays and on hearing assistive devices to manage daily life.

The National Institutes of Health reports that 50 percent of those 75 and over have *disabling* hearing loss. 50 percent have a hearing loss that is serious enough to be a disability! Combine that with the fact that New York City has a large elderly population, and you can assume that many older New Yorkers cannot hear well enough to function without help.

Hearing loss is an invisible disability. Often even the person who has it is unaware of how much he or she is missing. When it *is* recognized, it may be dismissed as a natural consequence of aging and not worth treating. In 2016, a report from the National Academy of Sciences found that up to 86 percent of adults who could benefit from hearing aids do not have them.

So what does this have to do with discrimination and mental health?

Untreated hearing loss has physical and psychological consequences that far outweigh the simple inability to hear well. Depression, social isolation, and paranoia are all linked to hearing loss. Hearing impairment is also strongly correlated with cognitive decline, as well as an increased risk of dementia.

We can offset those negative consequences by taking proactive measures when working with the elderly. Failure to do so is discrimination – unintentional discrimination but very real nonetheless. The consequences are mental health issues like depression, isolation, and cognitive decline.

How do you correct for unintentional discrimination? It's not hard. Anything communicated orally must also be communicated in writing. Instead of PA systems we need LED signage. In addition to microphones at community board and other meetings, we need CART captions. Instead of a 911 operator asking questions we can't hear, we need Text 911.

First responders and emergency-room personnel need to know that a disoriented patient may have a hearing loss and not understand what's being asked. Emergency personnel should carry portable hearing-assistive devices, PocketTalkers. They're not expensive, less than $150, and they're very easy to use. Put the headphones on the patient and see if that helps. Every hospital emergency room should also have Pocket Talkers on hand.

Pencil and paper also provide a low-cost, low-tech means of communication. Police officers need to make sure someone can hear them before they act. All emergency announcements on any communications platform, including television, must be captioned. An ASL interpreter is routinely offered, but only a small percentage of adults with hearing loss understand ASL. The rest of us need captions.

Don't ask if someone has a problem hearing. *Assume it*, especially if they are seniors, and act accordingly.

Katherine Bouton, President, Hearing Loss Association of America, New York City Chapter.
katherinebouton@gmail.com.

New York City Council
Committee on Mental Health, Disabilities and Addiction
jointly with the Council Committee on Civil & Human Rights

Oversight Hearing - Negative Mental Health Consequences of Discrimination and Bias Incidents

Written Testimony by Seth Dressekie, RN, MSN, NP
NYC Human Resources Administration/NYC Health + Hospitals
Director-at-Large
NYSNA Board of Directors

Wednesday, December 12, 2018
New York City Council – 250 Broadway

Good Afternoon.

My name is Seth Dressekie, and I am a registered nurse and psychiatric nurse practitioner working at NYC Human Resources Administration/NYC Health + Hospitals.

I am also on the Board of Directors of the New York State Nurses Association (NYSNA), representing 42,000 registered nurses throughout the state.

Thank you for allowing me to address you here today.

Thank you to Chairperson Councilmember Ayala, Chairman Councilmember Dr. Eugene and the members of the Committee on Mental Health and the Civil & Human Rights Committee for allowing me to share my expertise on this issue critical to the health of New Yorkers.

NYSNA leadership stands ready to work with you to do what we can to support the expansion of mental health services and funding in our hospitals and acute-care facilities.

We are all aware of the shortcomings in our healthcare system. But, in no part of the system are inadequacies more pronounced than in the area of mental and behavioral health.

Here are some very sobering facts:

- ONE IN FIVE NEW YORKERS HAVE A MENTAL HEALTH DISORDER. 8% SUFFER FROM SYMPTOMS OF DEPRESSION. According to our own city data: "Major depressive disorder is the single greatest source of disability in NYC." "At any given time, over 500,000 adult New Yorkers are estimated to have depression, YET LESS THAN 40% REPORT RECEIVING CARE FOR IT." That's 95,000 individuals.

- And our children? 73,000 public high school students report "feeling sad or helpless each month."

The public system is carrying an enormous burden in this terms of this care.

Almost half of the available beds are in our city's public hospitals. Three public hospitals -- Bellevue, Kings County and Elmhurst Hospital -- account for 25% of all psychiatric beds in the city. Yet this cannot possible meet the city's demand.

Note that Woodhull Hospital *dropped* 23 beds in 2017.

The recent proposal from New York-Presbyterian seeking the state's permission to "decertify" all 30 psychiatric beds at its Allen Hospital in Inwood would usher in further cuts to inpatient treatment for many hundreds of local residents each year.

Mount Sinai dropped 30 psych beds, cutting capacity by 60% recently.

Northwell's Staten Island University Hospital closed a unit, with just 35 beds now remaining.

Need is up while capacity is done. That is a recipe for healthcare disaster.

Mental illness is linked to other illnesses.

Mentally ill patients are not coming into our hospitals and facilities for just one condition. There is a strong link between mental health and chronic conditions including diabetes, cancer, and heart disease. Many of our patients are presenting themselves with a whole host of illnesses.

Our concern is greatest regarding the substantial disparities that fall hardest on marginalized populations -- people of color, in particular, and the poor and indigent, in general.

You may be aware that hospitalization rates for mental illness- including schizophrenia and mood disorders –are two times as high in displaced people versus those who remain in their neighborhood.

This is especially alarming given that nearly one million New York City residents are at risk of being priced out of their homes, with enormous implications for mental healthcare needs. “Housing insecurity” is placing our communities and patients under mental stress to and beyond the breaking point.

Nurses and caregivers, invoking our expertise and our central role as patient advocates, urge that the city achieve mental health care equity with other disease entities, and we seek more: improved, therapeutic and universal treatments for the rising numbers of seriously ill patients with mental and behavioral disorders.

We cannot allow this city to become a place with an expanding population of people whose mental and behavioral healthcare needs go unmet.

Our doors are open for care, but we need increased and adequate funding for mental health care to get the job done.

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

Joint Hearing RE: Oversight – Negative Mental Health Consequences of Discrimination and Bias Incidents

December 12, 2018

Testimony by:
Lisa Furst, LMSW, MPH
Assistant Vice President, Center for Policy, Advocacy and Education
Vibrant Emotional Health
(Formerly the Mental Health Association of New York City, Inc.)

Thanks to the New York City Council Committees on Civil and Human Rights and Mental Health, Disabilities and Addiction for providing the opportunity to comment on the issue of negative mental health consequences of discrimination and bias incidents. I am Lisa Furst, Assistant Vice President of the Center for Policy, Advocacy and Education of Vibrant Emotional Health (formerly known as The Mental Health Association of New York City, Inc.). For more than 50 years, our organization has been on the front lines of behavioral health care, and currently provides direct services to New Yorkers with behavioral health needs across the life cycle. We serve youth, parents/caregivers, adults and older adults in our Adolescent Skills Centers, Family Resource Centers, PROS, Supported Housing programs, and our geriatric ACT team, among other programs. In addition, as part of the ThriveNYC initiative, Vibrant Emotional Health administers NYC Well, which provides New Yorkers with 24/7 access to behavioral health services through telephone, text and chat counseling services.

Vibrant has also been actively engaged in providing training, technical assistance and other supports to organizations working on the front lines with at-risk populations, including those more likely to experience discrimination or bias incidents. Vibrant is a participating member of the New York Immigration Coalition's Immigrant Behavioral Health Roundtable, which seeks to understand the dynamics and trends associated with immigrant mental health in New York City, and to provide solutions to better address the behavioral health needs of this population. In addition, Vibrant regularly provides training and technical assistance in the area of trauma-informed practices, and implements a training curriculum focused on helping programs, particularly those in under-served neighborhoods where there are higher than average incidents of community violence or other traumas, adopt a more trauma-informed lens from

which to work and provide interventions. We also provide a training called *Staying in Balance*, which is designed to support nonprofit organizations working with vulnerable populations with the skills and resources needed to identify and mitigate workplace stress associated with working with populations who have experienced trauma.

The behavioral health research literature indicates that perceived discrimination has deleterious effects on mental health and quality of life for adults and for children.[1] Discrimination has been associated with clinically significant depressive and anxiety disorders, chronic stress, post-traumatic stress disorder, suicidality, and low self-esteem. Populations historically at risk for discrimination include women, racial[2], ethnic or sexual minorities[3], as well people living with disabilities, including psychiatric disabilities, and immigrants. Despite the increased risk for clinically significant symptoms among populations which experience discrimination and/or bias incidents, many find it difficult to access qualified treatment services, often due to a combination of stigma associated with behavioral health conditions, lack of information about behavioral health symptoms and their treatment, and how to find providers.[4]

Given the increased risk for clinically significant emotional distress among people who experience discrimination and bias incidents, it will be particularly important to ensure that vulnerable populations in New York City have information about how to access support and

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[1] Cooke, CL, Bowie, BH, Carrère S. (2014). Perceived discrimination and children's mental health symptoms. ANS Adv Nurs Sci. Oct-Dec: 37(4): 299-314. Accessed 12-11-18 at https://www.ncbi.nlm.nih.gov/pubmed/25365283

[2] Paradies, Y. (2006). A systematic review of empirical research on self-reported racism and health. Int'l Journal of Epidemiology. 35(4): 888-901. Accessed 12-11-18 at https://academic.oup.com/ije/article/35/4/888/686369.

[3] Mays, VM, Cochran, SD (2001). Mental health correlates of perceived discrimination among lesbian, gay, and bisexual adults in the United States. Am J Public Health. November; 91(11): 1869–1876. Accessed on 12-11-18 at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1446893/.

[4] Henderson, C, Evans-Lacko, S, Thornicroft, G (2013). Mental illness stigma, help seeking and public health programs. Am J Public Health. May: 103(5): 777-780. Accessed 12-11-18 at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3698814/

services through NYC Well. However, public education messaging should not only speak to the symptoms people may experience as a result of discrimination or being a victim of a bias incident or hate crime, but should also contextualize those symptoms as an expected response to the abnormal circumstance of being targeted due to perceived or actual identity or personal characteristics.

NYC Well can provide empathic and non-judgmental support to New Yorkers experiencing emotional distress or a mental health crisis 24 hours a day, 7 days a week by phone, text and chat. NYC Well is able to serve the diverse population of our city, as counselors speak English, Spanish, Mandarin, and Cantonese; people who speak other languages can be served via NYC Well's translation service. NYC Well crisis counselors are able to assess emotional distress and determine what services are most appropriate for individuals who make contact, and provide information and referral services for substance abuse treatment and mental health services as indicated. Additionally, NYC Well crisis counselors will assess for more severe concerns and connect people, as needed, to mobile crisis teams or EMS for more emergent crises.

Vibrant Emotional Health is grateful for the New York City Council's leadership and commitment to addressing the behavioral health needs of New York's most vulnerable populations, including those who experience negative emotional effects of bias incidents and discrimination. We look forward to continued work with the Council to continue to make New York City a place where the emotional well-being of all of its residents can flourish.

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THE CITY OF NEW YORK

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Name: Jean RYAN

Address: [illegible]

I represent: Disabled In Action

Address: pansies007@gmail.com

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I represent: myself

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I represent: Hearing Loss Assn. of America

Address: 180 Riverside Drive

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I represent: CCHR

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I represent: Arab-American Family Support Center

Address: _____

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Address: Deputy Commissioner

I represent: DOHMH

Address: _____

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Name: Lucy Freeman / Urban Justice Center

Address: 4525 48th St Apt 5H Woodside NY 11377

I represent: Urban Justice Center

Address: 40 Rector St 9th Fl. NY, NY 10006

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Name: Albert Cahn

Address: 40-21 30th Ave, Elmhurst, NY 11103

I represent: CAIR-NY

Address: "

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Name: CATHERINE HANSSENS

Address:

I represent: CENTER FOR HIV LAW + POLICY

Address: 147 PRINCE ST., BROOKLYN

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Name: Adina Miles

Address: 1416 East 16th St

I represent: self

Address: _____

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(PLEASE PRINT)

Name: LAUREN QUITANO

Address: 151 W. 30th St., 11th Floor New York

I represent: New York Lawyers for the Public Interest

Address: _____

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