File T2020-6223: "**New York City Hospitals' Response to the Mental Health Needs of Frontline Health Care Workers during the COVID-19 Pandemic"**

James H. Cho, MD
Primary Care+Hospitalist of Internal Medicine, Bellevue Hospital

Brief addendum to testimony for the New York City Council Committee on Mental Health, Disabilities and Addition, jointly with the Committee on Hospitals

Hearing on Tuesday, June 16 at 10:00 AM

Chair Ayala, Chair Rivera, and the City Council members:

I had a brief follow-up response to Chair Ayala's question regarding whether I had utilized any resources offered by NYC Health+Hospitals' "Helping Healers Heal (H3)" program. With Dr. Eric Wei and other representatives of Health+Hospitals on the call, I did not believe this public forum would be appropriate to raise criticism of the program. However, the simple answer is that a program meant to be a peer-facilitated support network is less effective when we do not see any peers engaged in the program. At the launch of H3 at NYC H+H, I was invited along with other colleagues to become a "Peer Support Champion" for H3. However, the introductory training sessions were day-long events and were announced a few weeks in advance. As a full-time practicing clinician with a patient care schedule booked 3 months out, it was impossible for me or many of my interested peers to attend. We asked for advanced notice of future sessions, as additional sessions were planned over time, in order to allocate time in our schedules to participate. Unfortunately the same scenario repeated again and again, limiting participation from our group.

Now, during a time when such a program could be uniquely posed to offer the much needed support for the mental health and well-being of our front-line workforce, I do not see any of my trusted colleagues or peers as participants in this program. The names I do see on the email blasts include members of our existing leadership team, who are not necessarily ideal parties to offer support to our workforce during a highly vulnerable time. I am happy to accept coffee during a respite activity that H3 may offer, and I have fully appreciated such efforts. However, the lack of peers involved in this program limits its effectiveness as support network for our staff.

I have taken this opportunity to share these same experiences with Dr. Wei privately. I appreciate your attention to such matters and thank you for your continued support of our frontline healthcare workers as our city continues on in this COVID-19 pandemic.

Sincerely,

James Cho, MD

Primary Care+Hospitalist at Bellevue Hospital

Testimony of Bobby Larson
Supporter of CCITNYC,
Correct Crisis Intervention Today in NYC: Fighting to Transform
Responses to Mental Health Crises

City Council Hearing
Public Safety Commission
Tuesday, June 9, 2020

Thank you to the members of the City Council for hearing this testimony today.

My name is Bobby Larson. I am a supporter of Correct Crisis Intervention Today in NYC (CCITNYC), a coalition of 80 organizations and over 400 stakeholders whose mission is to transform how the New York City responds to mental health crises by diverting responses away from law enforcement and the criminal legal system.

CCITNYC thanks Council Member Donovan for his role in forming the Mayor's Task Force on Behavioral Health and Criminal Justice. The first task force met in 2014 and the second task force, on Prevention and Crisis Services, met in 2018. But the recommendations of those task forces do not go far enough.

Substantial resources need to be diverted from the New York Police Department (NYPD) to mental health teams to respond to the 200,000 911 calls the City receives annually for mental health crises.

CCITNYC supports re-direction of funds from the NYPD to mental health teams so that the City will have enough funds to create these mental health response teams and this type of work will no longer be a role of the NYPD.

We ask you to carve out $15 million of those funds for a five-year peer pilot project.

CCITNYC has developed a detailed plan and budget for a pilot project in two heavily-impacted precincts. The pilot will pair emergency medical technicians (EMTs) with "peers" (individuals with lived mental health experience). The EMTs and the peers – rather than the police -- will be the first responders for people who experience mental health crises, and their families. The pilot will provide 24/7 mental health team responses.

(EXPLAIN YOUR REASONS FOR WANTING A PEER LED RESPONSE TO MENTAL HEALTH CRISIS HERE)

Even with additional training for police officers, the City will be unable to prevent the recurring injuries and deaths that occur when officers respond to mental health crisis calls. The violent response we have seen from the police in encounters with protestors is exactly what we have been documenting for years when they respond to people in emotional distress. Police do not de-escalate crises; they are not mental health care practitioners.

The people below did not receive mental health care. They never got that chance. They were killed by police who do not want to respond to mental health crises and who should never be asked to respond to mental health crises.

Since the NYPD started providing Crisis Intervention Training (CIT) to its officers in 2015, at least 17 individuals who were experiencing mental health crises were shot by responding police, and 15 of them were shot dead:

Mario Ocasio, Age 51– June 2015—Bronx – shot and killed

Rashan Lloyd, Age 25 -- June 2016 – Bronx -- shot 30 times and killed

Deborah Danner, Age 66 -- October 2016 – Bronx – shot and killed

Ariel Galarza, Age 49 -- November 2016 -- Bronx – shot and killed

Dwayne Jeune, Age 32 -- July 2017 -- Brooklyn – shot and killed

Andy Sookdeo, Age 29 -- August 2017 -- Brooklyn – shot and killed

Miguel Richards, Age 31 – September 2017 -- Bronx – shot and killed

Cornell Lockhart, Age 67 – November 2017 – Bronx – shot and killed

Dwayne Pritchell, Age 48 – January 2018 – Bronx – shot and killed

James Owens, Age 63 -- January 2018 -- Brooklyn – shot and killed

Michael Hansford, Age 52 -- January 2018 -- Bronx – shot and killed

Saheed Vassell, Age 34 -- April 2018 -- Brooklyn – shot and killed

Susan Muller, Age 54 -- September 2018 – Queens – shot and killed

Michael Cordero, 34 -- March 2019 – Manhattan -- shot and critically wounded

Jarrell Davis, Age 33 -- March 2019 – Queens -- shot and critically wounded

Kawaski Trawick, Age 32 – May 2019 – Bronx – shot and killed

Kwesi Ashun, Age 33 – October 2019- Brooklyn – shot and killed

We need a new peer-driven health care response to those experiencing mental health crises. We need a model like the one that has worked in Eugene, Oregon for over 30 years, adjusted to fit with the current New York City model of the Health Engagement Assessment Teams (HEAT).

Therefore, we urge you to examine our proposal and reserve $15 million over the next 5 years to pilot a peer-driven mental health crisis response program in New York City.
Now.

Testimony of NewYork-Presbyterian on the topic of
"New York City Hospitals' Response to the Mental Health Needs of Frontline Healthcare Workers During the Covid-19 Pandemic"
To the New York City Council Committee on Hospitals and the Committee on Mental Health, Disabilities and Addiction

June 16th 2019

Thank you for the opportunity to submit testimony on the issue of responding to the mental health needs of healthcare workers during the Covid-19 pandemic. At NewYork-Presbyterian (NYP), we are committed to providing the highest quality care to all of our patients, as well as offering a broad array of health care and other services to our employees.

NYP is one of the nation's largest and most comprehensive academic health care delivery systems. We have 10 hospital campuses in the Greater New York area, seven of which are located within the five boroughs. We also care for New York City residents at 150 primary and specialty care clinics in the City.

When New York became the epicenter of the COVID-19 pandemic, our amazing employees came together as a united front to fight the disease. Our frontline staff and other teams - in collaboration with our medical school partners at Weill Cornell Medicine and Columbia University Vagelos College of Physicians and Surgeons - have worked around the clock to serve our fellow New Yorkers and save lives.

Providing this care has required significant sacrifices on the part of our employees, especially our frontline workers. Early in the crisis we recognized the many different forms of support needed by our teams given the unprecedented and challenging conditions and worked to meet these needs. Among others, this support included providing on-site meals, transportation to and from our campuses, housing, and childcare. At the same time, we expanded the availability and accessibility of critical mental health and wellness resources for our staff.

NYP created "CopeNYP", an urgent counseling service, to provide our employees quick and free access to confidential and supportive virtual counseling. The program, staffed by trained mental health care professionals from the Departments of Psychiatry of Weill Cornell Medicine and Columbia Vagelos College of Physicians and Surgeons, provides compassionate support aimed at alleviating distress and identifying effective coping skills to help employees manage stress. Follow-up plans are developed that can include ongoing sessions and linkages to additional mental health resources.

Employees can also access NYP's Workforce Health and Safety Occupational Psychiatry Program to speak with a trained clinician. We have held facilitated support sessions for employees that have included a range of staff from many disciplines including licensed clinical social workers from the health and wellness team, pastoral care, psychiatry, crisis counselors and others. In addition, there are on-campus psychiatrists who are familiar with the challenges that residents and fellows face.

Our Employee Assistance Program includes the Healthy Mind program which offers confidential counseling with a licensed counselor, available for staff and family/household members 24 hours a day. The program specifically covers ways to manage the uncertainty and worries related to COVID-19 or any issue the employee or their family/household member may be experiencing.

Employees are also encouraged to participate in the Psychiatric Symptom Tracker and Resources for Treatment (START) program. This program, developed by faculty in the Weill Cornell Department of Psychiatry, is available to all employees to help monitor their mental health and connect to additional support if needed. Employees complete a brief online survey which tracks stress levels and mood. The survey, which can be completed anonymously, provides immediate feedback, including information on stress-management strategies and available support, such as crisis counseling. Participants receive timely evaluations and referrals. The survey can be completed multiple times, so employees can track how they are feeling, identify problem areas, and get help addressing issues.

In addition, NYP's Department of Pastoral Care and Education has spiritual messages in the major faith traditions and a non-denominational message for employees. These are designed to give staff an opportunity to reflect and gain encouragement from their tradition or from other religions for their inspiration and spiritual sustenance.

Pastoral Care has facilitated support sessions for staff along with members from the psychiatry team. They are also providing support and individual virtual memorial services for every NYP employee who has passed away. They have also performed two enterprise-wide virtual memorial services during the COVID-19 pandemic.

In order to give employees a quiet space to take a break, NYP created Employee Recharge Rooms & Quiet Rooms across all of our hospital campuses. These rooms are restorative spaces that allow employees to pause, take a deep breath, decompress, and recharge. Rooms have been stocked with healthy snacks and show calming videos to help inspire employees.

Beyond these, there are many other programs designed to improve our employees' emotional wellbeing including access to health and wellbeing coaches. Links and information are available to all employees on our internal website. Throughout the crisis our internal communications teams worked to promote these – and all of our wellness resources - to staff via a variety of forums so that employees would be well aware of the services available to them.

A sample of our emotional wellbeing programs includes:

- Wellbeing Coaching - coaches provide personalized support to employees so they can manage stress, stay nourished, remember to practice self-care, and work on personal wellbeing goals.
- Mindful Minute Break - this interactive experience offers staff a quick relaxation break and provides a hands-on way to learn simple relaxation techniques.
- Yoga and Meditation - Basic yoga and meditation classes, as well as special topics, such as anxiety, digestion, pain, and exhaustion, are available online for employees to access around the clock.

- Tips to Manage Stress and Anxiety - offers videos with tips from NYP experts on managing stress and anxiety during the pandemic.
- 12-Step Programs - NYP is providing links to remote 12-Step Support Groups such as Alcoholics Anonymous, Narcotics Anonymous and Overeaters Anonymous so that individuals can locate meetings being held virtually during the pandemic.
- Whil – Employees have complimentary access to Whil an online tool designed to foster resilience and emotional wellbeing. Whil's training programs include Emotional Intelligence 101, Mindfulness 101, and Yoga 101.

The health and wellbeing of our teams is a priority at NYP. We will continue to do all that we can to support our employees, both now and in the future.

Thank you for the opportunity to provide testimony.

New York City Council

Committee on Hospitals
Committee on Mental Health, Disabilities and Addiction

Hearing Testimony:
"Oversight: New York City Hospitals' Response to the Mental Health Needs of Frontline Health Care Workers during the COVID-19 Pandemic"

Jenna Mandel-Ricci, Vice President, Regulatory and Professional Affairs

GREATER NEW YORK HOSPITAL ASSOCIATION

Chair Rivera, Chair Ayala, and members of the Committee on Hospitals and the Committee on Mental Health, Disabilities and Addiction, my name is Jenna Mandel-Ricci, Vice President, Regulatory and Professional Affairs at the Greater New York Hospital Association (GNYHA). GNYHA proudly represents all hospitals in New York City, both not-for-profit and public, as well as hospitals throughout New York State, New Jersey, Connecticut, and Rhode Island.

During normal times, I lead GNYHA's efforts related to emergency preparedness and employee health and wellbeing. However, for the past several months, I have served as the Incident Commander for GNYHA's COVID-19 response effort, which has tackled a multitude of issues. These include sourcing supplies and equipment, helping hospitals expand their patient surge capacity, coordinating with the numerous city, State and Federal agencies involved in this response, synthesizing and sharing public health guidance, and supporting the emotional and mental health needs of the health care workforce, which has performed so heroically. Thank you for the opportunity to testify today about hospitals' response to the mental health needs of health care workers during the COVID-19 pandemic.

Today I will discuss the constellation of employee health and wellness resources and structures that hospitals generally use to support their workforce, how hospitals quickly pivoted and amplified these resources to meet the acute needs of the workforce during the COVID-19 patient surge, and current GNYHA initiatives to support ongoing workforce wellbeing.

The Pre-COVID-19 Focus on Employee Health and Wellness

Hospitals have long prioritized the safety, health, and wellbeing of their workers. Hospitals throughout our membership have established employee wellness programs that seek to address areas such as nutrition, physical activity, stress management, and chronic disease prevention and management. These programs work best when tied to other initiatives that impact the health care workforce including occupational risk factors, "second victim" programs, and workplace violence prevention and mitigation.

Hospitals recognize the emotional and psychological toll of caregiving, and many GNYHA members have incorporated emotional and mental health programming and resources into their broader wellness programs. These include forums in which staff can discuss the emotional impacts of caregiving such as Schwartz Rounds, self-care skill building and practice opportunities (e.g., yoga and meditation), peer support programs (especially immediately after crisis events), and referrals to counseling through Employee Assistance Programs or other pathways.

GNYHA Supports for Members

GNYHA helps members develop and continuously improve employee health and wellbeing programs. Since 2015, our Wellness Workgroup has brought together GNYHA members who develop and implement such programs, to share best practices, and discuss emerging issues. Last

year GNYHA also formed a Clinician Wellbeing Advisory Group of which Dr. Eric Wei of NYC Health + Hospitals is a member. This group of health care leaders focuses exclusively on the issues faced by frontline providers. In addition, GNYHA offers conferences and webinars on a variety of topics related to employee health and wellbeing. Focus areas have included clinician burnout and resilience, employee-centered workers' compensation programs, establishment of second victim programs, and a yearlong learning series on Workplace Violence Prevention and Mitigation.

Hospitals Pivot to Meet Staff Needs during COVID-19

In March, as COVID-19 advanced across the globe and the first patients began arriving at New York City hospitals, there was a recognition of the unique stressors on health care personnel, including the scope of the event, the unknowns of the pathogen, staff fears of becoming infected and/or infecting family members, and the stress and anxiety of caring for so many very sick patients.

Our member hospitals quickly pivoted and amplified their existing health and wellbeing structures to meet the physical and emotional needs of their staff during this unprecedented event. Their efforts fell into three broad categories:

1. Meeting basic daily needs including food, housing options, transportation to/from work, personal safety, and childcare
2. Enhancing communication for the delivery of current, reliable, and reassuring messages
3. Psychosocial and mental health support options

Below are a few examples for each of these areas:

Hospitals and health systems prioritized meeting the basic needs of employees to reduce stress and allow them to focus on patient and self-care. Tactics they employed included:

- Hotlines and call lines
- Dedicated supportive spaces
- Websites with access to hospital resources

For example, Mount Sinai Health System created a webpage for staff that outlined resources for employees seeking help with food, transportation, childcare, and other basic needs.

To reduce confusion and fear, and to help ensure accurate messaging, hospitals and health systems prioritized frequent communication to employees so they had access to the most up-to-date information about the response to COVID-19. Tactics they employed included:

- Dedicated email addresses for questions

- Dedicated intranet pages with Frequently Asked Questions
- Daily leadership messages
- Virtual town halls

For example, to inspire staff and inform the system's response to COVID-19, Montefiore Health System President and CEO led daily "Montefiore Together" phone calls for all Montefiore staff.

While hospitals and health systems prioritized the mental health of all staff during the COVID-19 crisis, they paid special attention to frontline workers treating severely ill COVID-19 patients. Tactics they employed included:

- Hotlines and call lines as well as proactive text message outreach
- Dedicated supportive spaces
- Unit-based rounding
- Peer group huddles (virtual or in-person)
- Celebrating when patients were discharged or taken off ventilators
- Creating thank you videos for staff

For example, NewYork-Presbyterian/Columbia prepared a guidance document on how to conduct small group debriefing sessions focused on coping strategies. NYC Health + Hospitals/Bellevue provided an employee respite space staffed by Helping Healers Heal peer support staff.

Understanding that not all staff seek help in the same way, hospitals offered a variety of ways for their workers to seek assistance. As we move into the next phase of the COVID-19 response, providing multiple help-seeking options is equally important.

How Hospitals and GNHYA Are Supporting the Health Care Workforce Moving Forward

In late April, as the surge of COVID-19 patients decreased, hospitals began focusing on the more intermediate mental health impacts on their workforce. Hospitals are further investing in many of the above-described strategies, which are designed to normalize feelings of anxiety, stress, and grief, provide staff members with strategies and opportunities for self-care, and other ways to process their emotions in a healthy manner.

GNYHA is actively supporting member hospitals as they expand mental health and emotional support initiatives. Guided by the expertise of our Clinician Wellbeing Advisory Group, we have undertaken a number of initiatives.

Promotion of the American Medical Association COVID-19 Coping Survey

To better understand the impact of the COVID-19 response on their workforce and to inform future interventions, many GNYHA member hospitals have shown interest in conducting workforce surveys. Recognizing that not all GNYHA members would be able to develop and field their own surveys, we have partnered with the American Medical Association (AMA) to offer our members the AMA's COVID-19 Coping Survey. This 14-question survey assesses concepts of stress, anxiety, and burnout among both clinical and non-clinical staff. GNYHA plans to support members with survey implementation and analysis, as well as technical assistance on programming and referrals.

HERO-NY

In collaboration with the US Department of Defense, US Department of Veterans Affairs, Uniformed Services University of Health Science, NYC Health + Hospitals, the New York City Department of Health and Mental Hygiene (DOHMH), and the Fire Department of the City of New York, GNYHA launched *Healing, Education, Resilience & Opportunity for New York's Frontline Workforce* (HERO-NY) earlier this month. This five-part online series adapts military expertise in addressing trauma, stress, resilience, and wellness for a civilian audience to support the mental health and wellbeing of frontline workers affected by the pandemic.

HERO-NY is open to all GNYHA member hospitals. Participating institutions were asked to identify "master trainers" (individuals with backgrounds in behavioral health, clinician and employee wellness, and training) to take part in the program. HERO-NY is designed to enhance skills and knowledge related to trauma-informed care and resilience-building principles that can then be layered into programming for hospital frontline workers. The first two sessions of this program occurred on June 3 and June 10, attracting hundreds of participants.

Dedicated Website Area

GNYHA has developed a dedicated section of its website that offers curated mental health and emotional support resources organized by phases of the pandemic, specific topical areas, and sub-sections of the workforce. The website also includes members' examples of approaches and resources.

Literature Review

GNYHA has undertaken a comprehensive literature review that will be shared with members upon completion. By reviewing peer-reviewed articles focused on past disasters and impacted sectors including the military and humanitarian aid workers, GNYHA is seeking to answer key questions, including:

- What impacts can we expect to see in the health care workforce?
- What moderating factors can mitigate negative impacts?
- What interventions have proven effective?

Project HOPE

GNYHA is also collaborating with the New York State Office of Mental Health and DOHMH on the design and development of Project Hope. This will be a Federal Emergency Management Agency-funded disaster response crisis counseling program, similar to population-based programs established after 9/11 and Hurricane Sandy. Health care workers will be one of the program's target populations.

New York City's frontline health care workers accomplished the extraordinary during the COVID-19 patient surge. As they process the grief and anxiety of that experience, they also face an uncertain world of living and working in an ongoing pandemic and social upheaval. GNYHA and our members intend to support them so that they can thrive during these difficult times.

Conclusion

Thank you for the opportunity to testify before the City Council on this critically important issue. GNYHA and our member hospitals are committed to the physical and mental wellbeing of every member of the hospital workforce.

I am happy to answer any questions you may have.

File T2020-6223: New York City Hospitals' Response to the Mental Health Needs of Frontline Health Care Workers during the COVID-19 Pandemic

Wendy Dean, MD
CEO, Moral Injury of Healthcare

The Moral Injury of Healthcare (MIH) would like to thank the Chair and members of the New York City Committees on Mental Health, Disabilities, and Addiction, and Hospitals, for the opportunity to submit this testimony about New York City (NYC) hospitals' response to the mental health needs of frontline health care workers (HCW) during the COVID-19 pandemic. MIH is a 501(c)(3) non-profit dedicated to addressing clinician distress. The organization is focused on reducing the conditions, which put clinicians at risk for distress, or moral injury, through research, raising awareness, and initiatives targeting change. For more information on the organization, please visit the website: https://fixmoralinjury.org/.

As a psychiatrist and an expert on distress in healthcare, I commend the Council for attending to the psychological recovery of frontline staff in the wake of the initial COVID-19 surge, and for bolstering psychological readiness for a potential second wave of the virus.

On February 24, as COVID-19 was stalking NYC, I testified before the Hospital Oversight Committee about safety in city emergency rooms. Distress—whether moral injury or burnout—was rampant among clinicians. COVID-19 magnified many of the preexisting challenges. ER staff, and most others in healthcare, already had been doing too much, with too little, for too long. But it also added severe resource constraints, questions of how to allocate them, physical distancing and social isolation.

File T2020-6223: New York City Hospitals' Response to the Mental Health Needs of Frontline Health Care Workers during the COVID-19 Pandemic

Wendy Dean, MD
CEO, Moral Injury of Healthcare

By many accounts, conditions in NYC hospitals during the peak of the initial COVID-19 surge were like nothing most of us have seen in our lifetimes in western health care. A crisis counselor I spoke with validated media reports. He acknowledged that neither his career as an Army medic deployed to Iraq nor his 20 years as a police officer prepared him to hear the stories he was told. Their recitations left him deeply concerned about the long-term psychological well-being of NYC hospital staff.

As discussed in an article published in STATNews, HCWs and others learn during their training to tightly control their emotions. Repeated exposure to intense situations teaches them how to lock away their feelings so they can stay functional. Each of those experiences is hastily closed off in the interest of continued functioning. In the midst of the surge, those on the front lines processed only enough to get them through that shift and to the next one. There was neither time nor energy nor the psychological distance to allow processing of the experience. As with any crisis, when the pressure to *act* subsides—when there is time to "breathe", as so many clinician friends say—the pressure to *feel* intensifies.

But there is no plan or contingency for when, in an unguarded moment, the door to those emotions blows open and the pent-up tsunami of grief and fear and sadness and anger and insecurity and doubt sweeps through.

Each will process his or her intense emotions and experiences in unique ways. Some will hear loud echoes in COVID of other, incompletely processed traumas or losses. Some

will process the experience in great gulps, all at once. Others will carefully calibrate if over weeks, months, or years. Grief does not resolve at our bidding.

As the surge ebbs, there are two powerful pulls to get back to business as usual. The first driver is the balance sheet of an institution. The second driver is a deep desire to return to the illusion of safety and predictability that "business as usual" before COVID represents. But the risk in both of those actions is ignoring the unprocessed trauma and grief that frontline workers experienced during the surge.

At the same time, it is prudent not to pathologize responses to this experience. Running an ultramarathon leaves most participants depleted and limping the next day. We give them food to restore glycogen supplies; fluids to rehydrate; gentle massage to clear lactic acid; a place and time to rest their bodies and encourage recovery. Analogously, it is an obligation to provide the time, supports, and opportunities to foster psychological recovery from pandemic experiences.

Organizations will face challenges in providing support for psychological recovery to their frontline workers. Many clinicians are reluctant to seek help for mental health concerns and there is a habit among those who work in healthcare to minimize their own needs in the face of greater perceived suffering by patients and families. It is part of a culture steeped in self-sacrifice and deeply uncomfortable with personal vulnerability.

Wendy Dean, MD
CEO, Moral Injury of Healthcare

The discomfort with vulnerability is in part due to challenges with corporatized medicine. Trust was brittle between workers and organizations prior to COVID as financial constraints cut staffing, supplies, and space to the bone, micromanaged and hyper-monitored staff to drive optimum efficiency, and offered tea carts and lunchtime yoga in return. Those offerings, though well-intentioned, were often perceived by staff as either performative or patronizing. The pandemic only highlighted the vulnerabilities in healthcare organizations, often increasing tension with staff, and sometimes devolving into painfully public breaks in decorum.

Nevertheless it is critical that healthcare systems in NYC make a concerted effort to acknowledge the losses, grief and trauma their workers experienced. Hospital staff is the most valuable asset and most expensive resource for a health care organization. The staff is the repository of an institution's culture and its ambassadors in the community, and they very really put their lives on the line for the institutions they work for. It is the right thing to do to support them in psychological recovery.

Principles to consider when establishing psychological support for staff:

1. Ease up. The work of recovery is hard and highly variable. The majority of people who experience crises will recover completely, but not at the same rate, and not all by the same path.

Both the military and school disaster plans account for the added work of processing difficult experiences by lightening workloads to accommodate unexpected crisis reactions. Hospitals should be no different, despite the short term financial impact.

- Staffing at 110% is the suggested ER staffing level, which is often not met. Redoubling efforts to meet that recommendation is critical right now.

Check in — and mean it. During surges of Covid-19 cases, the main concern for the well-being of health care workers was their physical safety, which was often grossly inadequate. A second failure to protect staff, this time their mental health, could be catastrophic on many levels.

- Show up in person, be genuinely interested in what workers need and make those resources simple to get.

2. Provide support. This pandemic has been unimaginably isolating for everyone, at work and at home and have derailed many common coping strategies. Using internal resources to provide support is expedient, and cost-effective, but those resources are finite and, especially if pre-pandemic levels of organizational trust were low, staff may not want to see someone from their own institution. Moreover, while peer support and programs to train seem like a good idea, a report by the Rand Corporation in 2015 reviewing evidence to support Mental

Health First Aid found that studies, "demonstrate little support for MHFA's effectiveness with respect to potential aid recipients."

- Every healthcare organization in the city has the same need to offer services and to make allowances for outside entities to be available. Perhaps working together across the city to develop a collaborative approach to the challenge would be wise.

3. Beware Appropriating "Hero". The Oxford dictionary defines a hero as "a person who is admired or idealized for courage, outstanding achievements, or noble qualities."

When the streets erupt every night at 7:00PM in a cacophony of banging pots and pans, cheers, whistles and shouts, the public is recognizing those qualities of essential workers the only way they can. It was uplifting to hear that cacophony initially; finally essential workers were being recognized and celebrated rather than ignored or vilified.

But, there are echoes of 9/11, when we called the firefighters who ran into the Twin Towers heroes. They fit the definition of a hero, but they were in those buildings, as Rebecca Solnit wrote, because, "of an uncoordinated, unprepared, and ill-equipped system." Twenty years later, the reality of the devastating lack of preparedness on 9/11 is lost in the through line of "hero."

When the organizations responsible for inadequate pandemic preparation talk about their "healthcare heroes" it cannot help but seem, at best disingenuous, and at worst, an attempt to distract.

- Healthcare organizations and other agencies may want to reconsider referring to frontline workers as heroes. Instead, get them the equipment they need to do their jobs and stay safe, or have the difficult conversations about the predicament and work together to find an acceptable solution.

4. Prepare for a long tail of need. Some organizations have been disappointed that crisis mental health services for essential workers were used less than expected. Psychological recovery may take two years or longer, according to research from previous infectious outbreaks of severe respiratory acute syndrome, SARS, and Middle Eastern respiratory syndrome, MERS. It may take months before a staff member can even begin to assess its impact, much less work out how to process the experience.

- Responses must be long term, flexible, and convenient.

Many frontline workers in NYC hospitals have had experiences they were unprepared for, which will have prolonged impact. It is the respectful, responsible, compassionate

thing to do to support their psychological recovery and to insure psychological readiness for a potential second wave of coronavirus.

MIH applauds the NYC Committees on Mental Health, Disabilities, and Addiction, and Hospitals, for having the courage to confront complex psychological challenges facing frontline workers in NYC hospitals. Your leadership may forge a path for others to follow.

Thank you for the opportunity to submit this testimony. Should you have any further questions, please do not hesitate to contact Wendy Dean, MD at wdean@moralinjury.healthcare.

My name is Lin Yuan and I am a resident of Brooklyn in District 33. Last April, NYC Mayor Bill De Blasio proposed major budget cuts for the Fiscal Year 2021, especially to education and youth programs, while refusing to slash the NYPD budget by any significant margin.

I am emailing today to demand that an emergency budget meeting is held to reject the Mayor's FY21 proposed budget and that NYC defund the NYPD by $1 billion. I urge you to pressure the office of the mayor towards an ethical and equal reallocation of the NYC expense budget, away from NYPD and towards social services and education programs, effective at the beginning of FY21, July 1, 2020.

Governor Cuomo has doubled the presence of the NYPD on New York City streets. I am asking that city officials lobby the same amount of attention and effort towards finding sustainable, long term change.

Good Afternoon, My name is Judith Cutchin. I am the President of NYC H&H Executive Council and Mayoral/agencies, representing over 9,000 public sector nurses in the public sector. I sit on the NYSNA Board of Directors and I am a registered nurse for 30 years; 29 at Woodhull Hospital where I currently work. I would like to thank Hospitals Committee Chair Carlina Rivera, Chair Ayala and Committee Members for their work on this critical issue; New York City Hospitals' Response to the Mental Health Needs of Frontline Health Care Workers during the COVID-19 Pandemic. At NYC public hospitals we struggle with not having enough. During COVID the shortages took a toll on the mental health of our frontline workers. Many worked endless hours losing patients in a situation out of their control. Others struggled with taking time to care for themselves when they received their own diagnosis. There was the burden of possibly exposing our own family members as well.

First I would like to point out programs offered through Health and Hospitals to all staff. NYC Health + Hospitals' program "Helping Healers Heal" offers frontline health care workers direct mental health support in the form of a dedicated, 24/7 behavioral health helpline staffed by psychiatrists/psychologists; peer support champions for one-on-one or group support; and 26 wellness areas across 11 hospitals and five skilled nursing facilities for staff to take a break from patient care areas. The program also supports wellness rounds at all facilities to actively engage employees working in areas heavily affected by COVID-19. Wellness rounds focus on identifying and supporting employees showing symptoms of anxiety, depression, fatigue and burnout, and connecting them to services if requested—including one-on-one telephonic, in-person debrief, or anonymous counseling.

Expanding these types of programs to all frontline workers is crucial during this time. New York State Nurses Association is an organization of frontline workers. Our members also have access to 24/7 behavioral health helpline through their union. We also offer member-to-member support. Frontline nurses put their patients' needs before their own but in the comfort of their union they can let their guard down and be open with peers. During COVID NYSNA created our own "Wellness Rounds" in weekly town hall meetings where members discuss issues and share experiences.

While Health + Hospitals has 11 Wellness Centers that is just not enough. New York City needs to insure that every facility has a place where workers can escape the work and seek the rest needed even for short periods of time. During COVID we saw an incredible need for mental health services and expanding the programs mentioned today will increase mental wellness for our frontline workers.

Thank you again for your time and your commitment to this very important issue.

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Testimony of Jessica De La Rosa
Systems Advocate, Brooklyn Center for Independence of the Disabled

City Council Hearing, Public Safety Committee
Tuesday, June 9, 2020

Thank you to the members of the City Council for the opportunity to present this testimony. I am Jessica De La Rosa, Systems Advocate at Brooklyn Center for Independence of the Disabled (BCID).

We're one of five New York City grassroots, nonresidential independent living centers and a part of the independent living movement, which seeks to empower people with all kinds of disabilities to live full, independent lives. We're also members of the Correct Crisis Intervention Today in NYC (CCITNYC), whose mission is to "transform how the New York City responds to mental health crises by diverting responses away from law enforcement and the criminal legal system."

At the most basic level, then, the work of CCITNYC aligns perfectly with BCID's mission. If New Yorkers with disabilities are to live full, independent lives, then the City of New York must also take an entirely different approach to intervention when someone has a mental health crisis.

Unfortunately, all too often in New York City, the standard response is to send police officers who are poorly trained, who do not want to respond to these kinds of calls, who can appear threatening and otherwise do not or cannot help people in a crisis. The result has been tragic, with 17 New Yorkers shot since 2017. Fifteen of them were killed, killed by New York Police Department officers.

Police do not de-escalate crises; they are not mental health care practitioners.

I know from my own family that the police often do not know how to respond appropriately and in a way that calms people. For example, my partner's sister experienced a mental break and was laying outside in obvious distress. If it were not for neighbors finding her and bringing her back home, an encounter with the police might have gone completely differently. Even then, though, after an ambulance was called to take her for an evaluation, police officers who accompanied EMS misinterpreted his sister's situation. When she, in a precarious mental state, tried to give one of the police officers a hug, officers immediately handcuffed her, though she was not posing a risk to the officer at all. She was treated as a criminal and given a police escort to the hospital, handcuffed to the gurney.

That must end, and, as cities across the nation look at ways of diverting money and responsibilities from police forces in the wake of the murders of George Floyd and others by the police, this is the time to make change.

We join CCITNYC in calling for the Council to carve out at least $15 million in funds for a five-year peer pilot program for mental health teams. We also urge you and to explore other ways of redirecting funding to largely eliminate the use of police resources in responding to the 200,000 911 calls the City receives annually for mental health crises. These approaches have worked in other cities and can work here.

We thank Council Member Donovan for his role in forming the Mayor's Task Force on Behavioral Health and Criminal Justice and urge the full Council to use this opportunity to rethink how the City deals with mental health crises and policing as a whole. Thank you.

Morgan A. Plummer

June 12, 2020

Understanding Overspending of funds in correctional facilities and the Criminal Justice system, in Regard to Mental Health Provisions and Funding; Defund said Correctional Facilities and other Governing Allied Police

I am writing on behalf of Americans in communities affected by socio-economic hardship, especially during Covid-19. I will be covering the subject of health care in the criminal justice system, and why Federal and State funds going to specific parts of said system should be reduced and placed elsewhere. The subject of providing Full-Coverage Health Care (including Mental Health Care), in communities affected by socio-economic oppression in America has been a topic for too long. Most Americans incarcerated with mental illness stay 4x longer than the average New York inmate. Governing officials, police, and institutions like Correctional facilities, have not been hesitant to Over Fund the incarceration of people in communities heavily affected by socio-economic factors, specifically targeting people with mental health symptoms. A high percentage of those Americans also have unmet mental needs, which are continuously neglected while incarcerated. One might say “well, correctional facilities aren’t mental health clinics, and they have to deal with whatever comes in. Plus, if their needs were not met before their incarceration, then how would they be diagnosed?”

Correction officers are generally trained to detect subtle signs of mental illnesses or other problems based on an inmate’s behavior. Should a correction officer believe that mental health

intervention is needed in a particular case, and the situation is not believed to be an emergency, the inmate's attorney must be notified of the scheduled clinical encounter if the inmate has consented to the release of this information to the attorney. There may be occasions when emergency intervention is necessary if an inmate is seriously decompensating and is believed to be a danger to himself or others. In such cases, even where the inmate has consented to the release of this information to the attorney, mental health service providers may meet with an inmate without having given prior notification to the attorney of the clinical encounter. Where authorized by the inmate, the attorney must be notified immediately. (NYOMH, 2020) In short, most Americans don't get diagnosed UNTIL they are incarcerated, which is a large socio-economic problem. Which leads to government officials giving severely under qualified correctional officers the ability to pass judgment on situations that only a medical professional should undertake. Whether or not someone is having a mental health emergency should not be determined by an officer. Furthermore, the government obtained and used funding to add onto their criminal facilities, instead of paying to hire more Doctors (Psychiatric, Neurologic, and Physician), provide funding for free services after release, and implementing funding for Psychiatric institutions to become more adequate.

In fact, on an average day, 9 % of men and 18.5 % of women entering local jails have a history of serious mental illness, rates two to three times higher than the general population. (Teplin, 1996) In addition, 75% of those with mental illness also have a co-occurring substance abuse disorder, and are likely to stay incarcerated 4–5 times longer than similarly charged persons without mental disorders. (APA, 2000) First, over the past twenty-five years, de-institutionalization associated with the downsizing of state-run psychiatric centers has led to the discharge of patients into communities. Unfortunately, community-based mental health programs

struggle to provide the comprehensive services necessary to support the special needs of this population. Legislation (Chapter 99 of the Laws of 1999) requires local correctional facilities and other local criminal justice agencies to be part of the planning process for development of local services or unified service plans. The intent of the legislation is to improve coordination between local governmental units and local criminal justice agencies/correctional facilities in the delivery of services to persons with mental illness who come into contact with the criminal justice system. This coordination can be facilitated by involving representatives from local jails and other criminal justice agencies in the planning process. Some counties have also established mental health–criminal justice system/corrections committees to focus on planning in more detail for the delivery of mental health services to people with mental illness in the criminal justice system. These committees have produced outcomes such as interagency policies and procedures, new program designs, and applications for grant funding. (NYOMH, 2020) The chilling realization after reading the previous paragraph is that I'm right. Officers in correctional facilities have the ability to deem Americans mentally incapable and our government and other Americans are unknowingly providing funding through tax dollars and grants to facilitate and equip the Officers. This perpetuates the problem, because inmates are not receiving professional help or diagnoses. So, how does this affect people not incarcerated?

When looking at the George Floyd case they deemed a normal man that any person who watched even a clip of the footage can imagine as themselves and/ or a loved one, as mentally unstable due to suspected drug use. Which was proven to not be the case, at all. George Floyd had past mental health issues that none of the officers were aware of, and even with all the training The Minnesota police department claimed to have on mental health not one officers listened to that man when he pleaded for his life, and all of them prioritized violence over

protection. When the officer Derek Chauvin kneeled on George Floyd's neck, him and his fellow team deemed Mr. Floyd incapable of being able to advocate for his own breathing needs. That is not training, its Inhumane, at best. They murdered that man, because they governed and deemed a situation they were severely underqualified to govern, and now our criminal justice system is showing just how badly they lack, even with all the funds that our American tax dollars have provided them.

My proposal is to defund the psychiatric wings of correctional facilities in New York altogether and reinvest the proceeds into physiatrist facilities, specifically facilities within the communities heavily impacted by socio-economic factors and reflecting a high incarceration rate of those with mental disorders. Defund does not mean prisons should get rid of or stop providing mental health outreach for inmates, this means that the funding we have provided has been focused in the wrong areas. All the Mental health information the New York State Correctional facilities are advising and giving to inmates have been inadequate and on their website they recognize these services as being such, but instead of asking to fund the facilities that would help Americans they asked to fund the facilities by claiming Americans as a burden and asking for funding to help contain the burden. If the psychiatric facilities are inadequate and the facilities that are funded are only meant to send inmates to said inadequate facilities, then that leaves only one conclusion: Americans are funding Police officers to doctor us and oppress us instead of them doing their intended job of serving and protecting us. But we cannot Fund this system anymore. In my Proposal I am also asking that there be assigned officers to said reinvested psychiatric facilities and these officers must undergo a 12-24 week Schooling to study and become a mental health officer. It would also be great to mandate some sort of mandatory schooling throughout the country, in every police station and correctional facility, because

Americans want officers who serve and protects the community not just physically but intellectually. If officers have to go to police academy, they can also take mandatory focused health courses, like we provide for CPR, except for mental health. My proposal would also support the funding of free health care for Americans. The United States Government has shown time and time again that they can provide a lifestyle for a mentally unstable inmate for 4x longer (4x the tax dollars), than there is no reason they cannot provide free health care to the citizens that work hard for their country before it gets to the point of incarceration and by that point wasted tax dollars. This would allow for Americans predisposed to mental illness to be diagnosed and treated sooner, as well as allow for Americans who have unmet needs to afford health care, adequate health care. Lastly it has become apparent to Americans that Officers governing our streets and roads are doing just that, they governing. There are two harsh realities that come after hearing that statement; First, the people who are supposed to serve and protect us are governing us and being funded by our money; Secondly it would only make sense that they still want to govern us like slaves, since our mental health guidelines and official government documents are sourced as far back as the year 1950, but no earlier than the year 2000. We are in the year 2020, that's 20 years of undocumented or updated official medical progress within our system; the same medical progress that was asked to be funded. If our official government documents and guidelines haven't been updated one can only assume that the training officers receive goes based on information from before the 2000, as well as many other guidelines. That is laughable at best, we must do better. New York State has not practiced the death penalty since 2007, but the NYOMH official documents still refer to capital punishment as the death penalty in their documentation because they have not cared to re-evaluate or update their guidelines. The guidelines are so outdated it still address the inmate as though they will be lethally injected. With

that being said funds should be reinvested into the reevaluation of said guidelines and documents. Guidelines should be voted on and addressed by the public, for the public! Obviously with adherence to the law. As stated earlier correctional facilities were not hesitant to obtain funds to build facilities to hold Americans due to high intake burden of mental health inmates, but they haven't even cared to use any of that funding to update their research or care guidelines from the 70's. They have updated the public on how our money was spent, and it was obviously used to over fund a project that perpetuates the problem. If facilities in prisons are still inadequate to help the mentally unstable, after millions in funding from American tax dollars, then I speak on behalf of the American people when I say pull our money out and let's try a different approach.

File T2020-6223: "**New York City Hospitals' Response to the Mental Health Needs of Frontline Health Care Workers during the COVID-19 Pandemic"**

James H. Cho, MD
Primary Care+Hospitalist of Internal Medicine, Bellevue Hospital

Testimony to the New York City Council Committee on Mental Health, Disabilities and Addition, jointly with the Committee on Hospitals

Hearing on Tuesday, June 16 at 10:00 AM

Hello Chair Ayala, Chair Rivera, and the City Council members present today. My name is James Cho, and I am a primary care physician and hospitalist of Internal Medicine at Bellevue Hospital, though I am here today as an individual health care worker rather than representing the hospital. Thank you for the opportunity to testify before you today.

I speak from the perspective of someone who has worked in the Adult Primary Care clinic and the hospital wards of Bellevue for over a decade as well as someone who staffed the hospital in March and April as our city braced for the worst of the COVID-19 surge. I shared in the care of the sickest patients in the hospital as our city faced looming shortages of ventilators, supplies, and hospital beds; while we saw colleagues going out each week with illness; while we saw the mortality rates rise rapidly to levels beyond anything we could have imagined. I also speak with the perspective of a primary care physician who is now engaged in the evolving pivot to telehealth and telemedicine as we try to re-engage our community in primary care - a community which, at Bellevue, includes the most vulnerable populations of our city, many of whom are constituents of your districts, and also the city residents who have been most affected by the suffering of this pandemic.

I will not share with you today the worst of the patient stories that will stay with me for the remainder of my career. Instead, I would like to share some of the feelings I had during the past few months as I worked in the hospital. I remember vividly the feeling of helplessness as I saw my elderly patients slip into depression and delirium while struggling to breath in a hospital bed, away from loved ones. I remember the resentment I felt of the daily compromises we made to a fundamental aspect being a health care worker - the ability to comfort in times of distress, which

no longer included the ability to sit at the patient's bedside or to offer the comfort of touch as our patients suffered in isolation rooms. Instead, too often we spoke by phone over the sounds of hissing oxygen and faced each other through a glass window or a rapidly fogging face-shield and mask. I also remember a feeling of horror as I imagined the patient's experience of dying in the hospital surrounded by blue gowns, never having even seen our faces behind masks.

Now, as I return to my role as a primary care doctor, I feel ineffective in my attempts to help my most vulnerable patients who lack a personal phone number, or those who are enrolled in a contact tracing program that operates without transparency or updates to primary care providers in the city. At times I feel helpless as I struggle to complete basic patient care tasks without an established workspace, appropriate conferencing tools or access to a fax machine, an outdated tool which stubbornly clings to relevancy in the world of healthcare.

I share with you these feelings today to illustrate what I believe is the biggest challenge for frontline workers of this pandemic. Facing risk of infection from contagious disease is not new. We have the training, skillset, and leadership to manage the endless uncertainty of this novel disease. We also have a support system to promote healing as we move beyond the worst of the covid surge in our city, as Dr. Wei and the Health and Hospitals team described. What we do not have as health care workers, even those with a lifetime of experience under their belt, is the ability to restore the losses to our professional identity during COVID, in our ability to provide basic comfort to ease the suffering of our patients.

I ask that you keep that in mind as you formulate your approach to the looming mental health crisis in our frontline workers. I ask that you consider the time one may need to cope with such a loss, of a professional identity which has been developed through daily challenges over the entirety of one's adulthood. I ask that you consider the impact of operational challenges that lead to even brief delays in distribution of PPE, which may prevent us from sharing a moment of humanity with our patients as they lie in the hospital with the fear of dying alone in an isolation room. I ask that you consider the impact to our well-being when we pass empty hand sanitizer

dispensers in the hospital, as we weigh the safety of calling one of our most vulnerable patients into the hospital for necessary care. And I ask that you consider the impacts of even the simplest operational challenges of conducting telehealth visits without the basic tools to do so.

My recommendations to the committee:

1. To reframe and reinforce statements already made, health care workers must be provided time to grieve for their losses. For many, this includes the loss of family and loved ones, but this also includes the loss to aspects of our professional identity.
2. Our health care workers need appropriate space, facilities and support to fulfil our continued and existing roles in the hospital. It has long been the culture to "make do" without space to take breaks, to store personal items, to easily access snacks or water, and to easily access a computer workstation or telephone. We cannot make-do with neglect of our personal needs, which have expanded as we try to maintain our PPE and social distancing precautions. And we cannot ask our staff to work without providing robust operational support, which is only highlighted as agency staff is added to support our workforce.
3. Direct, real-time feedback, updates and engagement must be facilitated between leadership and frontline health workers that is not in the form of email and newsletters to prevent operational delays which strip us of our ability to effectively serve in our roles as frontline workers.
4. The reinforcement of operational expertise is just as relevant as the reinforcement of our clinical workforce. Our leaders need to accept assistance from available resources and move beyond political disagreements that add to operational delays and harm the resiliency of our workforce.

In closing, I would like to emphasize the importance of considering the nature of work that is health care, recognize which elements have been lost during COVID-19, and focus efforts toward systematic support to facilitate the restoration of our professional identity as health care

James H. Cho, MD
Primary Care+Hospitalist of Internal Medicine, Bellevue Hospital

workers. Thank you all for the opportunity to participate in this hearing and offer my testimony for consideration. I am happy to offer additional perspectives or respond to questions via jamescho.md@gmail.com.