CITY COUNCIL
CITY OF NEW YORK

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TRANSCRIPT OF THE MINUTES

Of the

COMMITTEE ON HOSPITALS JOINTLY WITH THE
COMMITTEE ON MENTAL HEALTH, DISABILITIES
AND ADDICTION

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Chairperson for Committee on
Hospitals

Farah Louis,
Chairperson for Committee on
Mental Health, Disabilities, and
Addiction

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23

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2 SERGEANT BIONDO: Recording to PC has started.
3 SERGEANT HOPE: Recording to Cloud started as
4 well.
5 SERGEANT PEREZ: Backup is rolling.
6 SERGEANT HOPE: Thank you. Sergeant Sadowsky,
7 you may begin with your opening statement.
8 SERGEANT SADOWSKY: Good morning and welcome to
9 today's Remote New York City Council Hearing of the
10 Committee on Mental Health, Disabilities and
11 Addiction jointly with the Committee on Hospitals.
12 At this time, would all Council Members and Council
13 Staff please turn on their video.
14 To minimize disruption, please place electronic
15 devices on vibrate or silent mode. If you wish to
16 submit testimony, you may do so at
17 testimony@council.nyc.gov. Once again, that is
18 testimony@counci.nyc.gov. Thank you Chairs, we are
19 ready to begin.
20 CHAIRPERSON RIVERA: [GAVEL] Good morning, I am
21 Council Member Carlina Rivera, Chair of the Committee
22 on Hospitals and I would like to start with thanking
23 my colleague Council Member Farah Louis for Co-
24 Chairing this important hearing with me today on
25 Access to Mental Health Services in New York City

2 Hospitals. I would also like to acknowledge my
3 fellow members of our Committees. We've been joined
4 by Council Members Maisel, Borelli, and Moya.
5 We are all here today to discuss access to mental
6 health services in New York City hospitals. In June
7 2018, our Committees held a hearing on the future of
8 psychiatric care in New York City's hospital
9 infrastructure at New York City Health + Hospitals
10 Metropolitan. At the time, we explored how H+H can
11 cope with its increasing role as the main provider of
12 inpatient mental health services in the city. And
13 the role voluntary hospitals can play in the
14 treatment and care of individuals with mental health
15 conditions.
16 At the time, H+H had nearly 1,500 licensed
17 psychiatric beds representing 48 percent of all
18 psychiatric inpatient beds in the metropolitan area.
19 Since that hearing, these trends seem to have
20 continued. H+H has seen a significant increase in
21 the hospitalization of patients with mental illness
22 in the last several years. The New York State Nurses
23 Association noted in its 2020 Report that as
24 financial pressures to close beds in voluntary
25 hospitals mount, H+H has been tasked with providing

2 more and more inpatient mental healthcare to New
3 Yorkers.
4 According to a New York Times, an independent
5 budget offices study on New York City psychiatry
6 services, H+H often ended up with patients with
7 severe mental illness who were unable to seek any
8 other type of outpatient services or care as they
9 would present in the emergency department of a public
10 hospital in serious crisis with few alternatives to
11 hospitalization.
12 For example, in 2017, the H+H system had nearly
13 70,000 ED visits stemming from mental illness.
14 According to the Treatment Advocacy Center, a minimum
15 of 50 psychiatric beds per 100,000 people is
16 considered necessary to provide minimally adequate
17 treatment for individuals with severe mental illness.
18 However, as of 2018, New York failed to meet this
19 standard. As evidence by its ratio of 16.3 beds per
20 100,000 people capacity.
21 Unfortunately, the COVID-19 pandemic
22 significantly increased the demand of behavioral
23 healthcare services as mental healthcare treatment
24 became harder and harder to find. In fact, it was
25 estimated that as lockdowns eased and facilities

2 returned to normal, an estimated 14,000 psychiatric
3 admissions were reportedly lost because people who
4 needed care were unable to get it.
5 The continue decline of psychiatric beds and
6 units in the midst of a historic mental health crisis
7 created by COVID-19 exacerbated in already deepening
8 mental health emergency. Today, we hope to hear from
9 H+H about how their role as a main provider of
10 inpatient mental health services in the city has
11 shifted since our last hearing on this issue in 2018.
12 But more particularly since the COVID-19 pandemic.
13 We are also interested in hearing more from H+H
14 about their outpatient and community-based behavioral
15 health program. We wish to focus on equity, access
16 and quality of care. We want to know the wait times
17 people experience when accessing this life saving and
18 crucial care and how hospitals are emphasizing access
19 to culturally humble and relevant services.
20 The Committee on Mental Health, Disabilities and
21 Addiction is also hearing a bill today, which I
22 sponsored proposed Into. Number 2141-A, which amends
23 the New York City Charter and the Administrative Code
24 of the City of New York, in relation to removing
25 outdated clinical language. It is important that our

1
2 laws be able and amended to reflect changes in
3 language over time and this bill removes dehumanizing
4 and offensive language, which reenforces
5 discriminatory attitudes towards individuals with
6 intellectual and developmental disabilities. Thank
7 you to the Administration and to everyone who is
8 present to testify today. And as always, we are
9 mindful of the incredible work of our frontline
10 healthcare workers and all hospital staff as we
11 continue to increase the impacts of the COVID-19
12 pandemic. Thank you all for your tireless efforts.
13 I would also like to thank the Hospital Committee
14 Staff Counsel Harbani Ahuja, Policy Analyst Em Balkan
15 and Finance Analyst Lauren Hunt for their work on
16 this hearing. And all of the other people at the
17 Council who have made today possible.
18 And now, I'll turn it to Chair Farah Louis to
19 give her opening statement. Thank you.
20 CHAIRPERSON LOUIS: Thank you so much Chair
21 Rivera and good morning everyone. I'm Council Member
22 Farah Louis, Chair of the Committee on Mental Health,
23 Disabilities and Addiction. I'd like to thank my
24 colleague Council Member and Co-Chair Carlina Rivera
25 for Chairing this important hearing with me today on

2 Access to Mental Health Services in New York City
3 Hospitals. I'd like to also acknowledge that my
4 fellow colleague, Council Member Riley has joined us
5 today.
6 This morning, we are here to learn more about the
7 roles that the Health and Hospital system plays in
8 providing behavioral health services for so many New
9 Yorkers. We know that before the COVID-19 pandemic,
10 H+H had seen significant increases in patient
11 presenting for both inpatient and outpatient
12 treatment services. With the onset of the COVID-19
13 emergency, many hospitals across New York State were
14 repurposed and as a result, hundreds of psychiatric
15 detox and drug rehabilitation beds were closed to
16 make room for COVID-19 patients.
17 As mental healthcare treatment became harder to
18 find, New York healthcare workers described some
19 patients as being discharged early to free up space.
20 Or moved into facilities far from their homes, even
21 though many patients exhibited signs of acute
22 behavioral health needs. As COVID locked down eased
23 and facilities returned to normal, it was reported
24 that an estimated 14,000 psychiatric admissions were
25

2 lost because people who needed care were unable to
3 get it.
4 Aside from the decreased number of inpatient
5 beds, we are also aware of mental health labor
6 shortage caused by multiple factors that complicate
7 and block the creation of robust culturally sensitive
8 and mental health workforce in New York. These
9 factors include a range of issues including insurance
10 barriers, financial barriers, language and cultural
11 competency barriers and a lack of true parity and
12 mental healthcare reimbursement rates.
13 Practically, this means that there is little
14 financial incentive for individuals to go into the
15 mental health field. And that hospitals struggle to
16 hire mental health providers and to financially
17 justify provision of a full range of mental health
18 services. However, it is not just a lack of provider
19 that limit hospital provisions of mental health
20 services, but it is also the lack of culturally
21 competent providers. According to the American
22 Psychological Association, in 2018, about 86 percent
23 of psychologists in the United States Workforce were
24 White and fewer than 15 percent from other racial and
25 ethnic groups. This means that individuals often see

2 mental health providers that do not share racial
3 ethnic and language religion or cultural experiences.
4 All of which can influence the quality and
5 effectiveness of care that they receive.
6 Culturally sensitive providers have practical and
7 particular skills such as language ability, cultural
8 knowledge and experience treating the special
9 healthcare needs of the diverse communities of New
10 York City.
11 Finally, waiting lists for mental health services
12 can be extremely long. Due to the reasons I outlined
13 earlier but to reiterate, lack of comprehensive,
14 culturally sensitive mental health workforce.
15 Growing mental health needs due to COVID isolation.
16 Poor financial incentives to provide mental
17 healthcare and lack of infrastructure in supportive
18 services within communities to share the burden with
19 hospitals.
20 This is specifically true for particular care,
21 such as pediatric mental healthcare and where
22 patients experiencing suicidality and seeking
23 outpatient services can wait over a month to receive
24 care. The same is true for substance use disorder
25 treatments, which are available on a very limited

2 basis within our hospitals and which can have long,
3 long, long wait times, both inpatient and outpatient
4 treatment. Patients experiencing addiction or mental
5 health emergencies may not have weeks or months to
6 wait, but hospitals simply lack the available beds
7 and referrals to provide inpatient and outpatient
8 care.
9 Today, we are hearing Proposed Intro. 2141-A
10 sponsored by Co-Chair Rivera, which I'm proud to Co-
11 sponsor in relation to removing outdated clinical
12 language and in relation to a report on the
13 establishment of the Department of Health and Mental
14 Hygiene.
15 At today's hearing, our Committees look forward
16 to hearing from the Administration along with
17 providers, community-based organizations, and
18 advocates throughout the City of New York on how we
19 can provide access to mental health services in New
20 York City hospitals. In particular, I want to thank
21 H+H, the Greater New York Hospital Association and
22 all hospital workers for all the work they do to
23 serve New Yorkers, particularly for those that are
24 experiencing mental health issues.
25

2 I know you all are committed to the treatment and
3 care of New Yorkers and to creating more accessible,
4 equitable and comprehensive mental health
5 infrastructure in the city and we look forward to
6 hearing from you.
7 I also want to thank my colleagues as well as
8 staff Legislative Director Kristie Winter,
9 Legislative Liaison Alex Tymkiv, as well as Council
10 Committee Staff Senior Counsel Committee Staff Sara
11 Liss, Legislative Policy Analyst Cristy Dwyer and
12 Financial Analyst Lauren Hunt for making today's
13 hearing possible.
14 Now, I'll turn it over to our Moderator and
15 Committee Counsel Sara Liss. Thank you.
16 COMMITTEE COUNSEL: Thank you so much Chair Louis
17 and thank you Chair Rivera. Good morning everyone,
18 happy Friday.
19 Before we begin, I just wanted to go over a
20 couple of procedural matters. I wanted to let
21 everyone know that I will be calling on them, on
22 panelists to testify. I wanted to remind everyone
23 that you will be on mute until I call on you. You
24 will then be unmuted by the host. Please note that
25 there may be a few seconds of delay before you're

2 unmuted and we thank you in advance for your
3 patience.
4 If at any point Council Members have question, we
5 encourage you to use the Zoom raise hand function and
6 we'll call on you in the order that you used the
7 raised hand function.
8 At today's hearing, the order will be the
9 Administration testifying followed by the Hospital
10 Association and then the public will testify. Uhm, I
11 will now call on members of the Administration to
12 testify. And that includes Dr. Charles Barron Deputy
13 Chief Medical Office, Office of Behavioral Health,
14 Dr. Rebecca Linn-Walton Senior Assistant Vice
15 President, Office of Behavioral Health and Dr. Omar
16 Fattal Deputy Medical Director, Office of Behavioral
17 Health.
18 I will administer the oath and call on each
19 panelist, so please listen for your name to respond.
20 Do you affirm to tell the truth, the whole truth, and
21 nothing but the truth before this Committee and to
22 respond honestly to Council Member questions? Dr.
23 Charles Barron?
24 DR. CHARLES BARRON: Yes, I do.
25 COMMITTEE COUNSEL: Dr. Rebecca Linn-Walton?

2 DR. REBECCA LINN-WALTON: I do.

3 COMMITTEE COUNSEL: Thank you and Dr. Omar
4 Fattal?

5 DR. OMAR FATTAL: I do.

6 COMMITTEE COUNSEL: Thank you so much and Dr.
7 Barron, you can begin as soon as you are ready.

8 DR. CHARLES BARRON: Thank you. Good morning
9 Chairperson Rivera, Chairperson Louis and members of
10 the Committee on Hospitals and the Committee on
11 Mental Health, Disabilities and Addiction.

12 I am Dr. Charles Barron, the Deputy Chief Medical
13 Officer of the Office of Behavioral Health, and
14 Medical and Professional Affairs of New York City
15 Health + Hospitals. I am joined this morning by Dr.
16 Omar Fattal, the Deputy Medical Director of
17 Behavioral Health and Dr. Rebecca Linn-Walton, Senior
18 Assistant Vice President for Behavioral Health at
19 Health + Hospitals. I am happy to testify before you
20 today to discuss mental health services at Health +
21 Hospitals.

22 Health + Hospitals is the main provider of
23 behavioral health and inpatient psychiatric care
24 services in New York City, with over 1,300 licensed
25 psychiatric beds representing about half of all

2 psychiatric inpatient beds in the metropolitan area.
3 As such, we provide a significant portion of
4 behavioral health inpatient services in New York
5 City, which underscores the need for continued
6 stability in the public hospital system.
7 Our inpatient services provide individualized,
8 therapeutic care to stabilize mental illness episodes
9 and promote rehabilitation, recovery, a return to the
10 community, and less restrictive modalities of care.
11 In addition to inpatient psychiatric services, our
12 acute care behavioral health services include seven
13 adult, and one child and adolescent comprehensive
14 psychiatric emergency programs or CPEPs. These
15 include psychiatric emergency rooms, extended
16 observation beds, mobile crisis intervention
17 services, and access to crisis beds as well as four
18 psychiatric emergency departments, where psychiatric-
19 specific areas of the regular ER are present.
20 Health + Hospitals provides a comprehensive array
21 of ambulatory behavioral healthcare programs,
22 including eight mobile crisis teams, outpatient
23 clinics, day treatment, partial hospital programs,
24 and case management behavioral health programs. For
25 those patients who require significant levels of

2 support, our facilities operate Assertive Community
3 Treatment or ACT Teams. These ACT Team programs
4 functions as a clinic without walls treating
5 individuals in their homes and community. Of the 38
6 ACT Teams in New York City, Health + Hospitals
7 operates 12.
8 Children and adolescents receive services through
9 developmental evaluation clinics, family support
10 programs, adolescent treatment programs, school-based
11 programs, and outpatient clinics. Pediatric
12 psychiatry emergency services are available at all 11
13 acute care hospitals, while Bellevue boasting the
14 only Child and Adolescent Comprehensive Psychiatric
15 Emergency Program in New York City. In addition to
16 emergency services, Health + Hospitals offers
17 pediatric inpatient services and the innovative
18 OnTrack New York First Break program at its Bellevue,
19 Elmhurst, and Kings County locations.
20 Apart from the services provided at its acute
21 care facilities, Health + Hospitals also offers
22 ongoing therapy, psychiatric evaluation, medication
23 management, and other clinical services at 12
24 outpatient mental health clinics throughout the city.
25 Through these clinics, Health + Hospitals launched

2 the new Pathways to Care program in collaboration
3 with the Office of Community and Mental Health and
4 the Department of Education. Recognizing the need to
5 bring additional support to children in the
6 neighborhoods most affected by the pandemic, Pathways
7 to Care expedites referrals from schools to connect
8 students to care at our outpatient mental health
9 clinics.
10 Harmful substance use is a significant population
11 health problem in New York City, and Health +
12 Hospitals is a major provider of substance use
13 services. Each year over 90,000 unique patients with
14 substance use disorder come to us for care.
15 Approximately 20 percent of primary care patients are
16 at moderate risk of substance use disorders. Of our
17 patients with substance use disorders, about 15
18 percent have a primary diagnosis of opioid use
19 disorder; and 45 percent have a primary diagnosis of
20 alcohol use disorder.
21 To respond to this need, Health + Hospitals
22 facilities provide an extensive array of SUD services
23 including: Outpatient intensive detoxification
24 provided at four of our facilities currently; 13
25 outpatient substance use disorder counseling

2 programs; the largest substance use disorder Peer
3 Counselor workforce in New York City; four methadone
4 treatment programs; and growing SUD support for
5 families, adolescents, and women in medicine.
6 As part of the $7 million annual investment from
7 Healing NYC, the Mayor's initiative to reduce opioid
8 overdose deaths in New York City, Health + Hospitals
9 has implemented several initiatives, including
10 specialized funding for: Consultation for Addiction
11 Treatment and Care in Hospitals or known as CATCH
12 teams; Buprenorphine Expansion in Primary Care;
13 Emergency Department Peer Advocates Addressing
14 Substance Use; and Judicious Prescribing Training and
15 Guidance.
16 Most recently, in October, Health + Hospitals
17 received a $1.8 million award from the New York State
18 Office of Addiction Services and Supports or OASAS to
19 expand services to opioid and stimulant use in
20 underserved communities in the Bronx, Manhattan, and
21 Queens. The funding will help coordinate emergency
22 department substance use access, the Consultation for
23 Addiction Treatment and Care in Hospitals program,
24 outpatient services, and virtual access to substance
25 use care, and bridge between substance use disorder

2 and psychiatry for patients with co-occurring mental
3 health and SUD diagnoses.
4 This vital funding facilitates a unified system
5 of care so that New Yorkers can easily access quality
6 support for substance use. We expect thousands of
7 new patients will be served through this expansion of
8 services made possible through the additional
9 funding.
10 When COVID-19 saw its first case in New York City
11 in March 2020, Health + Hospitals was at the
12 forefront responding to the needs of its patients and
13 the City overall. Behavioral Health has continued to
14 play a vital role in the COVID response. Amidst
15 unprecedented circumstances, Health + Hospitals kept
16 its doors open so that New Yorkers could safely
17 access care. We utilized all modalities, including
18 in-person, telephonic, video calls, home visits,
19 mobile crisis outreach, to provide this type of care
20 during the pandemic.
21 Working hand-in-hand with the Department of
22 Health and Mental Hygiene, the office of Community
23 Mental Health and the New York State Office of Mental
24 Health, and OASAS, Health + Hospitals ensured
25 coordination of all available behavioral health beds

2 across all hospitals. To accommodate the surge in
3 critical COVID-19 patients, Health + Hospitals worked
4 as one system to safely transfer behavioral health
5 patients to other facilities that had capacity, even
6 standing up COVID positive psychiatric units in
7 several of our hospitals.
8 Prior to COVID-19, Health + Hospitals had not
9 conducted tele mental health sessions; all sessions
10 were held in person. When the pandemic began, tele
11 mental sessions rolled out in psychiatry and
12 substance use services and the Family Justice Centers
13 for domestic violence victims and families, Addiction
14 Consult teams for both Med Emergency Departments and
15 Inpatient Medicine was done. And mobile treatment
16 through both mobile crisis and the ACT teams as well.
17 To help make this possible, Health + Hospitals
18 distributed iPads to inpatient, emergency department
19 behavioral health consultation services. To date,
20 Health + Hospitals has completed 350,000 behavioral
21 health sessions telephonically and virtually. Other
22 initiatives launched during the pandemic are the
23 Virtual Buprenorphine Clinic, created to provide
24 same-day buprenorphine access to existing and new
25

2 patients. Our Virtual Buprenorphine Clinic Pilot at
3 Bellevue Hospital served 553 patients.
4 We also partnered with the State Department of
5 Health and Mental Hygiene and OASAS to provide
6 methadone delivery to patients on quarantine at
7 hotels and in their homes. Or to stable patients who
8 were at high risk of complications from COVID for
9 whom it was not safe to attend in-person sessions.
10 For New Yorkers who required quarantine at a Test &
11 Trace hotel, we provided access to behavioral health
12 services. Once COVID-19 vaccination outreach began,
13 and Test & Trace launched the Street Health Outreach
14 & Wellness or SHOW mobile vans, we also began
15 providing free mental health screenings on these
16 units.
17 Health + Hospitals has a long history of taking
18 care of the most vulnerable New Yorkers and will
19 continue to do so come what may. We look forward to
20 continuing to partner with government and key
21 stakeholders to forge solutions. I thank your
22 Committee for your attention to this important topic
23 and we are happy to answer any questions you may
24 have. Thank you.
25

2 COMMITTEE COUNSEL: Chair Rivera, you can begin
3 questions when you are ready.
4 CHAIRPERSON RIVERA: Thank you so much for your
5 testimony. I really do appreciate you being here and
6 answering some of our questions on all the work that
7 you have done thus far. I try to lay out in my
8 opening statement the challenges and quite frankly
9 the burden that you all have in terms of how many
10 beds, how many units of services you offered to the
11 city that you provide and how instrumental it is to
12 our healing and recovery, especially going forward.
13 How has the pandemic impacted access to inpatient
14 mental health services at H+H? And what about out
15 patient services?
16 DR. CHARLES BARRON: Uhm, Chair Rivera, as you
17 mentioned, this is a — it’s been a citywide sort of
18 crisis for behavioral health services. Uhm, at H+H,
19 the COVID-19 certainly put a stress on our system and
20 on the whole city but we have remained committed to
21 providing this level of care. We continue to operate
22 our inpatient services. Although, some of our units
23 were converted into SURGE units. We were able to
24 continue to provide acute care, inpatient services to
25 whoever needed service. Anyone who came to our

1
2 emergency rooms, uh, our special psychiatric
3 emergency rooms, are presented in any fashion who
4 needed acute care with grant of that immediately.
5 So, we continue to operate those and since the
6 time that this is has happened, we have continued to
7 operate and provide this service.
8 CHAIRPERSON RIVERA: You mentioned some of this
9 information in your testimony but as of today, how
10 many inpatient mental health beds are within H+H
11 hospitals?
12 DR. CHARLES BARRON: Uh, we currently, we
13 currently have 1,004 beds completely operational.
14 Uh, the few beds that still remained in a sense,
15 "temporarily closed," are due to some of the
16 workforce issues that both Chairs have referred to
17 you know, the whole nation is experiencing lack of
18 psychiatrists and practitioners and other mental
19 health professionals.
20 Also, we are taking the opportunity to renovate
21 some of these units to bring them up to a higher
22 standards of code. And we are in the process of
23 reopening all of those beds as well. But currently,
24 it's 1,004 open.
25

CHAIRPERSON RIVERA: Which of the facilities are currently under construction?

DR. CHARLES BARRON: I'm going to have to get back to you on the specific facilities. There's only I think three or four that have this going on but I can get that back to you. I'm sorry.

CHAIRPERSON RIVERA: No, that's okay. If you'll let us know, of course we want to be helpful. I think I could confidently say uhm, you know this term, this Council, has invested serious dollars, especially capital funds into our H+H system and I think that's our responsibility.

You know of course, the state has its own responsibility but we certainly have to do what we can. Overall, our healthcare system is shifting from inpatient services to outpatient and at a similar hearing held in June 2018, H+H discussed their efforts to increase capacity for outpatient mental health services and can you please speak to this increase in capacity and provide an update on available services?

DR. CHARLES BARRON: Certainly, thank you and I also thank you and the Council for their ongoing support of Health + Hospitals. Yes, the trend in

2 mental health, one is to have as many people as
3 possible stay in the community and receive treatment
4 in a variety of outpatient ways. We have a full
5 range of outpatient services from our general mental
6 health and substance use clinics. We also have
7 intensive outpatient clinics that are allowed to
8 where patients go more than once say a week. Uh, and
9 receive a variety of different services.
10 We have partial hospital programs where people
11 attend daily for up to around six weeks to two months
12 to have increased and intensive outpatient services.
13 Uh, that includes both adult and we have two child
14 and adolescent partial hospital programs. One at
15 Bellevue and one at Elmhurst.
16 We also have certainly been expanding some of our
17 community outreach programs. We have the mobile
18 crisis teams. We have our specialized ACT team,
19 which is really the clinic without walls and moves
20 into the community to see the patients where they
21 are.
22 And we have now certainly started and ramping up
23 on our telehealth services. During the pandemic,
24 this was a very successful effort in the sense of
25 really reaching people who needed to stay at home uh,

1
2 to isolate but still get the mental health services
3 they deserve and need.
4 Uh, we had an overwhelming response, positive
5 responses to the virtual visits and we are in the
6 process of — we're continuing those and actually
7 increasing the ability that we have across the
8 system. I think that the use of telehealth and
9 virtual visits for certain people, increases the
10 access to the mental health system. Uh, and it is
11 very successful in reaching them.
12 CHAIRPERSON RIVERA: What is the average wait
13 time to receive an appointment for outpatient mental
14 services? And how does this differ from the wait
15 times for substance use specific services and youth
16 seeking mental health services?
17 DR. CHARLES BARRON: Uh, in general, we really
18 work very hard to avoid wait times. We really work
19 to try to get people in and quick access. Hopefully
20 our usual idea is to get them in the same day or
21 within two or three days. Uhm, so we've set up — uh,
22 one of the ways that we do this in this particular
23 stressful time where there is such a demand for
24 mental health services in the outpatient areas, uh,
25 we have stood up a lot of walk-in clinics and most,

2 all of our clinics have the ability of having like an
3 immediate walk-in service. Someone can walk in the
4 door and we would do you know an evaluation and try
5 to quickly, according to their need, fit them into
6 the appropriate ongoing treatment. Uh, this is for
7 adults or children or any age or need.
8 Substance use, we also have immediate access. We
9 have the ability to provide buprenorphine even
10 through our emergency departments and through our
11 virtual view clinic. And we have physicians at all
12 of our facilities who are licensed and ability to
13 buprenorphine.
14 Let me ask my colleague Dr. Walton to comment a
15 little more on some of the other substance use
16 services that we did.
17 CHAIRPERSON RIVERA: And if you could, if someone
18 could answer what's the longest a person may have to
19 wait for mental health services.
20 DR. CHARLES BARRON: Uhm, it really varies.
21 That's a little bit of a difficult question to
22 answer. As I said, our target really is to try to
23 get someone in within a few days to a week. There
24 might be some outliers in that but generally, no, we
25 will work in some way to get them hooked up. Either

2 through face to face or through virtual telehealth
3 services into our program.
4 DR. REBECCA LINN-WALTON: Yeah, thank you and on
5 the substance use side, we really try to do the same
6 and I think people are aware, I mean, clinicians are
7 always aware of wait times, and so we set things up
8 like if you've been medically detoxed on inpatient
9 medicine for opioids or alcohol withdrawal. We have
10 what's called the CATCH team bridge clinic, so if you
11 have your appointment in four days, you may need to
12 talk to the same people that you've been talking to
13 on inpatient to help you get through those several
14 days until you have your first appointment.
15 So, you may even be seeing the same people on
16 inpatient that then do a shift in the bridge clinic
17 and also work in outpatient. So, we really do try to
18 recognize that there have always been wait times but
19 we're trying to mitigate that and make sure you're
20 still connected. I know that mobile crisis teams
21 during the pandemic have done more follow-up than
22 they typically did. And so, people are really just
23 trying to work with what they have and make sure
24 people are connected while they're waiting in a way
25 that they haven't historically.

CHAIRPERSON RIVERA: So, what level of care is necessary to require access to same day outpatient care? And what about inpatient care?

DR. CHARLES BARRON: Well, certainly inpatient care, if you need inpatient admission, if you really have the acuity that requires that level of care, you receive that the same day. There is really no wait for getting inpatient, if that particular facility for some reason is full and is not being discharged that day. We would work with you to go to one of our other facilities that — inpatient is really accessible you know immediately.

Outpatient uhm, certainly as I said, we have walk-in clinics and we have services for triage and if you have something seriously wrong, such as a higher acuity of that then we're going to one, we may consider do you need a higher level of outpatient care and move you to that level.

But we will also try to work out again with all of the variety of ways that we do through walk-in or telehealth services. If you need to be in immediately, we work to do that.

2 CHAIRPERSON RIVERA: Thank you. I just want to
3 acknowledge we've been joined by Council Members
4 Alicka Ampry-Samuel and Antonio Reynoso.

5 So, once someone is discharged and/or leaves the
6 emergency department, how does Health + Hospitals
7 follow-up with them about any necessary discharge
8 planning or follow-up services?

9 DR. CHARLES BARRON: So, of course whenever
10 anyone is admitted, they have a comprehensive
11 discharge plan when they leave and we do follow up
12 with them. We have a follow-up system where we will
13 have people contact the person whose been discharged
14 to help them, remind them about appointments coming
15 up. But also to ask them if there's any barriers,
16 any problems in connection and try to work with them
17 to make sure that they get connected.

18 This follow-up system has multilayers. It can be
19 telephonic and many times we have the care managers
20 that may also visit with the patient to help them and
21 their families, their support systems connect with
22 the next level of care.

23 CHAIRPERSON RIVERA: I wanted to ask about
24 pregnant individuals who require mental health
25 services. According to the New York City Maternal

2 Mortality and Morbidity Review Committees, April 2021
3 Report, mental health conditions are one of the top
4 two leading causes of pregnancy related death. And
5 how does H+H work to meet the needs of pregnant
6 people who require mental health services?
7 DR. CHARLES BARRON: Uh, if I may ask my
8 colleague Dr. Walton, she has been working — we work
9 very closely with our maternal health department,
10 both maternal health and pediatrics, sort of as a
11 team to really provide services to the pregnant
12 people that need mental health services and ensure
13 their health. But Dr. Walton's been working
14 directly, so I'll let her comment on that.
15 REBECCA LINN-WALTON: Thank you very much. Uhm,
16 I would say, so for folks who are already in
17 treatment, the very first day you hear that your
18 patient is pregnant, you are working with them on
19 safety plans on support, making sure they are engaged
20 in medical care. But there's also an issue of
21 substance use as well among this population. So, we
22 want to have expertise with working with pregnant
23 women or mothers in both substance use and
24 psychiatric facilities.
25

2 We also are working on the other end of the
3 spectrum. Someone who may develop or already have
4 needs and they aren't getting met for psychiatric
5 care or substance use care who are in women's health.
6 And so, we're doing a systemwide training for working
7 with pregnant women and we just continue to work on
8 the ground. You know we want to make sure we're
9 talking to the people who are providing care, making
10 sure that the questions they're asking are both non—
11 stigmatizing and supportive of getting to care and
12 that they know where in our very large system people
13 can get to care as well. So, I would say it's a
14 hands on, ground up effort.
15 CHAIRPERSON RIVERA: Thank you. I appreciate
16 your answer and I know you know we've done — this
17 Committee has done a lot of work around this issue
18 and you all have always been present to answer our
19 questions. Uhm, I want to just move to those
20 experiencing homelessness. How does Health +
21 Hospitals work to meet the needs of those
22 experiencing homelessness who require mental health
23 services? And can you speak specifically to how H+H
24 collaborates with city agencies here?
25

1
2 DR. CHARLES BARRON: So, the homeless population
3 is certainly one of our big populations and
4 responsibilities. We really take very seriously the
5 need of many of the homeless to receive mental health
6 and substance use services. So, we make the access
7 to them really important and available.
8 Uh, we run many services specifically for
9 homeless people. One example of that is we have what
10 we call the extended care unit and this is a longer
11 term. Our average length of stay generally on an
12 acute unit is anywhere between 12 and 18 days. This
13 particular unit focuses on homeless who need extra
14 time, extra support, extra stabilization, in order to
15 really participate in the housing situations.
16 We work with DHS, HRA, DOHMH, uh, the Office of
17 Community Mental Health around a lot of these
18 individuals to make sure that they can get into our
19 system and get the treatment they need, get the time
20 that they need in order to complete while we're doing
21 the mental health or substance use treatment. We
22 also work with them on issues of housing and try and
23 work with them on to get them in some level of
24 housing.
25

2 And have been successful through our extended
3 care unit in doing so. And as I said, we work with
4 many of the homeless agencies helping them out.
5 Having immediate access for someone who they identify
6 as needing care and hospitalization.
7 CHAIRPERSON RIVERA: I understand there are many
8 agencies involved and you're staff has done
9 incredible work and uhm, you know I would say at
10 every level and I know specifically you have interns
11 and residents that work with care and compassion and
12 uhm really do inspire me. And I know we had a
13 hearing just in September on their own mental
14 wellbeing and according to a survey of 700 residents
15 performed by the Committee of Interns and Residents,
16 doctors are two times more likely to commit suicide
17 than those in other professions. And residents, they
18 site long work hours and student debt as well as a
19 culture of hazing and bullying, out of title work and
20 a lack of mental health services is causes of
21 depression and suicide, all of which have been
22 exacerbated by the pandemic and of course the demands
23 on all of the services that you provide. Has there
24 been any updated actions that H+H has taken since our
25

2 September hearing on this topic given the robust
3 feedback provided by the residents then?
4 DR. CHARLES BARRON: Uh, yes, we took that very
5 seriously. I'm going to ask Dr. Omar Fattal; he has
6 been a lead in establishing a lot of the programs for
7 our residents and other staff.
8 DR. OMAR FATTAL: Yeah, thank you. Yeah,
9 defiantly, we heard everything that has been said and
10 feedback from the session and we've been — we put
11 together a taskforce and we've been meeting regularly
12 to address the things that came up in the hearing.
13 And the one immediate thing that we're launching very
14 soon is an anonymous reporting platform for residents
15 everywhere in our system to be able to report
16 anonymously and in a confidential way any issues
17 they're having with you know any of the topics that
18 came up out of title work or duty hours violation or
19 retaliation or anything like that.
20 But in addition, we have scheduled one on one
21 meetings with each facility dealership to address the
22 specific issues that came up at both facilities and
23 we're requesting an action plan to be submitted to
24 the taskforce in order to follow-up on making sure
25 that all of these issues have been resolved.

2 CHAIRPERSON RIVERA: Thank you for that. I'm
3 looking forward to it and of course, I imagine you're
4 working very closely with the Committee and interns
5 and residents as well as some of the actual staff and
6 employees there uhm to make sure that we're covering
7 as much as possible.
8 So, just a couple more questions and then I want
9 to make sure we turn it over to Chair Louis. What is
10 the total number of social workers, clinicians,
11 psychiatrists, psychologists and psychiatric nurse
12 practitioners that are hired by H+H and can a report
13 be provided by facility?
14 DR. CHARLES BARRON: Uhm, I do not have those
15 numbers specifically today but we can get you, yes we
16 do. We can do a report by facility on the number of
17 mental health staff that we hire, psychiatrists,
18 psychologists, nurse practitioners etc. So, I will
19 have to get you that, yes we can.
20 CHAIRPERSON RIVERA: Okay and specifically uhm, I
21 wanted to ask, you know when I went to visit Jacobi
22 with Council Member Riley, uhm we spoke to Stand Up
23 to Violence, the program there, the doctors, all the
24 individuals involved and they made one very clear ask
25 which was to have a psychologist added to the staff,

2 to the program because of the need for families to
3 have someone there when you had young New Yorkers as
4 young as seven-years-old having a dire need for
5 mental health services. And clearly, I know that
6 when it comes to psychiatrists and the shortage
7 across the country, but a psychologist would also
8 meet their needs. And I've asked for this a few
9 times. I'm not sure if there is an update on filling
10 that role. If there is not, I ask that you go back,
11 review, reconsider. I think this is something that
12 will be critical to that community and to the healing
13 process and to the needs there.
14 DR. CHARLES BARRON: I can certainly understand
15 that. I don't have a follow-up for you but I will
16 get that for you.
17 CHAIRPERSON RIVERA: I appreciate it. Thank you.
18 So, my last question is just going to be on
19 correctional health services. How does Health +
20 Hospitals work to meet the needs of those who are
21 incarcerated who require mental health services?
22 DR. CHARLES BARRON: Uhm, what I can say to you
23 about that is that people leaving our incarceration
24 services also have uh, especially mental health or
25 substance use disorder, something of that, have a

2 comprehensive plan. Often times that involves our
3 own programs, our own clinics, etc., but also works
4 with many of the special organizations that help the
5 post-incarcerated people to do that.
6 I can get you more details but we follow-up very
7 quickly. We have clinics specifically geared to help
8 them reenter the community and provide the supports
9 that they need in order to do that.
10 CHAIRPERSON RIVERA: Uhm, thank you. I wanted to
11 uh just follow-up with you know I know that we heard
12 from the Administration that you likely won't have
13 the data for the specific questions regarding
14 services under correctional health services but uhm,
15 we know the point of reentry transition program, the
16 PORT program, that's going to be important to ensure
17 continued behavioral health services. Health
18 services for people released from incarceration and I
19 know that there are other members of the Council who
20 have done incredible work around this issue.
21 So, with that, actually I will just turn it over
22 to Chair Louis and I want to thank you for answering
23 my questions. If I have any follow-ups, we'll come
24 right back around but thank you for being here.
25

2 Thank you for your testimony and thank you for all
3 that you do. Chair Louis.
4 CHAIRPERSON LOUIS: Thank you so much Chair
5 Rivera. Uhm, I wanted to continue the conversation
6 on specific populations as Chair Rivera was sharing
7 earlier. I wanted to know, how does health and
8 hospitals work to meet the needs of those with
9 disabilities who require mental health services?
10 DR. CHARLES BARRON: Uh, all of our services,
11 we're all compliant with disability issues and the
12 ability to access services. We have the ability to
13 access services for any disability and would make
14 accommodations for anyone who has a disability that
15 needs mental health or SUD services.
16 CHAIRPERSON LOUIS: And Dr. Barron, you mentioned
17 earlier in your testimony how successful virtual
18 services and tele mental health services has been.
19 Can you talk more, a little bit about and your
20 colleagues could join you on this, regarding safe
21 transfer and how Health + Hospitals has been involved
22 with NYC Well?
23 DR. CHARLES BARRON: Uhm, yes, I think we work
24 very closely with NYC Well. We are a huge referral
25 from NYC Well, when they talk to someone and they

2 need services, then we, our clinics are available or
3 our emergency services are available. And so, we get
4 many referrals from that particular program NYC Well
5 and incorporating them into our clinics both face to
6 face and/or virtually. So, yes, and that has really
7 increased the ability to access services quickly as
8 well.
9 CHAIRPERSON LOUIS: And how has that process been
10 to meet the needs of those with limited English
11 proficiency who require mental health services? Do
12 you have enough staff for that?
13 DR. CHARLES BARRON: Well, we always have
14 staffing issues but yes, one of the things that
15 Health + Hospitals and mental health along with the
16 rest of the system focus on. We have a very diverse
17 population that we care for and treat and that
18 certainly includes languages and uh, at one of the
19 facilities that I previously worked at, there are
20 hundreds of languages spoken.
21 Each of the facilities may have a number of
22 cultural language etc., issues and we make a point of
23 recruiting people from the communities that the
24 patient serves to sort of match our patient
25 population. Uh, we do have language, our own people

2 who are certified translators. We have our
3 clinicians that speak multiple different languages
4 and when it’s really problematic, we use the
5 professional resources of language lines etc., but
6 our mental health population are very frequently
7 fluent in languages. And that certainly is true in
8 our telehealth services to.
9 CHAIRPERSON LOUIS: Alright, so if you could
10 share with us, how does Health + Hospitals coordinate
11 with other agencies when patients are referred out?
12 DR. CHARLES BARRON: Uh, if for some reason a
13 patient wishes to be referred to another facility,
14 another system or a community based organization, we
15 as I mentioned, we have a follow-up system to kind of
16 work to make sure that they can make that transition.
17 We would make you know with the patients
18 permission; we would make certainly information that
19 would be important for treatment available to the
20 provider that they have chosen to go to and follow-up
21 to make sure that they have you know connected with
22 that provider and if there is any barrier we can help
23 with, we will continue to do that.
24
25

1
2 CHAIRPERSON RIVERA: And how do you engage in
3 follow-up? How long does that take? What does the
4 follow-up system look like?
5 DR. CHARLES BARRON: The follow-up system is a
6 multilayered sort of care management system. As I
7 said, it could be we might initiate something with a
8 telephone call to say, you know you're appointment is
9 tomorrow, don't forget. Do you need help getting
10 there? Uh, can we in anyway assist you with that?
11 Also, people who may be identified as needing a
12 little higher touch than that, we also have community
13 health workers who go out into the community, maybe
14 to the patients home and help them. Make sure that
15 they go to the appointments and connect to the next
16 level of care.
17 So, the follow-up system is usually, is once you
18 leave the inpatient service or if you're leaving our
19 outpatient service and going to a different service,
20 we would still sort of trigger that ability to follow
21 up with you to make sure that you have what you need
22 to get to that and that your provider has the
23 appropriate information as well.
24 CHAIRPERSON LOUIS: And are those services
25 provided — is it culturally competent? Those

1
2 services? Is it, yeah, if you could talk a little
3 bit about that.
4 DR. CHARLES BARRON: Sure, we always try to match
5 someone with match them as well as we can from a
6 diversity point of view. We, as I say, seek to
7 employ a very diverse and cultural, different culture
8 a knowledge base staff. In addition to that, we have
9 our human resources department has a training academy
10 that also provides additional training that each
11 individual goes through about cultural competency and
12 the different issues and different cultures. And
13 that's very important in mental health.
14 CHAIRPERSON LOUIS: Right, so the Mental Health
15 Services Corps program was shifted from Department of
16 Health to H+H as of January of last year. So, can
17 you share with us how successful that program has
18 been?
19 DR. CHARLES BARRON: Uh, yes, this has actually
20 been a very successful program. It is a great joy to
21 see you know especially young social workers get the
22 training and expertise and they go out into either
23 our place or into the community and provide services
24 to them.
25

We have — we basically have 65 slots for this. They work in both the primary care areas delivering mental health services and our own behavioral services as well. And we've seen an increase in the number of people that join and finish the program since we have taken this on.

CHAIRPERSON LOUIS: And what's the retention rate of the clinicians in the program? You mentioned 65 slots, are you looking for a new group? What's that looking like now?

DR. CHARLES BARRON: Dr. Walton, could you help me out? I don't have the number right this second.

DR. REBECCA LINN-WALTON: Yeah, we're up to 75 percent retention rate that has gotten better over the course of having the program and also, a lot of the vacancies are due to people graduating.

So, that's exciting. So, we're always actively recruiting and some of the people are being graduated and one of our graduates went on to join the Be Heard program. So, I would say that's a great success for the program, if we're not only retaining people, but training them well enough to go do some really intensive work in the community.

1
2 CHAIRPERSON LOUIS: Alright, thank you for that
3 and I just have a quick question about reimbursement
4 rates. I know we're all aware of the issues related
5 to reimbursement to mental health services and the
6 barriers for reimbursement and access to care despite
7 mental health parity issues and laws. How do these
8 barriers impact H+H from doing their work?
9 Especially now that you have new clinicians coming
10 in.
11 DR. CHARLES BARRON: What I can say is from a
12 programmatic point of view, the rates I don't think
13 impact our you know delivery of care. Our mission is
14 to serve all people, regardless of insurance or not
15 insurance or ability to pay or any of that measures.
16 While there are new rates, we are always hoping for
17 even higher rates but the rates both inpatient and
18 outpatient don't directly influence our ability to
19 provide care, as that's our mission.
20 CHAIRPERSON LOUIS: Alright, I'm going to kick it
21 back over to Sara Liss, Committee Counsel just in
22 case if any other members have any questions. Thank
23 you. Thank you to the panel.
24 COMMITTEE COUNSEL: Thank you very much Chair
25 Louis and I want to again remind members that they

2 can use the Zoom raise hand function to ask any
3 questions. I'll just give them a minute to do so.
4 Okay, seeing no questions, I'll turn it back to Chair
5 Rivera, if you have any follow-up questions. And if
6 not, you can make some closing remarks.
7 CHAIRPERSON RIVERA: I don't have any follow-up
8 questions for the Administration.
9 COMMITTEE COUNSEL: Okay, Chair Louis, do you
10 have any follow-up questions or closing remarks?
11 CHAIRPERSON LOUIS: No, I don't have any follow-
12 up questions but I do see that we're joined by
13 Council Member Eugene and Council Member Ayala.
14 CHAIRPERSON RIVERA: Actually, I just, sorry, I'm
15 so sorry to interrupt but I just wanted to ask a
16 general question about the legislation that we're
17 hearing today. Is that okay? Good, okay. Uh, I
18 guess my question is just generally on the
19 legislation that we're hearing today. Just the
20 Administration being in support. How will the
21 changes made by this bill affect how city staff,
22 DOHMH for example, adapt to the language of
23 intellectual disability instead of the outdated
24 clinical language still in use today? And if any of
25 you can speak to how the Administration will monitor

2 over time as language rightfully evolves outdated,
3 stigmatizing and potentially harmful language in the
4 City Charter and Administrative Code?
5 DR. CHARLES BARRON: Uhm, we, Health + Hospitals
6 definitely supports this bill. We are definitely
7 supportive of any change in our language that
8 decreases any stigma or discrimination against people
9 with any kind of behavioral health issues.
10 We actually already have been using this language
11 in some of our work and look forward to continuing a
12 more formal way of doing this yes.
13 CHAIRPERSON RIVERA: Thank you. I appreciate
14 that. All set Committee Counsel.
15 COMMITTEE COUNSEL: Okay, thank you so much Chair
16 Rivera and that concludes this panel, the
17 Administration. Thank you all so much for being
18 here. Our next panel will be the Greater New York
19 Hospital Association Alison Burke and we'll put five
20 minutes on the clock. Alison, you can begin when you
21 are ready.
22 SERGEANT AT ARMS: Starting time.
23 ALISON BURKE: Good morning Chair Louis, Chair
24 Rivera, and members of the Committee on Mental
25 Health, Disabilities and Addiction and the Committee

on Hospitals. My name is Alison Burke and I'm a Vice President at Greater New York Hospital Association and I'm also its point person on behavioral health issues.

I think in an effort not to be completely repetitive and I will try and skim through my bullet points and not repeat a lot of what Dr. Barron and Dr. Walton have said, and we work very closely with H+H.

I do just want to start off though by saying that Greater New York's hospital members, both voluntary and public, are strongly committed, as Dr. Barron noted to this mission and providing the highest quality behavioral healthcare to all individuals in need throughout New York City and frankly, throughout New York State.

So, today I will discuss a little bit about how the COVID pandemic has affected behavioral health services and how we all kind of pivoted and reacted quickly. And then the other issue, uhm, which I heard some conversation about is really this long standing and policy focus on changing from institutional care to more community-based care.

2 So, New York hospitals have been at the forefront
3 of the COVID-19 pandemic now, we're going on two
4 years and obviously preserving hospital capacity
5 including behavioral health capacity across the
6 continuum has been a complete priority. We're still
7 operating as you know with many constantly changing
8 issues. Last nights press conference between the
9 governor and the mayor with the new Mariette
10 certainly has people on their toes and under these
11 constantly changing conditions, the hospitals really
12 do stand ready to flex and surge. Which was this
13 strategy that gave hospitals the ability to cancel
14 elective surgeries, move beds, add beds, move
15 patients and staff and all of that in an effort
16 really to keep the system accessible.
17 So, despite all of these challenges, the
18 hospitals really have continued throughout the entire
19 pandemic to provide essential behavioral health
20 services.
21 At the very beginning of the pandemic, the
22 hospitals acted swiftly, all of them in New York with
23 city partners, our state partners and our community-
24 based organizations partners to coordinate the
25

2 consumer needs and to ensure that the system had
3 adequate capacity.
4 All hospitals, like Dr. Barron and others have
5 mentioned this as well, quickly pivoted operations to
6 maintain access and all of our hospitals including
7 H+H who already mentioned it, continue to operate all
8 of the levels of care that they have. Inpatient,
9 outpatient and emergency services, some of which are
10 at the hospital location, whether they be
11 comprehensive psych emergency programs, distinct
12 areas for psychiatric emergencies in general,
13 emergency rooms and also these other crisis services
14 that happen to be in the community.
15 I will say and it was alluded to that behavioral
16 health capacity, it did shift in response to COVID-19
17 in New York City and throughout the entire state.
18 Uhm, but the hospitals with behavioral health
19 expertise and as Dr. Barron noted, a couple of units
20 being updated to get up to code and those are for
21 safety reasons for individuals at high risk. A lot
22 of those programs accepted patients when hospitals in
23 the city needed space and staff and equipment to
24 treat the overwhelming numbers of really seriously
25 ill COVID-19 patients. And how did we keep the flow

2 of patients and access to all these levels of care.
3 Uhm, we worked immediately as Dr. Barron noted with
4 the Office of Mental Health and one of the strategies
5 we — I'm going to get in — a little bit into the
6 weeds here but one of the strategies we worked on was
7 transferring certain patients to state operated
8 psychiatric centers. And those are hospitals where
9 individuals are determined to need longer term care
10 than is provided in an acute care hospital. And we
11 got that done, I can't even tell you the timeline and
12 we have had patients in the past, prior to COVID, who
13 have waited months and months and months for that
14 level of care. We were able to facilitate this in
15 sometimes in a matter of days and that was done when
16 appropriate for certain patients, so that the front
17 door to the communities, there was access for
18 individuals in the communities for acute care. We
19 also quickly worked with our partners in the city and
20 as well as the office of addiction and support
21 services to make sure that life saving medication and
22 care for individuals with substance abuse disorders
23 was addressed. And Dr. Barron mentioned and there's
24 ongoing — there are some positives that have come out
25 of COVID. There are ongoing conversations to

2 continue some of the processes and operations, like
3 delivering methadone and to individuals who have
4 difficulty or buprenorphine.
5 SERGEANT AT ARMS: Time expired.
6 ALISON BURKE: Expired?
7 CHAIRPERSON RIVERA: He's uh, if you could wrap
8 up your testimony.
9 ALISON BURKE: Okay, I will quickly. I will
10 touch base quickly on the telehealth. It's widely,
11 positively reviewed by both patients and consumers.
12 We continue to maximize that and that is facilitating
13 hospitals ability to see more patients in a more
14 timely manner.
15 And I do just want to say that you know,
16 inpatient care, as important as it is and our members
17 are completely committed to it. It shouldn't be the
18 first entry point and it shouldn't be relied upon and
19 members are making enormous investments in outpatient
20 care.
21 And the last thing I will say and then I'll be
22 happy to answer any questions. Someone asked the
23 question about Medicaid reimbursement. It's long
24 been understood that it's been woefully under
25 reimbursed and we are constantly advocating in Albany

2 for higher Medicaid rates and in addition to that,
3 for further investment in behavioral health services
4 and that's for all hospitals and all provider types
5 to make sure the behavioral healthcare is available
6 for everyone in the community. Thank you very much
7 and I'm happy to answer any questions.
8 CHAIRPERSON RIVERA: Thank you. Thank you, our
9 Sergeants do a lot of work behind the scenes, so
10 they're just making sure that we're keeping to time.
11 ALISON BURKE: I see.
12 CHAIRPERSON RIVERA: So, I appreciate you
13 wrapping up. So, thank you for your testimony. It
14 seems, you mentioned the shift towards the pandemic
15 and how things have kind of changed, evolved some of
16 it. Because of the response, some of it just again,
17 I guess the evolution of services. So, have your
18 members seen an increased demand for mental health
19 services during the pandemic and let me just ask
20 because prior to the pandemic, the city was seeing a
21 decrease availability of hospital based mental health
22 services. And between 2009 and 2014, there was a 20
23 percent increase in mental health discharges at New
24 York City Health + Hospitals. And then in the same
25 period, there was a five percent decrease in mental

2 health discharges at New York City's Voluntary
3 nonprofit hospitals.
4 So, I guess the first question was, have you
5 remember seeing an increased demand during the
6 pandemic and has the trend that I described
7 continued?
8 ALISON BURKE: Yeah, so I think the pandemic is a
9 very unique situation and many individuals who
10 probably would never have needed or sought behavioral
11 healthcare are seeking it now. So, yes, telehealth
12 has been an enormous help in that regard to
13 efficiently uhm, see individuals in a timely manner.
14 And all of our members have done an enormous amount
15 of progress in telehealth. But the other thing,
16 they've all maintained the ability to see people in
17 person. And the inpatient decrease, you know, that's
18 a positive trend. That means that the entire system
19 is working better and sooner for individuals and
20 we're not waiting for a crisis or an emergency.
21 And that's been a longstanding goal, policy
22 initiative, not just in the city but the state and
23 nationally.
24 CHAIRPERSON RIVERA: I hear you. I think, I
25 guess our concern is how disproportionate the

2 services are and that are provided in terms of
3 whether health and hospitals is taking on you know
4 more New Yorkers who are having serious mental health
5 crisis and you touched on the reimbursement rates and
6 we're very aware of issues related to reimbursement
7 for mental health services and that there are still
8 barriers to reimbursement and access to care, despite
9 mental health parity laws. But I mean, I think it's
10 clear the barriers impact the work of the hospitals.
11 So, and again thank you for touching on the
12 Medicaid compensation earlier. Could you speak
13 further on how is inpatient verse outpatient
14 psychiatric care compensated through Medicaid and how
15 is psychiatric care factored into indigent care pool
16 funding?
17 ALISON BURKE: I will have to get my fiscal
18 colleagues really to tutor me and get back to you on
19 the indigent care pool and how all of that feeds in
20 and specifically trickles down to the behavioral
21 health services line. But just for example, Medicaid
22 and the most recent data we were able to look at,
23 right before this hearing, 2019 data on Medicaid
24 reimbursement for inpatient psychiatric services,
25 it's covering 64 percent of the cost of care.

2 The cost that's not covered is somewhat made up
3 by some commercial plans, right? And but the
4 commercial plans only represent about 25 percent of
5 the overall utilization of inpatient. So, the long
6 story here made short is that Medicaid is a critical,
7 critical piece to making sure that these services
8 remain viable for the entire community.
9 CHAIRPERSON RIVERA: Understood and any
10 information you can give me from your colleagues
11 would be most helpful. I'm just going to ask one
12 more question and turn it over to Chair Louis. It's
13 on the certificate of need process. Is there a
14 certificate of need process for closing psychiatric
15 beds? And during the pandemic, the certificate of
16 need process was suspended. Has that been reinstated
17 and what does it look like?
18 ALISON BURKE: So, the Office of Mental Health
19 who is the state oversight entity that certifies
20 funds and oversees all mental health services in New
21 York State, absolutely has got a process for adding
22 or removing services. And our hospitals are also
23 subject to the Public Health Planning Council's
24 processes as well. Now, what happened during COVID
25 were some beds were taken off line temporarily for

social distancing purposes to end the curve on spreading the virus. Patients were transferred to other or sent to or directed to other facilities where there was capacity. Any facility that took lines off — out of service for COVID purposes have all been in conversation with the state oversight entities to one, either get them back online and the overwhelming majority of them have in fact gotten them back on line.

And there are a couple as Dr. Barron noted that they are taking the opportunity really to make these even safer and more consumer friendly environment setting them up to code.

CHAIRPERSON RIVERA: Understood. I just want to emphasize; I know you mentioned that the decreases is a good thing and I just can't kind of pull myself away from that because I would agree with you and it sounds good but the increase at Health + Hospitals is there. So, I think that's where the disparate part comes from and with the certificate of need process, you know trying to bring as much transparency to what happens in our hospital systems as possible. But it becomes, again, there are so many challenges within the CON process in and of itself. So, we just again

2 want to make sure that our city hospital system,
3 which does incredible work and I know that you
4 represent them under this larger umbrella. But they
5 have seen an increase in services and that is clear.
6 And these are serious, serious cases. Uhm, so we
7 just want to make sure that there is a balance there
8 and that uhm, they receive their fair share, which I
9 know is ongoing.
10 But with that, thank you for answering my
11 questions. I appreciate you being here and I'll turn
12 it over to Chair Louis if she has any questions.
13 CHAIRPERSON LOUIS: Thank you Chair. I only have
14 one quick question. Hopefully you would have the
15 answer for it. I wanted to know, besides the mental
16 health services program, as we recognize the mental
17 health labor shortage, I wanted to know how is your
18 agency working with the city to engage the medical
19 schools to bring new students into this career
20 trajectory?
21 ALISON BURKE: So, interesting. One specific
22 example I can share with you and I want just make
23 sure that it's understood that the social workers
24 that Health + Hospitals have are dedicated to Health
25 + Hospitals and the voluntary hospitals don't have

2 that but we just one example of this is we uhm worked
3 on a project with about a dozen of our emergency
4 departments and amazingly in the last year, while we
5 were still juggling and dealing continuing to deal
6 with COVID, about 12 emergency departments in some of
7 the hardest hit communities with dealing with the
8 opioid epidemic.
9 And we work very closely with our colleagues here
10 at greater New York and our members who provide
11 graduate medical education and internship and
12 training opportunities and we just put out a request
13 to get more information on how some of our members
14 and their medical schools and their training programs
15 are preparing the upcoming workforce to deal with
16 behavioral health issues.
17 CHAIRPERSON LOUIS: Thank you for that. I'll
18 turn it back to Chair Rivera.
19 CHAIRPERSON RIVERA: Thank you. Thank you very
20 much. Well, I just want to thank you for being here
21 and for answering our questions and I know that you
22 and your colleagues at Greater New York are committed
23 to ensuring that you know, no hospital was a newly
24 burden and we're all there to achieve the same thing,
25 which is quality of care for every single New Yorker

2 regardless of their immigration status, regardless of
3 their socioeconomic status.
4 Uhm, and mental health is clearly going to be
5 something uhm, that we'll be struggling to address
6 fully as we try to recover and lead a just recovery.
7 So, thank you. Thank you for being here. Thank you
8 for your testimony and I'll turn it back over to
9 Committee Counsel.
10 COMMITTEE COUNSEL: Thank you so much to this
11 panel. We will now move on to public testimony. All
12 public testimony will be limited to two minutes.
13 After I call your name, please wait a brief moment
14 for the Sergeant at Arms to announce that you may
15 begin before starting your testimony. And to begin,
16 we will start with Khari Edwards followed by Brian
17 Moriarty. Khari, you can begin as soon as the
18 Sergeant calls you and you're unmuted by the host.
19 SERGEANT AT ARMS: Starting time.
20 KHARI EDWARDS: Thank you for having me. My name
21 is Khari Edwards, I'm the Former Vice President of
22 Brookdale Hospital, the Brooklyn Health System. I
23 also spent five years as the Director of State Senate
24 Initiatives around health policy for the New York
25 State Senate.

2 Uhm, my testimony is really just to piggyback on
3 what a lot of the other groups said today. Alison,
4 good to see you from Greater New York. But the
5 reality that we have to understand is that mental
6 health is now the new fashionable thing and what it
7 is saying is that identifiable processes of mental
8 health still fall into the fact of lack of access for
9 communities.

10 I represented Brookdale Hospital, which we had
11 almost 1.1 million people in our catchment area;
12 however, we weren't able to sustain any mental health
13 or sustainable mental health support because of lack
14 of access. Whether it's because we didn't have
15 enough doctors, enough social workers, but we didn't
16 have a clear communication between other agencies
17 much like ACS or DOE to get the support, specifically
18 for children.

19 And so, the reason why I'm glad to testify is
20 because we have to really understand that access for
21 Black and Brown communities specifically around any
22 health comorbidities, especially mental health has to
23 be opened up and a little outside of H+H but also the
24 voluntary hospitals because like I said Brookdale,
25 Kingsborough, Interfaith represent areas that H+H do

2 not have sites. And so, what we end up doing is that
3 we lose a lot of our patients to the fact of the
4 stigma, to the fact of the impossibility of getting
5 support. And Chair Rivera, as you said, that having
6 a lack of inpatient should be a good thing but it's
7 not because folks are not coming to get help. So,
8 I'm under by two minutes, so ready for any questions
9 if possible.
10 COMMITTEE COUNSEL: Thank you so much. We will
11 next turn to Brian Mariarty and Brian, you can begin
12 as soon as the Sergeant calls you.
13 SERGEANT AT ARMS: Starting time.
14 BRIAN MARIARTY: Hi, my name is Brian Moriarty,
15 and I am the Assistant Vice President of Behavioral
16 Health & Senior Housing at Volunteers of America
17 Greater New York. Volunteers of America Greater New
18 York is part a local affiliate of the national
19 program. I would like to thank the Chair of the City
20 Council Committee on Hospitals Council Member Carlina
21 Rivera, and Chair of Committee on Mental Health,
22 Disabilities & Addiction Council Member Farah N.
23 Louis, for the opportunity to submit the testimony
24 today.
25

2 VOA Greater New York is an anti-poverty
3 organization that aims to end homelessness in Greater
4 New York by 2050. As one of the largest providers of
5 services to families and individuals experiencing
6 homelessness in the Greater New York area, we deliver
7 services to more than 11,000 adults and children
8 annually through 66 programs in New York City,
9 Northern New Jersey, and Westchester.
10 These include four shelters that offer a range of
11 on-site services for residents who experience
12 persistent mental health and behavioral health
13 issues, including frequent hospitalizations, serious
14 physical health diagnoses, including frequent
15 hospitalizations, serious physical health diagnosis,
16 and substance use issues.
17 At the Wales Avenue Residence and Creston Avenue
18 Residence, we provide comprehensive services to
19 adults and young adults with persistent behavioral
20 health issues. We also operate scattered site
21 apartments across the Bronx for chronically homeless
22 single adults with substance abuse disorders, mental
23 health and living with HIV.
24 One of the things I wanted to speak about today
25 that the time has come to stop using call 911 as the

2 answer to every one of the emerging mental health
3 related request through the precisely what has become
4 the norm for serious mental health issues is we get
5 responsive, just call 911. And this is especially
6 amped up the demand during the COVID where services —
7 SERGEANT AT ARMS: Time expired.
8 COMMITTEE COUNSEL: You can finish your sentence
9 and wrap up.
10 BRIAN MARIARTY: Oh, I'm sorry. Uh, we've really
11 seen and I've submitted this via writing so you can
12 look at it but this rotating door whereby clients
13 behaviors too often and too quickly deemed to be
14 substance induced and not looking at the underlying
15 mental health. So, when we get someone to a CPAP or
16 emergency room, it's — our input is often not looked
17 at and they are too often what I call treated and
18 streeted and sent back to the community, which is
19 further putting a strain on not only emergency
20 services, police services, it impacts the client and
21 retraumatizes the client significantly over and over
22 again with the idea of mental health services when
23 they act out or become violent. Just call 911, even
24 though as the clinicians on site, we can predict when
25

2 someone is going to become violent based on their
3 prior history and where far to often overlooked.
4 So, I have a lot more in the written statement
5 but you guys can read that. I don't want to you know
6 abuse my time here, so I'll be quite. Thank you.
7 COMMITTEE COUNSEL: Thank you so much for your
8 testimony and thank you for the reminder. For anyone
9 who wants to submit testimony via writing, you can
10 submit it at testimony.council.nyc.gov and it will
11 included in the official record.
12 I'm going to pause here to allow the Chairs to
13 ask questions of these two panelists, if they have
14 any questions for them.
15 CHAIRPERSON LOUIS: No questions on my end.
16 CHAIRPERSON RIVERA: Nope, just want to thank you
17 for being here and for all you do. Looking forward
18 to supporting you.
19 BRIAN MARIARTY: Thank you.
20 COMMITTEE COUNSEL: Thank you so much to this
21 panel and we'll next turn to Kimberly Sylvester
22 followed by Cherray Mathis followed by Dreana
23 Bellamy. And Kimberly, you can begin as soon as the
24 Sergeant queues you.
25 SERGEANT AT ARMS: Starting time.

2 KIMBERLY SYLVESTER: Hi, good morning. My name
3 is Kimberly Sylvester. I work for the Bridge Mental
4 Health and Housing Solutions and funding for programs
5 like this one is crucial for recruitment retaining
6 staff. Without this type of funding for staff, we
7 will overwhelm the Health + Hospital systems. We are
8 your first line of defense. We see the violent
9 behaviors, the mental health issues before they make
10 their way into the community.
11 A lot of times we have one staff person who
12 covers an entire facility of 60 people. When that
13 happens, we have no choice but to call NYPD and
14 ultimately, into the Health + Hospital system, uhm,
15 with funding for programs like these, we may be able
16 to help alleviate the problem that the Health +
17 Hospital systems are having. We are using so many of
18 their beds for our clients and unfortunately, a lot
19 of our clients are unmedicated, they are violent.
20 Although they do have mental health issues, some of
21 them are sex offenders. They have committed the act
22 of murder. And we just simply cannot — these
23 programs are not sustainable without funding for
24 staff. We have no choice but to send them into the
25 Health + Hospital systems into the criminal justice

2 system without more funding for more staff. Thank
3 you so much.
4 COMMITTEE COUNSEL: Thank you very much for your
5 testimony and we'll next turn to Cherray Mathis
6 followed by Dreana Bellamy and Cherray, you begin as
7 soon as the Sergeant queues you.
8 SERGEANT AT ARMS: Starting time.
9 CHERRAY MATHIS: Good morning. My name is
10 Cherray Mathis. I currently serve my community as a
11 Care Manager at the Bridge, a nonprofit mental health
12 and housing solutions organization. I take pride in
13 my role assisting the most vulnerable individuals in
14 our community as they effect change in their lives.
15 Throughout the COVID-19 pandemic I have juggled being
16 a full-time graduate student, full-time care manager,
17 and per-diem residential counselor working overnight
18 shifts.
19 I look and am every bit the part of a dedicated
20 and selfless social service essential worker. My
21 community counts on me to expertly balance working
22 two jobs and continue going to school. But let's be
23 transparent. Maintaining two jobs and going to
24 school is not just me giving the altruistic
25 performance of a lifetime, it is a must. My current

2 salary as a care manager does not support the
3 financial burdens I have to bear.
4 Furthermore, the shortage in the workforce, due
5 to high rates of burnout and turnover of individuals
6 leaving for better, higher paying fields, means that
7 I am desperately needed to assist with shift coverage
8 in 24-hour supported housing programs. Dropping out
9 of school personally affects me by jeopardizing long
10 term salary gains and dimming career outlook. For my
11 community, abandoning my educational advancement once
12 again stresses the social services workforce
13 shortage.
14 I recently began to wonder where does this
15 mindset of social service workers not deserving to
16 make a living wage come from? When I talk to my
17 peers, we all want to make living wage. We have
18 hopes and dreams, we want financial stability and on
19 a daily basis we would like to adequately self-care.
20 I would like to — no – need to see the narrative of
21 social services being a thankless and underpaid
22 profession change.
23 In the future, my community can count on me to
24 become a licensed clinical social worker and a
25 wellness life coach. I am asking to count on you to

2 increase the funding needed to support living wages
3 for social service essential workers. Thank you.
4 COMMITTEE COUNSEL: Thank you very much Cherray.
5 And we'll next turn to Dreana Bellamy, and you can
6 begin as soon as the Sergeant queues you.
7 SERGEANT AT ARMS: Starting time.
8 DREANA BELLAMY: Good Morning City Council
9 Members. Thank you for meeting with us today. We
10 appreciate your efforts to improve behavioral health
11 services. My name is Dreana Bellamy I am an 1199
12 Organizer in the community-based organization and I
13 serve the Bridge as an Organizer.
14 The Members that work at The Bridge are frontline
15 behavioral healthcare givers. These Members work
16 every day around the clock with a very challenging
17 population to provide direct mental health services
18 and coordinate medical and other services for The
19 Bridge clients. The issues that these Bridge staff
20 face in this challenging work force, is low pay.
21 This is the primary challenge to both keeping
22 current and attracting new behavioral healthcare
23 workers, which prevents patients from accessing
24 needed behavioral healthcare services. Often Staff
25 with Bachelors and Master Degrees are currently

2 earning $25,000 to $35,000 per year for this very
3 challenging work. This is not sustainable and we
4 will continue to lose staff as wages in many low
5 skilled jobs such as McDonald's, Starbucks, Amazon,
6 meet or exceed these salaries for this critical work.
7 During the pandemic, these workers were the
8 firefighters of healthcare. They walked into a
9 burning building every day and risked their lives.
10 State and Federal agencies need to increase the level
11 of wages and provide a cost of living increase
12 yearly. When the City Council considers policy
13 proposal to improve behavioral health services, it is
14 important to remember that the frontline caregivers
15 are critical to both of the quality and access to
16 care, and much of what needs to improve the working
17 conditions of those providing care. Thank you for
18 listening.
19 COMMITTEE COUNSEL: Thank you very much for your
20 testimony. And again, I'll pause here for any
21 Council Member questions or for either of the Chairs
22 to ask any questions of any of the panelists.
23 CHAIRPERSON LOUIS: So, I wanted to thank
24 Cherray, Dreana, Khari, I saw somebody else earlier.
25 Uhm, and Kimberly for all of your testimonies. I

2 wanted to know if you could give some examples of pay
3 parity that anyone is experiencing. And I also want
4 talk for the Bridge, how many employees do you have
5 there?

6 DREANA BELLAMY: Currently, I believe there's
7 about 283 workers at the Bridge.

8 CHAIRPERSON LOUIS: How many locations?

9 DREANA BELLAMY: 25.

10 CHAIRPERSON LOUIS: Can you name the areas?

11 DREANA BELLAMY: They're located in the tristate
12 area. Uhm, I believe that uhm, the workers could
13 give but I believe the Bronx, Brooklyn, Manhattan
14 uhm, I'm not sure if any other areas, but I know that
15 I service the Bronx, Brooklyn, Manhattan. And Kim or
16 Cherray, is there any other areas? Staten Island? I
17 don't believe Staten Island though.

18 KIMBERLY SYLVESTER: I believe it's just three
19 boroughs currently.

20 CHAIRPERSON LOUIS: Those three and how many
21 patients, how many clients to you see there?

22 KIMBERLY SYLVESTER: Each facility has a
23 different number. Uhm, my facility currently has
24 over 40. I've seen as many as 60. Uhm, honestly
25 each facility has a different number.

2 CHAIRPERSON LOUIS: And which location?

3 CHERRAY MATHIS: I worked on a pathway home
4 program as a care manager and then as a per-diem
5 residential counselor. I float between the different
6 sites that they have.

7 CHAIRPERSON LOUIS: And how many clients for each
8 site?

9 CHERRAY MATHIS: Uh, I can't remember off the top
10 of my head. It can vary of the residences.

11 DREANA BELLAMY: Uhm, Chair Louis I know you were
12 asking Kim where she works, as she works on the East
13 River in Harlem on 125th Street.

14 CHAIRPERSON LOUIS: Okay.

15 DREANA BELLAMY: And if I may, I would just like
16 to speak a little bit to uhm, the workers who are
17 working on a one man shift in the evenings where
18 they're servicing 50 to 60 clients in one shift or
19 double shifts because of the understaffing. There's
20 a serious understaffing in these residents and it's
21 dangerous for these members to be alone when things
22 happen. Sometimes again, clients can become manic
23 and then, uhm, our members can be hurt. There's a
24 list of things that I'm always getting called as an
25 organizer asking me to help them because you know

2 uhm, there's women that work at midnight and we keep
3 asking management to have a two man shift and not
4 have a one man shift.
5 Uhm, but because of the minimum wages, they
6 cannot keep — people are coming, it's a revolving
7 door. They can't retain workers because of the low
8 paying wages and these are members who have bachelors
9 and master degrees. And we're going into
10 negotiations — uhm, we're in negotiations. We start
11 negotiations I believe on December 8th and we're
12 asking that they raise the minimum wages for these
13 members who are making only $15 an hour. Which is, I
14 mean, it's like ludicrous and it doesn't make sense.
15 CHERRAY MATHIS: I'd like to add that as a per-
16 diem counselor, I have almost always worked a single
17 shift. I believe I can count on one hand the amount
18 of times when I was paired with someone who is a
19 regular staff at the residence. And for me, it can
20 be a concern because clients would like to bend the
21 rules a little bit. As they know that you are not
22 quite aware always of the different operational
23 procedures that go on at the different residences.
24 So, that's a concern not just for my safety but their
25 safety as well.

1
2 KIMBERLY SYLVESTER: It's very true, like a lot
3 of times our staff, when you're working one person,
4 we've had staff sexually assaulted. Uhm, physically
5 assaulted, uhm several workers have gone out on
6 disability for several months because of injuries
7 sustained. It's just, we can't work single coverage,
8 yet almost every night we do have workers who do it.
9 When you have a building of 60 people, we're
10 overwhelming every system, the Health + Hospital
11 system, the NYPD system, EMS. Uhm, we've had to have
12 [INAUDIBLE 1:31:20] respond. It's just, we can't
13 continue to do it and at minimum wage, nobody wants
14 to do it. So, we're really hoping for more funding.
15 CHAIRPERSON LOUIS: I want to thank the three of
16 you for sharing all of this information. It's
17 definitely heart wrenching to hear all this. I just
18 have a quick question and then I'm going to go over
19 Khari next. I just wanted to know uhm, is your
20 organization working with H+H? Are you one of their
21 key providers or partners?
22 DREANA BELLAMY: Are you talking 99?
23 CHAIPERSON LOUIS: Health + Hospitals. Do you
24 partner with Health + Hospitals?
25

1
2 DREANA BELLAMY: Yeah, we work with Health +
3 Hospitals. We work with the HHQC. We do work with
4 them. We are a union 1199 healthcare union, so we
5 work with both the legal hospitals, the greater and
6 the community-based organizations. So, we work with
7 all three. I'm the organizer, which I come in and
8 force the collective bargaining agreement. So, we
9 don't have any funding that goes to uhm, any of these
10 facilities, the Union, 1199 Union. We're just, the
11 Union is enforced in a collective bargaining
12 agreement.
13 CHAIRPERSON LOUIS: Okay. Thank you for that and
14 my next question is for Khari, I wanted to know how
15 financially difficult is it for hospitals to provide
16 a full range of mental health services according to
17 your experience working at Brookdale and just the
18 state?
19 KHARI EDWARDS: I mean, it's extremely difficult
20 because one thing that you guys highlighted is the
21 reimbursement rates, right? And so, the
22 reimbursement rates for uhm, OB mother, baby, to
23 reimburse through the rates for mental health,
24 they're deplorable, right? And so, what happens in
25 communities of color, specifically the ones that I

2 represented, as well as 1199, you have so many people
3 who need the services. You have so many parents who
4 need the services but we're really understaffed.
5 It's not a sexy job for residents to want to get in.
6 You have some psychiatric residents who are part of
7 it but social work is not the thing and like my
8 colleagues are saying, you know you basically get
9 minimum wage.
10 So, when you literally talk about a million plus
11 people in the catchment area and then you put the
12 kids in there as well, how could we have a capacity
13 of ten doctors, maybe 12 residents but we literally
14 could have almost 25,000 people who need services.
15 So, that's something that I think the city and state
16 really have to work hard on is looking at the
17 reimbursement rates specifically because of what
18 happened during COVID. And I didn't mean to call it
19 like the new sexy thing to say but it is the reality
20 that this is something that's now prevalent and
21 people are paying attention to it and we have to be
22 able to fund the need for it.
23 CHAIRPERSON LOUIS: Thank you. Uhm, I'm going to
24 turn it back to Chair Rivera. I don't know if you
25 have questions.

2 CHAIRPERSON RIVERA: No, thank you Chair Louis.
3 You did a great job.
4 CHAIRPERSON LOUIS: I'll turn it to Committee
5 Counsel Sara Liss.
6 COMMITTEE COUNSEL: Thank you so much Chair Louis
7 and Chair Rivera. I'm just going to pause here
8 again. If there are any other Council Members who
9 have questions, please use the Zoom raise hand
10 function.
11 Okay, seeing none, uh, I'm also just going to
12 just wait a moment in case there's anyone who we may
13 have inadvertently missed. Please use the Zoom raise
14 hand function.
15 Okay, I see that Dreana Bellamy has an additional
16 question or point to make. So, you can speak when
17 you are ready.
18 DREANA BELLAMY: Uhm, I just want to thank both
19 Chair Louis and Chair Rivera for putting together
20 this panel so that our voices can be heard and the
21 members voices can be heard. This is phenomenal, we
22 never really have a voice and I really thank you.
23 I'm always advocating for the members at the Bridge
24 and my mental health facilities. And I know the
25 members are in doubt and I thank you, I thank you

2 deeply for advocating for the mental health that
3 sometimes I feel like gets lost and you know is like
4 pushed to side. Thank you.
5 CHAIRPERSON LOUIS: Thank you for your service.
6 COMMITTEE COUNSEL: Thank you so much. And
7 additionally, I see that Khari Edwards has his hand
8 up. So, you can speak when you are ready as well.
9 KHARI EDWARDS: Yes, I just really wanted to uhm,
10 Dr. Nadia Lopez, who was the Principal of my Mott
11 Hall Bridges Academy in Brownsville representing
12 obviously Council Member Ampry-Samuel's area, she was
13 supposed to testify. I don't think she came back on
14 but because me and her work very closely together as
15 well with the Council Member, the reality of what I
16 said earlier about agencies being able to partner,
17 not only with healthcare institutions of the city but
18 just private ones, there's a huge disconnect in that
19 as well. Because to refer a student from a school
20 who should basically have mental health capabilities
21 on site, by the time they get to the hospital, by the
22 time we have a lack of staff, then all of a sudden,
23 the children get put through the system and then they
24 get lost. And then the parents get frustrated.
25

2 So, again, Chairperson Rivera, the reason why I,
3 you know I said, yeah, it's cool to not have a lot of
4 folks in the hospital but folks are not coming
5 anymore because they don't feel like they're getting
6 the service. So, I also wanted to say kudos to you
7 as well as Chairperson Louis. Oh, I see Dr. Lopez is
8 on, so I can, I'll give my time to her because she's
9 the expert on this one from the student standpoint.
10 But I just wanted to say thank you for doing this as
11 well.
12 COMMITTEE COUNSEL: Thank you so much and yes,
13 we've been joined by Dr. Nadia Lopez and you can
14 begin as soon as the Sergeant queues you to testify
15 Dr. Lopez. Thank you so much.
16 SERGEANT AT ARMS: Starting time.
17 DR. NADIA LOPEZ: Uhm, good morning. So, uhm,
18 here's what I'm going to say. There is a disconnect
19 between schools and hospitals in terms of mental
20 health support. I'm grateful to Khari Edwards as
21 well as Councilwoman Alicka Samuels because they have
22 been a great support through my tenure when I was the
23 principal of Mott Hall Bridges Academy.
24 I want to just be very candid in saying that I
25 dealt with a lot of children with mental health

2 illnesses as well as their parents. Uhm, and one of
3 the struggles that we often say in our school
4 building is that the time period in which young
5 children were getting seen by mental health
6 providers. If they went to the emergency room and
7 they refer to getting a consultation, it could take
8 six weeks to three months. And then after that
9 initial meeting, they then had to wait to be assigned
10 a mental health provider.
11 Then after they got the mental health provider,
12 there were children who had seen within a two year
13 period, up to two to three different mental health
14 counselors just simply because of the high turnover
15 rate at the hospital.
16 I had to advocate plenty of times for parents in
17 regards to the 30 day medication that was provided,
18 so instead of giving refills, they were only given 30
19 day prescriptions. So, if you had a parent who was
20 working, you had a parent who had multiple children,
21 the idea was that they had to keep coming back to the
22 hospital to get their medication refilled, which was
23 inadequate.
24 Uhm, and then we also had an issue at the school
25 where there was a child who literally was in a

2 crisis, he had gone to Kings County, he had gone to
3 Bellevue and ultimately stopped at Brookdale Hospital
4 and the only reason why I got him the help that he
5 needed was because Councilwoman Samuel stepped in.
6 Khari Edwards was able to connect me with the
7 president of the hospital. But this child was in
8 crisis and had cut himself multiple times. Had
9 verbalized that he was going to hurt himself and
10 others and it wasn't until he created a manifesto
11 that was so disturbing that then they were like, this
12 is somebody that we actually have to treat.
13 And so, I want to say that schools are the hubs
14 in which the children who have mental health issues
15 go to every single day. We lack the support. We've
16 lacked the funding. We were referred to Thrive but
17 unfortunately, telling my staff that they have to go
18 through this crisis training, was inadequate when
19 they themselves was dealing with the trauma that was
20 happening in the building, dealing with vicarious
21 trauma from the poverty in the community.
22 And in addition to that, we were trying to
23 develop a program or have the mental health facility
24 within our school. Uhm, I was working with Khari and
25 the physicians at Brookdale but because of the

2 Department of Education, there was all the red tape
3 that was happening there and then what was happening
4 in the hospital, it never came to fruition. Yet, we
5 have one of the highest populations of individuals
6 who had mental health needs.
7 Uhm, so I apologize, I had to step away and I
8 didn't get to hear all the testimonies but having a
9 nursing background and then having been a leader in
10 education, it is a disservice as to what is
11 happening.
12 Because of COVID and many of the families losing
13 so many family members, especially those who may have
14 gone to Brookdale or prior to COVID, there is also
15 the trauma of going to the hospital that keeps family
16 members away from that. They are not often offered
17 tele mental health services. Which is something that
18 also needs to be addressed. Uhm, so I'll just stop
19 there because you know I know I've gone over my time.
20 COMMITTEE COUNSEL: Thank you so much Dr. Lopez
21 and I'm going to turn now back to Chair Rivera and
22 Chair Louis for any additional questions.
23 CHAIRPERSON LOUIS: Sorry, I just have one quick
24 question. I want to thank Dr. Lopez for coming on
25 and for sharing testimony, your experience. Over the

2 years, I've always heard about you speaking about
3 mental health and education, so I'm happy we got it
4 on the record and having this conversation today to
5 talk about it but also to find solutions.
6 So, I wanted to ask you Khari, Dreana, Kimberly,
7 Cherray, and one more person, Brian. I wanted to ask
8 all of you, what could we do to incentivize more
9 young people, students, people of color, to get into
10 the field of mental health? And is there anything —
11 that's the basic question. What do you think that we
12 can do on our level as City Council members to
13 encourage more people to get into the field?
14 COMMITTEE COUNSEL: Sorry, I'm going to just call
15 on people in order. So, it's not — so, Brian, why
16 don't you go ahead and start and then Dr. Lopez, you
17 can go next.
18 BRIAN MARIARTY: I apologize. Uh, I think it's
19 about access to higher education and free tuition, so
20 they don't graduate with significant student loans.
21 And then a higher rate of pay. I mean, we are
22 competing with a very small pool and requirements to
23 that, we are put under when we apply for contracts to
24 have a certain number of licensed master's level
25 employees.

2 I have one early career woman who works with us
3 at the Whales program and she's looking at graduate
4 school now and she's very concerned about how she's
5 going to pay for that and pay rent. Uh, and she gets
6 paid what is considered believe it or not, a $40,000
7 a year salary is considered good, when it really is
8 not adequate for her to meet all her standards. So,
9 you know, more scholarships at Hunter and some of the
10 schools in New York and higher pay when they
11 graduate. You know, so they don't have to live in
12 debt. That would be my number one suggestion.
13 COMMITTEE COUNSEL: Thank you so much. And then
14 we'll turn to Dr. Lopez and then Khari, you can go
15 afterward.
16 DR. NADIA LOPEZ: You know I think the first
17 thing is that you need to engage young people in
18 conversations. Simply because you need to really
19 find out what their interactions have been with
20 mental health. Talk to them about what they believe
21 are viable solutions. Uhm, and then provide them
22 with what those options can look like for them to
23 make change, right? We — too many times we just
24 assume and we say this is the best option but young
25 people are thoughtful and they're creative. They

1
2 have dealt with mental health issues and they see the
3 stigma in their community or they've had bad
4 relationships with prior therapists.
5 So, if you engage them in a conversation, it's
6 just like you know knowing what they've gone through
7 in their communities of poverty. What do you think
8 you need, right? They will give you a long list of
9 the things that they need. We need to do the same
10 thing as it relates to mental health. And then
11 saying to them, you know there's a way in which you
12 can be an advocate of change. There's a way you can
13 influence and impact your community. You can
14 actually become a mental health provider. What would
15 it look like for your to go to school? What would it
16 look like for you to be an intervention specialist?
17 And start listing those things and then bring
18 people of color who look like them into their schools
19 to have conversations about why they went into the
20 profession as well. But we have to do a better job
21 of engaging young people, not just assuming that you
22 know, they don't know what they need or just saying,
23 if we give them the money, they'll go. If they don't
24 know what they can aspire to, it's not even going to
25 make a difference.

2 COMMITTEE COUNSEL: Thank you very much. And
3 Khari, you can go next followed by Cherray.
4 KHARI EDWARDS: So, one of the great things in
5 her long list of great things that Dr. Lopez did, is
6 that she started in the I Matter program where she
7 brought students into the hospital and you know my
8 role was to introduce them to the different roles
9 that you know basically are in healthcare. And being
10 the first Vice President of color, it was a cool
11 thing but you know we had mental health. We had you
12 know physician assistance. So, she's actually
13 correct in that respect.
14 Also, to you know, we have to look at our
15 colleges right? You know King Borough Community
16 College does an amazing substance abuse course, two
17 years to help folks get started in something.
18 Then we look at 1199, right? And 1199, our
19 healthcare partners, our DC 37 partners, you know
20 doing a vital Brooklyn, the Governor at the time
21 Cuomo, decided that he was going to put in place you
22 know $20 million to 1199 to do training to move folks
23 from one side of healthcare to another side. I think
24 that there's an investment that the city can make,
25 especially with our unions who do the work every day,

2 to get that build in service work of who wants to go
3 back and finish school and do something different and
4 influence them that way. I think that there is so
5 many different ways that we can address this but I
6 think one, you know Dr. Lopez's piece too but we also
7 hit the unions and try to get them retrained with
8 state and city money because it will come back to
9 benefit us in the long run.
10 COMMITTEE COUNSEL: Thank you so much. And
11 Cherray, you can go and Kimberly, you can go next.
12 CHERRAY MATHIS: I'd like to add on to what
13 everyone has said about education so far. As I
14 stated earlier, I am doing my MSW and I am Hunter,
15 and I am only doing that because I have a scholarship
16 through the union. When I was considering it, it
17 just really looked so far out of range with my
18 salary.
19 So, I really appreciate that opportunity and I
20 would like to say other people would enjoy that
21 opportunity either through a union or other types of
22 scholarship opportunities.
23 To speak on the union, I would like to make two
24 points. The union has helped me personally, as well
25 as other members. When we report things that we

2 think are questionable or less than good faith
3 practices, when we are servicing our members. I also
4 remember earlier in this conversation, there was an
5 idea of anonymously reporting. I would like to see
6 more funding for that because at the end of the day,
7 it's really about giving the best care we can
8 possible to everyone.
9 And lastly, I would like to speak on the idea of
10 funding the unions again, as well as just funding new
11 ideas. As a young person, a millennial, I do have a
12 lot of ideas on how I think we can improve things,
13 make things better, make things innovative. I am
14 really holding on to telehealth. I like that and I
15 saw that there were a lot of ways that I was able to
16 engage clients more because of telehealth. So, just
17 continue to fund new ideas and new innovation.
18 COMMITTEE COUNSEL: Thank you so much. And
19 Kimberly, you can go followed by Dreana.
20 KIMBERLY SYLVESTER: Hi, uhm, to be honest, I'm
21 going to say the wages. You have to increase the
22 wages. I, personally, I have two college degrees and
23 I make very low wages. Uhm, to ask somebody to do
24 what we do knowing that you could be physically
25 assaulted, uhm, for minimum wage is just, it's just

2 not going to happen. We're going to continue to have
3 trouble recruiting and retaining staff and like I
4 said, without — we're overwhelming these you know,
5 Health + Hospital systems. We're overwhelming NYPD.
6 We've had to call 911 multiple time per hour. We
7 send hundreds of clients into the Health + Hospital
8 systems.
9 If we could just pay staff more and get them back
10 into these programs, we can help alleviate some of
11 the problems that these other organizations are
12 having. Thank you.
13 COMMITTEE COUNSEL: Thank you very much. And
14 finally Dreana, you can go when you're ready.
15 DREANA BELLAMY: So, I believe how this Council
16 can help I believe is funding. Making sure that
17 these members are getting adequate wages. There's a
18 burnout. There are members there that work for the
19 Bridge that are working two and three jobs in order
20 to make ends meet. Some are on public assistance.
21 Some are living in poverty and working at the same
22 time and these are people with master degrees and
23 bachelor degrees. It's disheartening you know when
24 we go to negotiations and people are saying, you know
25

2 I have all of these bills. I have student loans and
3 I'm only making $15.00 an hour.
4 So, I believe funding and wages. Increasing the
5 minimum wages. Having cost of living increasing
6 yearly and programs and making sure that these mental
7 health facilities get funding and provide the
8 programs that they get funding for.
9 I know a lot of times I hear from my members that
10 there are programs that they don't mandate are you
11 know, directly — these clients that need these
12 programs, they don't make them go to these programs.
13 They'll get the money but then they don't use these
14 programs. And enforcing that they use these
15 programs, so that we don't have to — so that our
16 members don't have to call 911. And so that they can
17 get the understanding and the treatment that they
18 need from these programs.
19 And so, I really hope you hear me and that when
20 we go — I'm not sure how this works and what the next
21 steps are but I know I'm in negotiations now for
22 better wages for my members. I don't know how long
23 this will take but these are the things that I
24 believe that will help. Not only my members but the
25 clients too and their wellbeing.

2 COMMITTEE COUNSEL: Thank you so much. And thank
3 you to all of the panelists who spoke. I'm going to
4 turn back now to Chair Rivera for any closing remarks
5 and then Chair Louis, you can give your closing
6 remarks.

7 CHAIRPERSON RIVERA: Thank you so much to all of
8 you that are here today. Our city hospitals are
9 hospitals that are serving low income, Black and
10 Brown communities have and continue to be
11 disproportionately affected by the state of mental
12 health, and how it is offered in our communities and
13 our neighborhoods. These neighborhoods have been
14 historically underserved and I think it's clear that
15 we have to prioritize the staffing and the services
16 in these areas of the city that are in crisis and to
17 show respect to those providing these services.
18 Those of you who are here today sharing your very,
19 very honest experiences at this hearing. So, I want
20 to thank you. You know trying to visit as many
21 hospital systems, facilities, and hearing the stories
22 that are happening very, very hyper locally. That is
23 why we are here today. That is why we are hosting
24 this hearing. That is why we want to push for you
25 know the right staffing, whether it's psychologists,

2 psychiatrists, more nurses, that person for that —
3 that second person for that shift. So, you can feel
4 safe and so that everyone feels like they're
5 receiving quality care regardless of what zip code
6 they live in.
7 So, I just want to thank you for being here
8 today. For everything that you offer to our city.
9 For taking care of so many people and we want to be
10 able to show you that we also want to take care of
11 you. We want you to be able to take care of
12 yourselves and I know that starts with paying you,
13 your value, your worth and to be taking care of these
14 facilities and the people that walk through those
15 doors.
16 So, I want to thank everyone for their testimony
17 today. For all the work that you've done this far.
18 All of your advocacy and I'll turn it over to Chair
19 Louis now for any closing remarks. Farah.
20 CHAIRPERSON LOUIS: Thank you so much Chair
21 Rivera. I want to thank New York City Health +
22 Hospitals, the Greater Hospital Association and the
23 public who came out to testify today, Brian, Dreana,
24 Dr. Lopez, Khari Edwards, Kimberly, Cherray for
25 sharing, just being vulnerable and for sharing this

information with us today. And I want to thank Health + Hospitals for sharing how their agencies were able to pivot during the pandemic and what we can do better moving forward. We look forward to working with you all to address the existing challenges and finding ways to streamline access to better mental health services for all communities.

I want to thank you Chair Rivera for partnering on this hearing with me today. We appreciate it and with that, I'll give it back to Committee Counsel Sara Liss.

COMMITTEE COUNSEL: Thank you so much and Chair Rivera, you can close out the hearing when you're ready.

CHAIRPERSON RIVERA: Okay, thanks again to everyone. Of course, the staff at the Council for helping us with all the technical support and to you all who are still here, please be in touch with us. Let us know how we can advocate for you effectively.

And with that, I will adjourn this hearing of the Committee on Hospital and Mental Health. [GAVEL] Thanks everyone.

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 January 29, 2022