CITY COUNCIL
CITY OF NEW YORK

---------- X

TRANSCRIPT OF THE MINUTES

Of the

COMMITTEE ON PUBLIC SAFETY

Jointly with

COMMITTEE ON FIRE AND EMERGENCY MANAGEMENT

And

COMMITTEE ON MENTAL HEALTH, DISABILITIES, AND ADDICTION

---------- X

September 17, 2019
Start: 1:14 p.m.
Recess: 4:23 p.m.

HELD AT: Council Chambers - City Hall

B E F O R E: Donovan J. Richards
Chairperson

Diana Ayala
Chairperson

Joseph C. Borelli
Chairperson

COUNCIL MEMBERS:
Adrienne Adams
Justin L. Brannan
Fernando Cabrera

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

COUNCIL MEMBERS: Andrew Cohen
Chaim M. Deutsch
Vanessa L. Gibson
Rory I. Lancman
Carlos Menchaca
I. Daneek Miller
Keith Powers
Ydanis A. Rodriguez
Paul A. Vallone
Alan N. Maisel
Alicka Ampry-Samuel
Robert F. Holden
James G. Van Bramer

Benjamin Tucker
NYPD First Deputy Commissioner

Matthew Pontillo
NYPD Assistant Chief

Oleg Chernyavsky
Assistant Deputy Commissioner for Legal Matters NYPD

David Shmerler
Director of FDNY Counseling Service Unit

Frank Leto
FDNY Captain

Nicole Papamichael
Inspector Commissioner Officer Medical FDNY

Nancy Carbone
Friends of Fire Fighters

Anitha Iyer
Vibrant Emotional Health

John Petrullo
POPPA

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

Julie Lawrence

Ben Sher
National Association of Social Workers

Regina Wilson
Vulcan Society

Oren Barzilay
President of FDNY EMTs

CHAIRPERSON RICHARDS: Good morning. I'm Council Member Donovan Richards from the 31st District in Queens, and I am the Chair of the Public Safety Committee. I'm joined by Council Members Diana Ayala, Chair of the Committee on Mental Health, Disabilities and Addiction, and Council Member Joseph Borelli, Chairman of the Committee on Fire and Emergency Management. We are also joined by Council Members Holden, Lancman, Brennan, Gibson, and Levine. We're here today to confront a difficult subject matter. The City is confronting a crisis in mental health services, and we have seen that the Police Department is not immune to that fact. This year alone, nine active police officers who have died from suicide and at least two other retired officers. I want to begin by reading the names of those officers we've lost to suicide this year followed by a moment of silence to honor them: Officer Robert Echeverria, Officer Jason Goldberg, Officer Johnny Rios, Deputy Chief Steven Silks, Officer Joseph Calabrese, Officer Michael Caddy, Officer Menkarani [sp?], Officer Kevin Preiss, Sergeant Terrance McAvoy, Retired Sergeant Jose Pabon, Retired Sergeant Edward Rosa. I also want to acknowledge the tragic deaths of two other

members of the Department that occurred this week: School Safety Agent Naire McCormick and Inspector Michael McGrath. I'm going to ask everybody to stand and let's just have a moment of silence for the--

[moment of silence]

CHAIRPERSON RICHARDS: Thank you. You may be seated. I personally saw the immediate pain these tragedies cause when I came upon the home of one of the most recent officers around the corner from my own home a few weeks ago. I was with the family of Officer Echeverria and spent time with his fellow officers in the hospital struggling to cope with the sorrow of losing one of their own. Until 2019, it was not unusual in a given year to see four or five officers lost to suicide, but when we see that we have twice that number already this year, it tells us that there is an urgent need to do more for officers in need of help. The truth is, four or five is four or five too many, in that this hearing is long overdue. We need to get to the heart of this problem and get right to finding a solution. I am proud to say that the Department has been eager to partner with us to find a path forward. We've had very productive conversations with several of the

NYPD witnesses before me today, and I know they are as committed as we are to getting this right. They understand better than I do that there are certain challenges in being a first responder. They are exposed to some of the hardest situations New Yorkers face. This about this. You call 911 when there's an emergency, when there's something wrong. People call 911 when they are in danger, when they are in crisis, when they are dying, when they have nobody else to turn to, and first responders have to not just see these situations, they have to try to fix the problem. They have to live that trauma with every person they help, from victims of gun violence to the homeless to domestic violence situations as we saw earlier this morning when an officer was shot in Staten Island helping a domestic violence survivor. Thankfully, it sounds like this officer will make a fully recovery. Dealing with traumatic situations is an officer's day job, and that trauma comes on top of the daily stresses that we all face. So the fact that some of them are struggling to cope with trauma should not be a surprise to anyone, and there is no shame in that struggle. If there's a single message that I wnt to deliver today which gets to the heart

of why we're here discussing this painful subject as well as the legislation that we're hearing, it's this: to all of the Department officers who are out there and who are struggling, there is someone who can help you. It may seems hopeless at times, but there is a path forward despite how hard it is to see sometimes. This hearing is about giving you the safe space you need to deal with whatever you're going through, whether that's within the Department, through care groups, through medical care. We are here to offer you help and to say that there is absolutely nothing wrong with asking for help. And this not just about suicide. I'm sure there are many offers who are just burying their frustrations and their stress and that can affect every part of someone's life. When we as a city have asked you to take on our greatest challenges, we need to do more to make sure you have what you need to cope with yours. That's why we're here introducing Introduction 1704, a local law requiring the Department to provide mental health information training, and support services to officers, sponsored by Council Member Levine, which he will talk about in more detail later. I'm cosponsoring this bill, and I want to give

my Legislative Director, Jordan Gibbons, a lot of credit for working with Council Member Levine's office on getting this bill done. He and I have been working hard on this issue for a long time, and I'm proud to support this bill with Council Member Levine. I'm looking forward to a discussion with some of the esteemed members of the efforts made by the NYPD thus far and how we can continue to work together to support the officers who dedicated their lives to serving our City. I'll now turn it over to chair Ayala, then Borelli, and then Levine for remarks. I also want to acknowledge we've been joined by Council Member Powers, Vallone, and Cabrera as well. I'll go to Council Member Chair Ayala for opening statement.

CHAIRPERSON AYALA: Thank you, Chair Richards. Good afternoon. I'm Council Member Diana Ayala, Chair of the Committee on Mental Health, Disabilities and Addiction. I would like to thank Chair Donovan Richards and Chair Joseph Borelli for holding this important hearing with me today. We are holding this hearing today to discuss a very serious topic, preventing suicide and promoting mental health for first responders. As everyone knows, New York

City has lost 11 officers to suicide this year. Before 2019, NYPD has seen a consistently low rate of officer suicide, but we still lost four to five officers to suicide each year for the last five years. Nationally, the suicide rate for officers is nearly four times the rate of the general public. First responders of all kinds, including officers, firefighters, and emergency medical personnel are generally more likely to die from suicide than in the line of duty. First responders are at far greater risk than the general population for depression, anxiety-related mental health conditions, burn-out, substance use disorder, and post-traumatic stress disorder. In fact, some studies show that nearly one-fifth of police officers in the United States suffers from PTSD, and up to one-third suffer from symptoms associated with PTSD but do not meet the full diagnosis. Further research shows that the occupational stress of police work is directly related to higher rates of heart disease, divorce, and acute stress disorder. These statistics and figures are alarming, but they do not make us feel collectively ashamed or embarrassed. It should remind us of the acute and significant dangers that first

responders face every day. Every day, first responders put their lives on the line and put themselves at risk for bodily and mental harm. The danger that first responders face and run towards every day affect them physically, mentally, emotionally, and psychologically through no fault of their own, just as they would any of the other human beings facing similar daily traumas. This summer, my district experienced an increase in shooting all around the same neighborhood. I witness the collective trauma, fear, confusion, and sadness that my neighbors experienced as a result of these shootings, and I was reminded of the importance of processing and seeking mental health resources when a traumatic event is witnessed or lived through. These are exactly the kinds of traumatic events that first responders respond to, witness and experience every single day. To be affected by these events mentally is a natural human response. Mental illness affects all of us, and it does not imply weakness. In fact, seeking mental help is a sign of tremendous bravery and inner strength. Seeking help for mental illness should not stigmatize. It should be celebrated. When we seek help and address these issues directly

to the community, we send a message to those in crisis or to those experiencing suicidality that they are not alone, that hope is not lost, and that we are here for them and have their backs. To the first responders of New York City, you are not alone. We have your back and we are here for you. We are holding this hearing to understand this issue more clearly, to learn about the resources that you're receiving and those that you still need, and to demonstrate our support. I want to thank the Administration for the commitment that they have made to bringing more mental health resources to first responders, and I look forward to hearing more about all of the work that we're doing and the role that the City Council can play. I also want to thank my committee staff, Counsel Sarah Lith [sp?], Policy Analyst Chrissie Dwyer [sp?], my Chief of Staff Lisa Lopez, and my Deputy Chief of Staff Bianca Almedina [sp?] for making this hearing possible. I now turn over to Chair Borelli for his opening statement. Thank you.

CHAIRPERSON BORELLI: Thank you, Chairwoman Ayala, and thank you to Chair Donovan Richards and of course, Chair Mark Levine for

convening this hearing that as we all know is somewhat overdue. Since 2017, there were-- there have been nine taxi driver suicides in our City, and we saw, in the wake of that tragedy and those horrible deaths, an acknowledgement that perhaps some of the things that we do here in City Hall may contribute to those things. I'm not an expert. I don't know the rationale. I don't pretend to know the rationale of people who make these decisions, but it was clear whether you read media reports or heard the testimony from the Administration that perhaps some of the things that we did led to those deaths. Taxi drivers were killing themselves at a rate of 4.5 per 100,000. The NYPD statistic is much higher. It's 25 deaths per 100,000. That's five times higher than the TLC. I'm hoping that so that we're not treating this like just a rubber stamp committee, that there's no topics that are off the table, that we acknowledge that perhaps some of the rhetoric of some of the policies that we at times make could lead to higher stress and higher pressures and higher demand on the work of people who already have high stress, high demand and high intensity jogs. So, I commend all three Chairs for hosting this hearing, and I mean frankly, this is

an issue that I don't think we're ever going to get-- we're never going to pin-point why these things happen, but if we could make some headway and we could get some progress and we could get some policy and programs designed to help people and to remove the stigma of seeking mental health treatment, then that's something I hope we can all get behind. Thank you.

CHAIRPERSON RICHARDS: Thank you. Alright, first we'll be hearing-- oh, we're going to go to Council Member Mark Levine for a statement.

COUNCIL MEMBER LEVINE: Thank you, Chair Richards, Chair Ayala, Chair Borelli, and thank you for eloquently stating the degree to which the members of the NYPD family are exposed continually to traumatic and intensely stressful conditions in a way that virtually no other profession is. That is why tragically the rates of suicide in the Department are estimated to be four times as high as for the general population, and we owe it to the people of this department to adequately serve them under these conditions. Our understanding today is that the total number of fulltime mental health clinicians on staff in the Department, which has 55,000 staff

overall and almost 40,000 uniformed staff, the total number of clinicians ready to serve the mental health needs of these men and women today is four. And that means that the vast majority of members of the Department under most circumstances will never meet with one of those clinicians, and it only makes it that much more likely that they will suffer in silence until their crisis escalates. And so I am very pleased to be introducing a bill here together with my co-sponsor Chair Richards, Intro 1704 which would ensure that the Department has adequate staffing of clinicians to a degree that allows them to be present in the commands in the precincts in a way that frankly makes it normal to help remove the stigma, the same way it's normal to see a doctor for an annual physical for physical ailments. It should be normal for members of the Department who wish to see a professional for mental health services. So our bill calls for adequate staffing to make that possible. It calls for the provision of voluntary annual consultations the same way people can seek an annual physical, and it calls for information in training in-person and online to give people the resource they need, the resources they need to access

help in the Department and outside the Department. and we are ever-mindful of the need to protect members of the Department who are fearful that this could harm their career prospects, that being honest about their problems could lead to their badge and gun being taken away, and we want to provide these services in a way that are confidential and to offer people the option to seek help outside the Department in a way that they are confident will not compromise their position within the Department. That's our goal here today, and I'm very, very grateful for the partnership of the PD leadership in this and the rank and file as well, and look forward to this important discussion. Thank you.

CHAIRPERSON RICHARDS: Thank you, Council Member Levine. We're also joined by Council Member Maisel as well. Alright, we're going to go to the first panel. We're joined by Assistant Chief Mathew Puntillo, First Deputy Commissioner Benjamin Tucker from the NYPD, David Shmerler, Director of FDNY CSU, Assistant Deputy Commissioner Oleg, Doctor Myla Harrison [sp?], Department of Health, and Captain Frank Leto, Deputy Director of FDNY. We're going to ask everybody, of course-- I'm going to have Dan

swear you in, and then we'll ask everybody make sure you state your name on the record as well. Thank you.

COMMITTEE COUNSEL: DO you swear to tell the truth, the whole truth, and nothing but the truth before this committee and answer all questions to the best of your ability?

CHAIRPERSON RICHARDS: Alright, you may begin.

FIRST DEPUTY COMMISSIONER TUCKER: Good afternoon, Chair Richards, Chair Borelli, Chair Ayala, and the members of the Council. I'm Ben Tucker, the Department's First Deputy Commissioner, and I'm joined by, as you already heard, Assistant Chief Matthew Pontillo who is a Commanding Officer of my office, as well as Assistant deputy Commissioner for Legal Matters, Oleg Chernyavsky. On behalf of Police Commissioner James O'Neill, we're pleased to offer testimony about the issue that is very personal to us and to every member of the NYPD, the issue of mental health crisis-- the mental health crisis facing the Department. While it is routine for the Department to appear before the Council to account for how the 55,000 members of the Department help

others, I want to take-- I want to thank this body for convening this forum to highlight the crisis we are facing and acknowledging the urgency of finding ways we can help our officers and offer them resources to help themselves. At the outset, I want to make clear to every active duty and retired police officers as well as our civilian members of the service that you are indeed not-- that you not suffer in silence and you are never, never alone. Help is always available whenever and wherever you need it. So, please reach out. Our officers are no less immune from the myriad of challenges and stresses many people experience in both their personal and professional lives. However, unlike most professions as was heard in the opening statements by our Chairs, police officers as well as other first responders are required to involve themselves in what are often unpredictable and intense situations when they respond to emergency calls, perform their patrol duties, and investigate the horrific crimes that often occur in our city. Imagine coming to work and routinely responding to and investing domestic violence, such as the incident this morning that was referenced, child abuse or exploitation, violent

rapes or murders. These experiences and others, these images, the image they imbed in our minds simply don't go away at the end of the tour. The fear of victim or helpless and innocence of a child can take their toll, and there's no question that the culture of antoagonism and disrespect toward our officers that we've seen recently and witnesses in the streets and on social media are powerful and emotional stressors for our officers. Unfortunately, it is nothing new, but it can have accumulative effect. The stress of the job coupled with the personal stresses of life weigh heavily and continuously on the minds of our officers. As you well know, we have seen a significant increase on the number of NYPD officers taking their own lives this year. There have been nine, as has been mentioned, such tragedies to date, seven since June. In response, Commissioner O'Neill declared a mental health crisis in June and charged me with impaneling [sic] a taskforce that immediately began to implement short-term solutions and to develop long-term strategies to assist our officers. Death by suicide is not new to law enforcement, the law enforcement community. In a typical year we may see four or five

of such tragic incidents in our city, but recently years have shown an upward trend. The risk of suicide for first responders is higher than the general population, and police officers suicides now outnumber line of duty death fatalities nationwide. The Department has put in place response protocols to these tragedies and has a number of services available to our officers and is seeking to establish additional services and programs. We recognize and appreciate the aims of Intro 1704, which seeks to address and fund the services we have begun to and intend to put in place. I want to thank Council Members Levine and Richards for meeting with us and all the bill sponsors for standing with us at this difficult time. Our force Investigation Division investigates each death by suicide as well as all firearm discharges, and we conduct psychological autopsies to help us gain further insight into what led to these events and to learn what we can do to prevent future suicides. The Department employs post-venation techniques to address any post-suicide contagion, contagion effects which might lead to other suicide attempts in the immediate aftermath of an officer taking his or her own life. For some time

now, the Department has taken affirmative steps to offer assistance to officers in need. Our Employee Assistance Unit, the EAU, offers access to peer counselors who are both uniformed and civilian active members of the service in a variety of ranks and titles. It also provides access to clinicians, social workers on a referral basis. The EAU members are available around the clock and are frequently deployed to assist officers at critical incidents, including officer suicides by lending counsel to the responding officers as well. EAU staff then makes follow-up visits to the affected commands to assess any lasting trauma from the events that impacted their officers. The primary role of peer counseling is to listen and refer. The peer counselor will lend a sympathetic ear in a private and confidential environment. Having a peer validate one's concerns by taking the time to listen is an important and critical first step. Often, this is all that is needed, but under circumstances where more must be done, the peer counselor can provide the officer with information, materials and referrals to mental health professionals or other supportive outlets. Information on these resources is available in every

command, posted on the NYPD internet and is retrievable through an app on the Department-issued smartphones. The NYPD Chaplain's Unit provides members of the service of all faiths with access to confidential counseling, spiritual assistance, or moral guidance from faith leaders of various faiths. This tradition dates back over 100 years and is a steadfast and enduring pillar of the Department's commitment to the wellbeing of our officers. And lastly, the Police Organization Providing Peer Assistance, or POPPA organization, is an independent, volunteer police support network. It provides a confidential, safe, supportive environment for offices and retirees alike. POPPA's services of intervention, prevention, self-care, and resilience are now provided by volunteer network of approximately 280 active and retired uniformed members serving as peer support officers. POPPA also maintains a network of 120 clinicians skilled at working with officers referred by POPPA volunteers. At any given time, about 25 officers in crisis situations are receiving support from POPPA's clinician referral network. Operating 24 hours a day, every day of the year, POPPA assists officers in

coping with personal life stressors and stress related to the law enforcement profession. POPPA has a specific focus on preventing and reducing post-traumatic stress, marital problems, substance abuse and suicide. The POPPA network reduces the gap between essential support services and officer's access to these services. Now, with all of that, there's still yet much more to be done. The Department is in the process of augmenting these programs and implementing new programs and initiatives. As with many challenges, listening, collecting relevant information and effectively disseminating information is key, and to that end, the Department has partnered with Thrive New York City, or NYC, to provide evidence-based training for members of the service in all ranks. At the executive level, we have completed a new Executive Health and Wellness Training Program over the past several weeks to ensure that every executive understands how critical their leadership will be as we move ahead with the reform efforts. All captains and above, roughly 800 people, as well as civilian executives took part in a three-hour training last month. The training focused on suicide as a health

issue, stress, mental health as it relates to the police culture, as well. It covered what the Department leadership can do to support officer wellness, providing executive with updated information on internal and external resources for those in their charge. Leadership must set the tone, and it is not only okay, but essential to seek help. This training is an important first step in raising awareness among executive leaders. At the borough level, every patrol borough is sending officers from each precinct to an eight-hour mental health first day training that is conducted and supported by Thrive New York City with the Department of Health and Mental Hygiene. We have completed seven sessions with almost 200 officers trained so far. This training will continue indefinitely. The officers trained thus far in addition-- are in addition to the roughly 8,000 members of the service, including School Safety Agents, 911 call-takers, and Traffic Enforcement Agents who have already received this training as part of the ongoing mental health first-aid training program which began by ThriveNYC in 2016. At the Command level we are collaborating with ThriveNYC's, New York NYC Well initiative to provide

training sessions for all personnel in the field, at every precinct, police service area, and transit district. This training covers risk factors and warning signs, how to talk to someone who may be in crisis, and where to go for help. We've also mandated that all officers take the online Shield of Resistance Training offered by the Substance Abuse and Mental Health Services Administration, a division within the US Department of Health and Human Services. This training provides coping mechanisms for officers confronting stress in their personal and professional lives, and over 24,000 officers have completed this training to-date. Looking beyond the expansion of training on mental health issues, the Department has important structural changes that are also underway. We are establishing a new Health and Wellness section and have established it within the Office of the Deputy Commissioner for Employee Relations. This new section will encompass a peer support unit, a wellness outreach unit, and it will include the already existing employee assistance unit. The Peer Support Unit is an expansion and an imagination of the existing peer counselling model that I mentioned previously. With the expansion,

peer support officers will be embedded in each command and will eventually number between 400 and 600 volunteers. The volunteers' responsibilities will be to ask, listen, and encourage. Ask the officer about his or her struggles, listen to what they have to say, and encourage them to have faith in themselves and to seek help if needed. Training of the new Peer Support Officers is currently underway. The Wellness Outreach Unit is modeled on the success of the LAPD program. It will provide officers with the highest level of targeted intervention available within the Department. The unit will deploy wellness outreach teams consisting of a psychologist, a social worker, and a liaison from the Employee Assistance Unit. After the complete roll-out, the unit will consists of approximately 58 teams or one team per 1,000 members of the service. Teams will regularly visit each command to establish familiarity and build rapport with members of the command and will proactively reach out to members of the service to offer services. Lastly, the Department has begun the process of reviving Project Cope, an initiative started in the wake of 9/11. Back the Department partnered with a private hospital to provide

counseling sessions with private clinicians and a 24-hour hotline without charge to the officers coping with the trauma from the attacks. We are in the process of currently an expedited procurement to establish such a service again with a full RFP to follow after about-- 18 months, Matt? We look forward to working with the Council to continue to find creative solutions to stem the tide of this crisis. The Department has a solemn duty to do everything in its power to support our officers' wellbeing and to build a comprehensive support infrastructure that provides them with a catalog of resources to choose from to meet their individual and unique needs. As been said already, we must ensure that every officer knows the Department will be there for them in their time of need, just as our officers are there for New Yorkers in their times of need. Officers respond every day to the call of duty. Now it's our turn as a department and as a city to fulfill our obligations to do the same for them. It is literally a matter of life and death. Appreciate the opportunity to speak on this critical issue, and we look forward to answering any questions you may have. Thank you.

CHAIRPERSON RICHARDS: Thank you, Commissioner Tucker. We'll go to Department of Health or FDNY?

DIRECTOR SHMERLER: Good afternoon Chair Borelli, Chair Richards, and Chair Ayala and all of the Council Members present. Thank you for the opportunity to speak today on the topic of preventing suicide and promoting mental health for first responders. My name is Doctor David Shmerler, and I'm the Director of the FDNY Counseling Service Unit. I'm joined today by Captain Frank Leto, Deputy Director of the Counseling Service Unit. At the Fire Department, the mental health of our members is of utmost importance. My background is as of civilian psychologist and Captain Leto is a Fire Officer with over 36 years of experience with FDNY. We know that while our members are highly trained to respond to the most dangerous situations that arise, they are still human. Issues such as anxiety, depression, Post-Traumatic Stress Disorder, job-related stress, family or emotional issues or substance abuse can impact their ability to perform their duties. We have very strong internal support systems among our uniformed ranks, but there are times when our members

need assistance from licensed mental health providers, healthcare professionals, and our certified peer support personnel. We know that it is critically important that the Department provide avenues for our members to seek that assistance, and that they are able to do so without feeling stigmatized or feeling the need to hide that they are in need of some support. The Counseling Service Unit, CSU, was established to provide resources for FDNY members and their families. We are proud of the work that our staff and volunteers perform. Every day, the New York City Fire Department is involved with traumatic incidents. The CSU has been in operation for over 30 years, and in that time has become the gold standard for providing mental health services for first responders. In addition to serving our own members, we frequently dispatch staff when requested to traumatic events around the country to provide support for our fellow first responder agencies and members of the public. Recent prominent examples of this include the Oakland ghost ship fire that killed 37 civilians, the school shooting in Parkland, Florida, and the mass shooting at a country music concert in Las Vegas. In addition to providing

direct services, we work with other fire departments to strengthen their own mental health and behavioral health programs, and many have patterned their program after hours. The CSU has offices in five locations: Manhattan, Queens, Staten Island, and Orange County. Our resources are available to all uniformed and civilian employees of the fire department and their families 24 hours a day, seven days a week, and they are free and completely confidential. Services are providing on-site, and we also provide referrals to other providers when appropriate. Our professional staff includes 25 fulltime and six part-time licensed counselors including social workers, licensed mental health counselors, a licensed creative art therapist, and for World Trade Center issues, psychiatrists, nurses, and nurse practitioners. We also have roughly 60 to 80 uniformed members of our peer support team. We work closely with our unions, as we realize that strengthening those partnerships leads to best practices that benefit our members. Generally, we perform three types of outreach. We make routine visits to firehouses and EMS stations. We visit work locations when requested by an officer, and we

respond proactively to major events. During our visits to firehouses and EMS stations, we speak to members about what services are available from CSU. When we respond to the scene of major events, we provide both immediate and both long-term outreach as sometimes trauma is not initially revealed in the immediate aftermath of an incident. Some examples of incidents to which we send members include a line of duty death or serious injury, a serious vehicular accident, or a mass-casualty incident, a pediatric event, a terrorist threat, and shootings. We send our teams to visit the incident scene, members of the hospital, the firehouse and EMS stations where members serve, and we conduct follow-up visits in the ensuing days and weeks. In addition to job-related stress, we also provide support to members and their families dealing with non-job-related incidents and issues. These include issues such as an illness or a death in the family, marital issues, mental health problems, family member substance abuse, and other personal problems. We have a 24-hour hotline that is staffed by our certified peer support personnel. We also offer a wellness program that includes yoga. We work closely with other programs within the Fire

Department such as the Family Assistance Unit to offer services to the family of deceased members and to promote CSU services. A major focus of the CSU is working to destigmatize the use of support services. We give presentations at the Fire Academy and the EMS Academy to new fire fighters and EMTs and to officers when they're training for new roles. We provide information to members when they receive their annual medical evaluations, and we publish information on the Fire Department's internal communication and training platform, Diamond Plate. The counseling service unit has evolved over time to fit the changing needs of our members. The World Trade Center attack created such a great demand that it generated innovation in the services and tactics of CSU employees. We found that members helping members was especially effective, so we enhanced our peer support program. We learned that members were having trouble, especially during off hours, so we created our 24-hour hotline. We found that conducting regular check-ins produced better results than stationing staff inside house for long periods of time, and adjusted our practices accordingly. We are pleased with the progress that we have made, but we

are also in a constant state of exploring new ideas about how to provide the services that we-- how to improve the services that we provide. Currently, we are undertaking an opioid awareness campaign, visiting half a dozen firehouses a day to discuss the dangers of opioid addiction and provide resources for members and their families who are dealing with what has become a widespread problem. We are also working with the Mayor's ThriveNYC program to develop and participate in mental health first-aid, which is an evidence-based program designed to educate civilians in recognizing mental health and substance abuse issues. To-date, more than 350 members of FDNY staff have been trained in mental health first-aid. The Fire Department's most important asset is our members, and we know the importance of supporting them, not only with physical training and equipment, but also with resources that enable them to deal with the trauma that they are exposed to on a regular basis. We have a strong program. We believe that is the strongest in the country, but we will continue-- we're looking for ways to enhance it to better serve our members. Talking about these issues and the importance of seeking assistance including through

public discussions like the one we're having here today helps to remove the stigma and encourage first responders to seek help when they need it. I thank the Council for the opportunity to engage in this important discussion. I'd be happy to take questions at this time.

CHAIRPERSON RICHARDS: Thank you so much, and we're also joined by Council Member Cohen. Alright, let's-- and also Deutsch and Maisel. Okay, let's hop into some quick questions. Can you talk about some of the challenges, and this is for the NYPD, you see in terms of getting officers to seek help when they need it?

FIRST DEPUTY COMMISSIONER TUCKER: I'll start off with it, and I'll ask Chief Pontillo to jump in. You know, challenges, it's the whole issue around stigma. Part of the challenges grow out of the myths about or misunderstanding of what the processes are when our medical division is involved, and so the notion that police officer, example, would have his or her guns taken away and their shield taken away, is-- you know, if you're a cop it is part of your identity. I mean, I've been in the business 50 years, and you know, I carry a shield still. I

don't-- I could carry a gun, but I don't. It's not who I am, but I think on our-- when you're in active duty you carry your weapon all the time on-duty and off-duty, and so that's part of who you are. and that, you know, if you're taking them away, the real question really and what we're trying to do is make sure people understand when that happens, why it happens, and what the protocols are. And also, getting people to understand that it doesn't happen as often as I think people believe it happens. And so, but listen, the myth, you know,--if the perception is there, then that becomes reality for our officers. We're doing everything we can to dispel that, those rumors, put information out there and give specific data around when that happens, what happens, and how quickly we get their weapons back. The other thing is I think is, you know, our goal with respect to the outreach aspect of the work that we're doing is designed to really build some familiarity as the Fire Department has done, as we saw has been the case in L.A. which is why we adopted that model, because we think it has the efficacy of that model really is-- we're all human beings, and if we have interaction-- if you have a psychologist and

a clinician that becomes familiar in the precinct or the PSA or the Transit District and you see these people on a regular basis, they could provide services and you'd be much more willing to maybe pull Ben Tucker aside if you know he's available to say, "Hey, can I talk to you about X,Y,Z." But Matt, you want to add a little bit more?

ASSISTANT CHIEF PONTILLO: Certainly. So, thank you, Commissioner. So, you know, I think if we look at society in general, of course, society there is this stigma associated with mental health and wellness and seeking help for mental health issues. Fortunately, through all the outreach campaigns that have been going on nationally and locally, that stigma is eroding, right? We see more and more people are more open to talking about mental health and wellness. That stigma does exist in the Police Department, and it's probably even compounded in the Police Department because of the unique culture of policing. So human being in general have been socialized to not acknowledge or admit to perceived weaknesses. That's very, very true in the Police Department, as well. People who join the Police Department have a general mindset that they're

joining the Police Department to serve others and to be the one to provide help, not the ones who get help. So there's that built-in culture that factors against members of the service, acknowledging mental health challenges and being willing to seek help. The police culture is oen that emphasizes strength and control. We're a para-military organization. We work because we have a hierarchal structure. We have a mission to serve others and we carry out that mission. So it's antithetical to our cultural paradigm to let our barrier-- let our guard down and acknowledge that we may have behavioral health issues ourselves and need assistance at times. Certainly, there is that stigma associated with receiving help. Some of that goes to uncertainty and distrust of health providers and lack of familiarity with the health insurance systems. Along those lines we have partnered with some of the health insurance providers now to conduct an outreach campaign, an information campaign to get more information out and make sure that people are aware of the services that are available.

CHAIRPERSON RICHARDS: And Commissioner Tucker, you just spoke of a myth that persists that

guns are taken away, and I do know that recently there was a New York Times article, I believe, that cited that you've changed your policy around taking badges away. Can you just speak to how many guns were taken away related to mental health? Do you have a number you can give us?

FIRST DEPUTY COMMISSIONER TUCKER: I don't know if we have any--

ASSISTANT CHIEF PONTILLO: Yeah, so I can speak to some of that. So, you know, let me be clear, the Police Department through our Medical Division, we do conduct assessments of members of the service who come to our attention for a variety of reasons either because they're involved in traumatic incident a supervisor refers them to us or they come to us on their own volition, because they're seeking some assistance. So, to be clear, we occasionally do remove firearms from members of the NYPD. We do it only when a clinician, a psychologist or a psychiatrist has determined that it is necessary to save that person's life to protect them or their family because they pose an immediate danger to themselves or others. Now, I will say that that is relatively rare. So just by example, last year, our

medical division dealt with or screened or interviewed over 1,300 members of the NYPD, over 1,200 of those uniformed members of the service. Of those, we removed the firearms from approximately 100, pending further treatment and re-evaluation. Of the 184 who have already gone to treatment and are in a position where they're able to return to duty and their firearms have been restored to them. So, in most cases it's not permanent. It's done to protect people's lives, and we do it judiciously, and we do it in consultation with the healthcare provider that is providing treatment to the member of the service. So, our clinicians will work with the individual members' clinician. We'll make a determination when and at what time is appropriate to return that person to full duty and restore their firearms. On the shield issue, so historically we had a policy when we had to take somebody off of full-duty status for medical reasons, because they were receiving some psychological or mental health treatment and there was information that they may be a danger to themselves or others. We'd remove their firearm. We would also remove their shield, because that this was necessary because there was a period of time where

possession of a shield was enough to enable you to purchase a firearm. So, the laws have changed. Purchasing a firearm is much more difficult these days. So there's no longer an operational or a safety reason to safeguard a member's shield. So we instituted a new policy when a member of the service has their duty status changed for a medical reason, includes a mental health reason, we no longer remove their shields. They can keep their shields. So when they're at work they don't have that visual stigma of being different than their co-workers.

CHAIRPERSON RICHARDS: And just go through-- can you just run through the process of when you strip an officer of their gun? Can you just go through the process a little bit of what does that look like? When does that happen?

ASSISTANT CHIEF PONTILLO: So, the facts can vary depending upon the unique circumstances in each individual case, but generally a member of the service will come to the attention of our Medical Division, and we have a team of clinicians there. We have psychologists. We have a Deputy Director and Director of psychological evaluation, and the whole thing is overseen by our Deputy Chief Surgeon who's a

board-certified psychiatrist. And what will happen is an assessment will be done on a case-by-case basis, and the assessments may vary. It'll depend upon the unique situation that the member was involved in. And members come to our attention for a whole variety of reasons. Like I said, it could be a self-referral. It could be a referral from a co-worker or a supervisor. It could be the result of a trauma debriefing after a critical incident. So when we become aware that a member requires some mental health treatment and/or medication, our psychologist will conduct an evaluation that may include looking at collateral information like speaking to family and friends, consulting with the individuals member's personal physician to conduct a more wholesome assessment of the situation and then make a determination on a case-by-case basis, and like I said, it's only done of the psychologist as-- and reviewed by the Deputy Director and Director of Psychological Evaluation concur, if there's an indication that it's necessary because that person may be a danger to themselves or others.

CHAIRPERSON RICHARDS: And just speak about modified duty a little bit. So what does that

entail, because I know that if perhaps you're a partner with someone and you probably are put on modified duty that there is a, you know, some sense of-- you're going to believe that there's a stigma attached to you. You may be asked questions. What does that look like when someone is put on modified duty?

ASSISTANT CHIEF PONTILLO: Sure. So when we talk about the uniformed members of the service, police officers, people who are full-duty, carry firearms, and conduct enforcement and public service operations, there are times when it may be necessary to change somebody's duty status. So when we're talking about a medical condition or mental health condition that prevents that person from carrying out their duties as a police officer, we change their duty status to restricted duty, and restricted meaning they're still paid. They still have their insurance; however, because of a medical or mental health condition, they cannot fully perform as expected as a police officer, so we change their duty status. Unless their duty status has changed, that status will be constantly re-evaluated by the psychologist in the Medical Division in consultation

with the members' personal practitioner, and we will also make a determination as to where that member works. So in some cases the member may stay in their permanent command. In some cases they make a transfer. It all depends upon the staffing at that command, perhaps staffing in other commands where we may need additional personnel, also taking into account kind of the causes of the individuals' issues. If an individual is having some issues where they work, it may be in their best interest to move them, but if they have a support network in their current command assignment, they may stay there. So, again, this is part of that evaluation that is done by the medical professionals when assessing what should happen, what the course of treatment should look like, and what follow-up actions need to be taken.

CHAIRPERSON RICHARDS: And let's go through after a traumatic event, and I know I've been at the hospital after a traumatic events, and I want to commend the work that ESU does, because I think that-- did I say the right--

ASSISTANT CHIEF PONTILLO: EAU.

CHAIRPERSON RICHARDS: EAU, I'm sorry, EAU does, because I know that they've done some very important work at the scene. So, at the scene, just take me quickly through what they would do and what is the follow-up after? Do officers go back out into the street after a traumatic event? You know, what does that look like? Do they come back to work the next day? Does EAU follow up after that? Just take us through that.

ASSISTANT CHIEF PONTILLO: So, all of those can occur. So, depending upon the nature of a traumatic event, one of our psychologists will conduct a trauma debriefing of the members involved, but also our Employee Assistance Unit will respond to the scene when the event occurs and consult with and provide services to everybody involved. So, for example, in the case let's say of a suicide, the most tragic of these type of events, they will meet with family and friends and offer their services. They will also meet with and speak to coworkers, and including the police officers who respond to the event and may not know the individual, but are nonetheless impacted by what they seen and the emotional trauma of what they've dealt with. So, EAU

will work with all of those people who are affected and will stay in touch with them for extended periods of time and check in with them months, even in many cases years later, to see if they have any needs and they require any services. In addition, our Family Assistance Unit works closely with employee assistance to tend to family needs. So, we have many cases where the families may need some extended services and they will help arrange those as well.

CHAIRPERSON RICHARDS: I'm going to ask a few more questions and get to my colleagues because I know they're waiting patiently. So, the bill we're hearing today requires, obviously, the Department to contract with or employ clinicians, and obviously, we're trying to get at the heart of what I believe is the issue around trust. So, all the things you said today sounds really good, but we know based on our conversations with members of the service, that they're-- there arguably is-- are some issues around trust and could we trust the Department not to take away our weapon and our livelihood as officers if we do report mental health-- we have a mental health issue. What are some of the advantages of having these clinicians, and can you speak to any

disadvantages you may believe these clinicians may serve by having them in-house, and what could we do to minimize those disadvantages?

FIRST DEPUTY COMMISSIONER TUCKER: You know, just on the clinicians, I can't imagine any disadvantages to having them. I think it's all value-added, when you're talking about people who have a skill that allows them to interact with people who have-- you know, they're depressed or they have some emotional challenges, I think those-- that's all-- you have to have people who-- and along with our psychologists who provide that support. so, I don't see a downside to it, and again, I'm not sure how widespread the challenges are with people who decide that they don't want to take advantage of the services or they worry about the way, you know, again, the myths that are out there about when their guns are taken or when-- whether or not they could trust the Department to treat them fairly. You know, we could ask some of our folks from the Medical Division, but I think they-- and our psychologists can speak to this better than I, but my sense is that we've-- it goes beyond just the issue of the challenges that the individual may have, and even

when they have challenges, their perception of what the reality is may be part of why they're concerned. Sometimes people don't know they're depressed, and so I think everything we're trying to do to get at that and to provide access to people how have the ability to provide the assistance, and those would be clinicians, at the very beginning it wouldn't be counseling by peer group, but actually peer group access to someone who they know and trust, and may say, you know, maybe you should, you know, go see Doctor so-and-so, or this clinician or whatever. So, I think that's-- I'm not sure that that's-- we have to deal with it case by case, but I don't know that it's a widespread challenge that the Department faces. Anything to add?

ASSISTANT CHIEF PONTILLO: Yeah, you know, I would just add to that. I think, you know, this idea of having clinicians, psychologists and social workers, and having enough of them to be embedded in commands where they can develop personal relationships. So the current staff that we have, in Employee Assistance and in the Medical Division, they're developing trust, but it's one person at a time. In an agency of 55,000 people that's not

necessarily scalable. So through good customer service we build trust. But I think in order to increase that exponentially, it's absolutely essential that we have people in the field how are developing personal relationships who police officers will see on a regular basis, so they get to know that the services are not some anonymous person at the end of an email or at the end of a phone number, and we do publicize all of our services, but there's a certain level of uncertainty and anonymity involved which may deter some people from reaching out and calling. So, by having real people embedded and conducting role call training on a daily basis and being available in commands and not being a stranger who shows up when there is a crisis or a traumatic event, developing those relationships builds trust and builds trust very, very quickly, and people will open up and start talking. Anecdotally we've seen that already. Back in August we began Command-level training where we sent our psychologist from the Medical Division along with a EAU counselor and one of our chaplains to visit each command to do basically an abbreviated version of the three-hour training we did for executives to just raise

awareness about signs and symptoms of suicide as well as prevention measures and resources that are available for assistance, and almost immediately we saw people opening up, either sharing their own personal anecdotes at roll call, or after the more formalized session in the command, approaching the Eau counselor or the psychologist on the side afterwards to talk about some personal experience. So we saw that happening very organically in small numbers. So imagine if we had a cadre of people dedicated to that fulltime, you know, not only could we-- and by addressing some of the stresses of policing like PTSD and anxiety, not only could we hopefully impact and reduce the number of suicides, but also reduce the stress that cops carry with them every day, and then make them better able to serve the public. And I would say this whole thing is analogous to neighborhood policing. So the core principle of neighborhood policing is building trust by developing personal relationships between cops and community all over the City. This is no different. This is internal neighborhood policing where we're developing trust between members of the service and

the support staff that can help them cope with their issues, but also make them better cops.

FIRST DEPUTY COMMISSIONER TUCKER: And I would just say to that, that you know, the whole reason for the executive level training, we started with the executives in the Department was to Matt's point, to create--

CHAIRPERSON RICHARDS: [interposing] Pull your mic closer, Commissioner.

FIRST DEPUTY COMMISSIONER TUCKER: to create an environment-- sorry-- to create an environment where, you know,-- it's just like because Matt referenced neighborhood policing. When we started down this path of neighborhood policing, the first people we spoke with and made sure that they understood what the mission was and where we were going were the executives. If you don't have this top-down under-- understanding from the top, from the very beginning of whatever the initiative, the effort is you lose-- there's diminishing returns. And so the executive training was designed to make sure that these executives, all 800+ uniform and civilians understand first of all the urgency and the seriousness with which we're taking this issue, but

also how critical their role is in ensuring and reinforcing and setting a tone that allows for this to happen, as Matt said, organically, almost. If you have a commanding officer of a precinct or a Transit District or a PSA who is open and understands the challenges and recognizes that an officer needs some assistance, we'll make sure that that environment is conducive to getting the help for that person that is needed, and that means conversations. It means speaking with the lieutenant or the sergeant, making sure his bosses or her bosses beneath them who are closest to the command staff, to the officers at the lowest levels of the organization, understand that this is important to the wellbeing of the agency overall.

CHAIRPERSON RICHARDS: Alrighty. I'm going to turn it over to Chair Ayala for questions, but can you speak to me as if I'm an officer struggling at this moment and tell me why I should trust you and trust this, and don't give the academic answer, but why should I trust you if I'm an officer through this process?

FIRST DEPUTY COMMISSIONER TUCKER: Well, I mean, listen, I think it's case-by-case. I mean,

I've-- in my career I've spoken to other officers who I thought needed some challenges. I could speak of one individual in particular who came to my command who came there with an issue and challenges, and we had conversations. You know, I was an anti-crime cop. He was-- they wouldn't-- he wasn't on the street. He was really assigned a modified assignment in the station house. But I think-- but he spoke to me. He talked to me about-- you know, just because I didn't treat him like a pariah. You know, it's the police culture. I mean, commands are structured if you're not one of the people who are part of that command sometimes, you're not really accepted. So, I think it all depends on-- and I think the conversation can be very different, and it may just be a word it two. It may just be that this person trusts you immediately. I don't think there's a particular formula. We're all human beings, and so we react differently to different stimulus, and so-- stimuli. So, it may be just the fact that someone is available, offers you some information or suggests something to you. you'll either accept it or you won't, but I think that's really what we're trying to do is to build this environment, this culture that

says it's okay to seek help, and you can seek that help in any way you think you're comfortable with seeking it.

CHAIRPERSON RICHARDS: Thank you. Chair Ayala?

CHAIRPERSON AYALA: I want to recognize that we've been joined by Council Member Alicka Ampry-Samuel. So, I guess I'll start off the first question with-- I mean, police officers, first responders are-- have been affected by these type of stressors routinely throughout their careers. That's not new. Do you-- has the Police Department or I mean studied? Is there a trend? Did something change this year that has contributed to such a high rate of-- such a huge increase in the number of suicides? What makes this year different than last?

FIRST DEPUTY COMMISSIONER TUCKER: Yeah, listen, it's hard to tell, and I don't think we know, and I don't think we'll ever know what these-- what happened. If there was a particular event. I suspect there hasn't been. You know, I've been asked in the past when we started this conversation a couple months ago about that, that same issue, a slightly different question, but it's the same, I

think, input, which is-- is there any-- between those nine individuals who took their lives, what's the common thread? There really was no common thread other than the end, which is that they took their own lives, and there reasons how they got there are very different stories, and we don't know all the facts. We perhaps never will, because only that person knows why they-- how they got to that point, and I think our goal is to really not think about the endgame with respect to the restful which is the suicide, but to really think about how do we really impact the culture and provide services and to encourage people to take advantage of as many services as we have and make sure that those services are the right, right services.

CHAIRPERSON AYALA: Did any-- did any of the officers that committed suicide this year attempt to be connected to any of these services?

FIRST DEPUTY COMMISSIONER TUCKER: Well, some have, some were in counseling at the time, and so but that's not always the case.

CHAIRPERSON AYALA: Now, I can't help but notice the fact that most of the suicides were males that were impacted. Is the type of service that's

rendered or available for male officers different than the female officers?

FIRST DEPUTY COMMISSIONER TUCKER: No, I don't think-- we don't make a distinction by gender or any other criteria and otherwise, other than being a member of this Department who needs help, whoever you are. So, no, there's no-- there's nothing that we can point to that suggests that that's an issue or a challenge or a problem.

CHAIRPERSON AYALA: I mean, I say it because my mother always said that I speak too much, but I think one of the benefits of speaking too much is that for women, primarily, we are better able to process and articulate because we do speak so much. We're a little bit freer, right? And really addressing what, you know, we're feeling at the moment, and we don't have a problem really articulating that. For men sometimes it becomes a little bit, you know, harder to do that, and I wonder if there's some sort of, you know, correlation. Should we be treating it, you know, differently? Should it be-- should we be looking at the edit from that lens?

FIRST DEPUTY COMMISSIONER TUCKER: Yeah, we had a conference in April. We had a one-day conference at One Police Plaza where we had 300 people who were clinicians, researchers, medical doctors, you know, EAU-type people who provide services and peer counseling and so forth, I mean a broad range of people. As you can imagine, the conversations that took place were pretty rich, and this was part of this conversation, I think this question, and I don't think we're any different. Matt just suggested to me, reminded me that, we kind of track the national trend with respect to the number of suicides or the fact that, you know, males may be most common versus females. So sometimes it just is understanding the larger picture may give us some insights as to maybe there's some other things we might do, or sometimes we learn some things and hope to learn things from the autopsies that I mentioned and referenced earlier. As I see it, you know, with the help of our clinicians with our psychologists and figuring gout how to get rid of the stigma, it's a work in progress, and we think everything that we're-- you know, this path that we're taking based on our best information and

evidence and research that we are on the right track, and you know, we hope to learn as we go. As I said, you know, we're looking at the immediate aftermath and the information that we get from the investigation that's conducted by our Force Investigators, Force Investigation Division folks, but then also sharing that information with our psychologists and sort of having a conversation about what we learned, because you get different-- you know, when they respond, the investigators respond, they may interview family members or neighbors or a variety of people who give them information, and then that information right now it may not be directly related to understanding why, but sometimes it is. Sometimes it's helpful. Sometimes they make statements. Sometimes they may tell you that so-and-so had problems, or in some of these cases was pretty clear. Sometimes there's a note, so you get some insight from that. So there's lots of ways in which the information comes in, and then we process that information to figure out and help us understand how to deal with and maybe change our policies, or do what we think is necessary. But I do think that we have a baseline that really says to us that we really

are at the very beginning of this process understanding that we need to figure out ways to connect with our officers as quickly as possible when they're in distress, whatever that distress looks like, and we have a number of things in place as you heard in my opening testimony are really a solid foundation. We now know that we can add to it in order to be more effective at the services that we provide and how we provide those services.

CHAIRPERSON AYALA: Were any of the officers that were still on duty on modified duty at the time of their deaths?

FIRST DEPUTY COMMISSIONER TUCKER: I don't have the specifics, so I couldn't tell you really, and I don't remember so I'm not going to try and mention it off the top of my head, and I don't know if we have that information available.

ASSISTANT CHIEF PONTILLO: Not with us.

FIRST DEPUTY COMMISSIONER TUCKER: Not with us, right? One? So--

CHAIRPERSON RICHARDS: [interposing] Can you come up and-- for the record.

FIRST DEPUTY COMMISSIONER TUCKER: Yeah.

CHAIRPERSON RICHARDS: Speak on the record. Just state your name and title, please.

INSPECTOR PAPAMICHAEL: Inspector Nicole Papamichael Commanding Officer Medical. We had one officer on restricted duty. He was actually seeing his psychologist, and he wound up hanging himself.

CHAIRPERSON AYALA: So, I wonder, I have a friend who's a police officers and I remember when she joined the Department many years ago how stressed she was. I was her exercise partner at that time many years ago, but I remember her sharing how stressful the process for undergoing psychological evaluation portion of entering the police force was. It put her under intense stress. She passed, you know. She was-- she's actually active as we speak, but when an officer has to go through that type of process to get in I would imagine that it would make it-- they would be a lot more reluctant to want to, you know, proactively seek help because it is a stigma that is attached to them. So I wonder when we-- you know, when an officer has been assigned to desk duty, do we do them a further disservice, because I mean, what is the confidentiality? Are they then singled out by their, you know, colleagues?

Does everybody know now that this person, you know? Like, how is that-- how does that contribute to the state of mind of and individual that may be going through something traumatic, something stressful at the moment once they're assigned, right?

FIRST DEPUTY COMMISSIONER TUCKER: Well, you're asking kind of a couple-- you made a comment that I just want to just address in terms of your friend coming into the job. I think that the lion share of people who become police officers go through that process, and it is-- it can be stressful, individually stressful, but not to the point I think where-- you know, you may discover as you go through it, and there's some candidates who don't make it through the process for whatever the reasons are, and we don't necessarily always know that. But coming in, that's just the process, and so the norm is you take it, you go through, you answer the questions, you had to take the exam and all of that. So, I think that's a little bit separate. That's a separate issue from what happens afterwards, perhaps, down the road, and so that's--

CHAIRPERSON AYALA: [interposing] I don't think, because I mean, if so much emphasis is put in

on the psychological part of it, and now you're experiencing some sort of trauma and you have to admit publicly that you are-- you know, you may be going through something psychological, that you may be a little bit reluctant to do that if you think that it'll cast some sort of, you know, light on you, unwanted attention, you know.

FIRST DEPUTY COMMISSIONER TUCKER: Well, listen, we have-- it may come up in a disciplinary fashion, you know, because-- in related to some particular violation that the officer has committed, it may come up in that context. Discipline is certainly stressful, and so we have to deal with that as we go, and we do to the extent that we discover that an individual who's being disciplined is just like any other one of these cases is in need of some assistance, we'll provide it. But you know, interestingly enough I think when it comes to discipline through our process, people know that they're going to be held accountable. We have rules and regulations and so forth, but even in the way in which we've dealt with discipline over these past several years, we've eased, I think, some of the stress and angst just as an example of officers who

in the past may have been the subject of a lawsuit and never knew the outcome of that lawsuit because the suits may have been settled, and no one ever told them that they were part of the lawsuit, and we-- our officers get sued frequently. But that creates stress, and so what we've tried to do over the past several years is- and the Chief mentioned it a moment ago-- we have to build trust with the community with the Neighborhood Policing. We understand we have to win back the community's trust in the way in which we do business with them and how our officers conduct themselves, but we also have to build trust inside the agency. You know, it's a, you know, paramilitary organization, but sometimes in the past the discipline has been really heavy-handed, and the question is, how do we-

CHAIRPERSON AYALA: [interposing] So an officer wouldn't know if you're on desk duty because it was a disciplinary case versus mental health evaluation that maybe determined you to need-- to be in need of-- I think you're force-- it forces people to disclose, right, that they're having an issue. Whether you're saying it or not, you're forcing a situation where people now know. If I'm going to a

psychiatrist because I'm suffering from depression, I don't want, you know-- I may not want my colleagues to know. I may be okay with that. I may, you know.

FIRST DEPUTY COMMISSIONER TUCKER: Well, but that wouldn't be general knowledge necessarily.

CHAIRPERSON AYALA: But would it be implied.

FIRST DEPUTY COMMISSIONER TUCKER: I mean, we should ask, you know,--

ASSISTANT CHIEF PONTILLO: [interposing] So, I--

CHAIRPERSON AYALA: [interposing] I don't think-- I'm not trying to imply that this is like a purposeful thing. I'm just trying to say sometimes we don't look at things from this angle, right? Is that-- would that contribute--

FIRST DEPUTY COMMISSIONER TUCKER: [interposing] I think if we put someone on modified assignment, that wouldn't necessarily be a flag that-- other than maybe there was some-- they're being looked at for some particular reason. Modified assignment is not a punishment, right? It is a way in which we can-- we make a judgment call about whether this person should continue in whatever their

initial assignment was for a particular reason. It doesn't flag that somehow this person has any kind of psychological problem, or it wouldn't be public. No one would know even if they are going to counseling or if they're involved in counseling if it was a domestic violence case or whatever. That wouldn't necessarily be known.

CHAIRPERSON AYALA: Okay.

FIRST DEPUTY COMMISSIONER TUCKER: So I'm not sure. I think, again, it's case by case by case, and we don't publicize for obvious reasons. Some of this stuff is just confidential, those conversations that take place, that they're seeing a psychologist or whatever it is. that's one of the things that we worry about is making sure people are comfortable getting the help and they're not refusing-- feel like they have to refuse to take-- to get help because they're afraid that they will be, you know, seen as weak or whatever it may be by then--

CHAIRPERSON AYALA: [interposing] Is there-- do you have a mandatory reporting requirement so that if an officer is assigned as a partner, and the partner is maybe identifying red flags that may be indicative of depression or something just being

slightly off with an officer that may require a certain level of intervention. Is that officer then, you know, required to report that to an immediate supervisor? What-- where do you get your information?

FIRST DEPUTY COMMISSIONER TUCKER: No, no--

CHAIRPERSON AYALA: [interposing] Where do you get your information? Does a person have to self-disclose most of the time, or is that information coming from colleagues, you know, commanding officers, family members? Where is that information coming from?

FIRST DEPUTY COMMISSIONER TUCKER: Which information?

CHAIRPERSON AYALA: Information leading up. I mean, if you have an officer that's going- you know, that's suffering from some sort of trauma, right? They're going through a divorce. They seem to be having a hard time at work. They are, you know, are exhibiting, you know, symptoms of depression, severe depression. Where are you-- how do you identifying that? Who's reporting that, you know? What happens with an individual like that?

FIRST DEPUTY COMMISSIONER TUCKER: Well, you're assuming that people will know that that's the case, and that may not be the case and often isn't the case, but where-- if you work-- if you and I are partners, and you-- I'm the way, the same way all the time, and then I come to work one day and I'm doing something bizarre, you might ask me, "Is there something I can do to help you?" Right?

CHAIRPERSON AYALA: Uh-hm.

FIRST DEPUTY COMMISSIONER TUCKER: Are you okay? That kind of thing. So we're encouraging people to seek help, and we're encouraging through this peer counseling, peer process, peer support process, for example, to have officers who, as the Chief referenced, that you're familiar with that you know. They can-- if they offer help that maybe perhaps you would be inclined to--

CHAIRPERSON AYALA: [interposing] But I would, if I was an officer in need of help, I would have to solicit the services of the peer support network?

FIRST DEPUTY COMMISSIONER TUCKER: No, that's just the opposite in many ways. You wouldn't have to do anything. All I'm saying is that we're

building this peer support network so that officers will be able to identify that there's maybe something wrong and be able to listen and to be able to make a referral or suggest that you get help. That's all that is. They're not counselors. They could make a referral to one of the clinicians, and so when we talk about the outreach, the wellness outreach process where we have the psychologist, the clinicians and the EAU teams embedded in the commands, it is our hope that the question that you're asking gets answered because those folks now have a relationship and build some trust within that environment in the precincts where this person-- anybody in distress might say, "Can I speak to you?"

CHAIRPERSON AYALA: Do you-- are you receptive to information coming from a family member of an individual?

FIRST DEPUTY COMMISSIONER TUCKER: We often are. Family members often do call.

CHAIRPERSON AYALA: Is there some sort of supportive service to the family member? Like are they directed to a team or is that a call to the Commanding Officer? What does that look like?

FIRST DEPUTY COMMISSIONER TUCKER: Well, there'll be a conversation and they'll get contacted when they call, and that person who they speak with will make a determination who they should put them in touch with.

CHAIRPERSON AYALA: Okay. Now, the EAU it is a unit?

FIRST DEPUTY COMMISSIONER TUCKER: Yes.

CHAIRPERSON AYALA: Where is it located?

ASSISTANT CHIEF PONTILLO: They're at 90 Church Street.

CHAIRPERSON AYALA: there's one per borough, or is it just one?

ASSISTANT CHIEF PONTILLO: No, well, that's where the unit-- that's where their main office is, but they have people assigned geographically to cover each borough, and they have often a civilian peer support person for civilian members of the service.

CHAIRPERSON AYALA: And if a person contacts the EAU unit, is there an average wait time?

ASSISTANT CHIEF PONTILLO: No, they're available 24/7, and our Medical Division as well is available 24/7, 365.

CHAIRPERSON AYALA: Does the NYPD use-- there's a tele-- there's like this some for profit organization use it, but they'll have like a number they'll give to employees and say, you know, if you're suffering from some sort of trauma, or you know, you're just feeling stressed out, you're going through something and you need somebody to talk to, here's his number. You can call. It's confidential, so that that way they kind of remove themselves a little bit from the Department if they're feeling some sort of intrepidation [sic] doing that, but they're also, you know, actively seeking the support in a way that they feel comfortable seeking that support?

FIRST DEPUTY COMMISSIONER TUCKER: Well, one of the-- we do have lots of numbers that you can call. We have a new app on-- all of our offices have a smartphone so we now have an app on that smartphone which provides them with information, and with no phone numbers and that they can get in touch with if they choose to use these resources. That's what we're trying to do--

CHAIRPERSON AYALA: [interposing] But are those resources connected to the NYPD, or are they independent?

FIRST DEPUTY COMMISSIONER TUCKER: Some are and some are outside, and you know, we're working with NYC Well, so there's lot of-- what we're trying to do is provide them with a broad range of resources that are at their disposal and encourage them to-- the message always is encourage them to, if they need help and they're stressed or whatever is happening with them, that they take advantage of those-- they take advantage of those resources, and to make it available to them in way in which they feel comfortable calling that number and maybe outside the agency. I mean, that happens now. People seek help in a variety of ways, and you know, that's been the norm and we're trying to expand the opportunity and the resource pool so that people have more options, I guess, and then trying to point them in those directions.

CHAIRPERSON AYALA: So, my last question. If an officer is responding, and I guess the same question for the FDNY-- if a first responder is responding to a traumatic, you know, event, a

shooting, an incident involving a child, what happens after that? Is there-- does the officer have to say, "I mean, I just witnessed something and I don't know how to process that," or is there an automatic response from that police station that says, you know, listen, this is like an awful, traumatic experience, you know, we want you to come in and do-- I think you referred to it as some sort of like reporting period or whatever, some sort of analysis that happens afterward.

FIRST DEPUTY COMMISSIONER TUCKER: Well, we are-- we will be proactive. I mean, when we have officers who were shot in the line of duty or injured in the line of duty, and-- or die in the line of duty, then we will-- our Family Assistance Unit, our Employee Assistant Unit all will be part of the network that kicks in to provide services to the individual officer, to the officers who were part of and partners on the scene and witnessed the event, and in cases where the officer-- there's a death that occurs, the families are forever really part of receiving any services that we-- that they need from us.

CHAIRPERSON AYALA: Is that service extended to-- does it go beyond police-involved shootings?

FIRST DEPUTY COMMISSIONER TUCKER: Yeah, I mean, it's not just police-involved shootings, it's not just where police die. I mean, shootings, people are injured, officers are injured and they live, they may, you know, be physically-- you know, have a physical disability. We've had, you know, officers who have been with us. Steven McDonald, Officer McDonald who was shot back in the 80's and then lived for another 37 or so years. We were always a part of the support for not only Steven, but his family, his son and his wife and his extended family as well.

CHAIRPERSON AYALA: But if-- so let's assume a key scenario, there's a fire and you have, you know, multiple fatalities in the building. I mean, we've all seen the pictures where we have officers, police officers, fire officials coming out with babies in their hands that didn't make it. You know, that's a very traumatic experience for anybody, and police officers and fire fighters routinely see and have these types of experiences, what does that-- what happens after something like that? Is there an

automatic response to, you know, with the individuals involved that addresses what they just went through that allows them to process it, or is the expectation that if they can't and they feel personally that they can't. A week later, they're still having-- you know, a problem with this, that they're going to come to an immediate supervisor and say, "Hey, you know, I need help." What does that look like for the NYPD versus the FDNY?

DIRECTOR SHMERLER: For FDNY, as soon as we're notified that there is an event, we immediately deploy our peer team who will go out to the sight itself as it's happening or to the hospitals, and then we'll follow up with the EMS houses, to the firehouses. We send them out immediately to both provide counseling, debriefing, and let them know of CSU services, and then we follow up. We keep going, because sometimes as the deployments change and members are placed different places where they'll come off service. We'll keep following up until we catch each member that was involved in the event to make sure that they're taken care of, and then providing, offering them services should they feel

the need, and that then extends to the families as well.

CHAIRPERSON AYALA: Appreciate that. Alright, thank you.

CHAIRPERSON RICHARDS: Thank you, I'm going to go to Chair Borelli and then to Council Member Levine.

CHAIRPERSON BORELLI: Thank you very much. So this is the Administration's panel. Is anyone here from Thrive New York?

FIRST DEPUTY COMMISSIONER TUCKER: No, this is PD and FDNY.

CHAIRPERSON BORELLI: Is anyone here in the audience from Thrive New York that will be testifying today? Okay, so just to be clear just for the record, we spend 250 million dollars a year on a mental health agency in New York City who decided that no one was able to come and testify about mental health issues regarding our city's first responders. That said, I would have started off by speaking about the 122 police officers nationally who killed themselves this year, but I saw news just broke this morning that a police officers in Chicago also killed himself, the fourth I think in Chicago, and it's a

national issue because the 122 to-date is almost the 140 that I was able to find happen in 2017, the last year on record, more than the number of police officers killed in the line of duty. So, I want to ask the question about what is driving this phenomenon nationally. Chief, you had said in your comments that police officers sign up to be the ones providing help. Do you think that rhetoric that we see nationally that frames police officers in devious ways, as monsters, do you think that affects the mentality of police officers showing up to work every day?

ASSISTANT CHIEF PONTILLO: So, I would say I've got 33 years of experience, and for my entire time on the job it has been a difficult job at times. Police officers deal with a great deal of stress. We see horrific crime scenes. We deal with people at their worst going through very difficult times, and certainly we're not oblivious to the political climate that may be going on nationally. So, all of that has always existed. I can remember throughout my career things like that occurring. So, I think it's maybe a mistake to try to pinpoint one particular issue. The science and the study around

suicide has evolved quite a bit over the last decade or so and we're learning a lot more than we knew even 10 years ago, but I also think that-- what I know is that what we've learned, there is no single cause of suicide. Suicide rates have been increasingly nationally since 1999. Nationally, we're up about 40 percent since that time period. It's the 10th leading cause of death in the US overall, second leading cause of death for people in their 20's. So it's a national phenomenon. So, the Commissioner was talking about, you know, who commits suicide in the NYPD when we look at the demographics, it really cuts across all demographics internally. People relatively new on the job, people with a lot of time on the job, and everything in between. We do tend to follow the national trends in terms of, you know, male whites are the single largest group who take their own lives by suicide, certainly more men than women. We see that nationally. We see it locally in the NYPD. Albeit the overall suicide rate in the NYPD is higher than the national average. Over the last several years, the national average was tracking at about 12 per 100,000; we were at 14, and then this year we've seen huge increase. But yeah, I get back

to that point, what we've learned from science is that there is no single cause of suicide. What we see is that the combination of biological, psychological, and then social and environmental factors. All of those on top of an individuals' current life events. Add to that, the availability of lethal means. You bring all those things together, once a person starts down that path and they kind of reach that point where it's just one stressor too many, they then develop what's known as cognitive inflexibility where they get this tunnel vision. They feel isolated and hopeless and helpless, and they feel that there's no way out and the only solution is suicide. Then, with the availability of lethal means, that then puts them basically in that position where they take their own life. So, I think it's a very, very complicated issue. We really don't understand. We're all looking for, we're all struggling for that why. We just don't know, but we do know that it's complicated and there are many, many factors, many risk factors--

CHAIRPERSON BORELLI: [interposing] Sure, I wasn't suggesting that that would be the pinpoint motive in all the cases, certainly not even the

majority perhaps. I guess, I'll ask the same question in a different way. If we asked the cop on the beat at the Staten Island Ferry Terminal right now whether or not the rhetoric we see nationally, the rhetoric we see locally, the policies and justifications for those policies we see here in City Hall and elsewhere, if I asked those cops, would they say that those factors are demoralizing and add to the stress level of a police officers' already difficult job?

ASSISTANT CHIEF PONTILLO: They may.

FIRST DEPUTY COMMISSIONER TUCKER: Yeah.

ASSISTANT CHIEF PONTILLO: But I think, you know, the point that we're talking about mental health and wellness and suicide, cops are like most people, remarkably resilient, and we all absorb a lot of stress and we all deal with a lot of risks every day, everything from family life to work life to other environmental and social factors that we all deal with, and we're all able to absorb that and deal with it. When we talk about suicide, certainly, there can be many, many combinations or factors that pile up.

CHAIRPERSON BORELLI: Was this a topic that was discussed in the day of conference that you had referenced, Commissioner?

FIRST DEPUTY COMMISSIONER TUCKER: We touched on many-- I mean, it was an all-day conference, and this topic I'm sure came up. I wasn't there for the entire conference. I was there for the morning conference primarily. But I think to the Chief's point, it is just that illusive in terms of understanding that dynamic. We just don't know, but again, cops are resilient. The jobs is stressful, it is. Fireman run into burning buildings. I would never become a fireman. I became a cop. You know, I'm willing to run in with the guys with the guns, but I'm not running into a fire, you know, so God bless the fireman. But I think cops are-- they're willing-- they take the job. They want to serve. They want to do good, and I think that's-- and they accept pretty much the stressors that come along with it. Most of them, a majority, a great majority I think cope, but I think to your earlier point I do think that what happens outside of the job and what impacts the job, the rhetoric, I referenced it in my testimony, the antagonism, the disrespect,

those things are certainly stressors. I'm not suggesting that those stressors will take you to the point where you become suicidal, but they are stressors.

CHAIRPERSON BORELLI: No, and thank you. I guess my point was more to just indicate that every job has stress. If I was going to a high-stress job where I may risk my life, and I'm not saying every cop needs a pat on the back every minute of the day or a medal, I'm simply saying that I think it probably is tremendously demoralizing. And I'm not speaking-- I'm not making this up. This is from the cops that I know, the guys and women that I share a beer with probably too often, but this is the topic of conversation quite often, that it's tough to want to do the job every day and risk life and limb, when you're fear-- you have a fear of the resentment that is sort of caused by your very presence. But nonetheless, I'll just move on a little bit. Can you talk about the overall budget allocated to the PD to mental health services, and also, Doctor Shmerler, same thing with the Fire Department, what is the overall budget allocated for these services?

DIRECTOR SHMERLER: I'll talk for the FDNY. For right now, there are 4.2 million are allocated annually to the CSU for mental health services for the Department.

CHAIRPERSON BORELLI: Do we have any idea for the police?

FIRST DEPUTY COMMISSIONER TUCKER: I think it'd be challenging for us to sit here--

CHAIRPERSON BORELLI: [interposing] Sure.

FIRST DEPUTY COMMISSIONER TUCKER: and sort of give you numbers, because the services are spread throughout the agency through EAU through our Medical Division. So I'm not sure. We could probably come up with a number at some point and share it with you that we think gets close to that.

CHAIRPERSON BORELLI: The follow-up question was an easier one. It's--

DEPUTY COMMISSIONER CHERNYAVSKY: Council Member, just to add, we're not short-changing. I think the take-away is that we're not short-changing any programs.

CHAIRPERSON BORELLI: I want to see if you guys need more money for this.

DEPUTY COMMISSIONER CHERNYAVSKY: No, no, I understand. So, the idea is that we're always striving to provide more services and more opportunity for our officers, and we do that in partnership with Thrive and other agencies and outside entities, and you know, we-- it's just dispersed throughout. It's not one single unit that we allocate a dollar amount to and everything falls under that one unit, so we can just carve out and spit out a number at you, but that-- that's our model.

CHAIRPERSON BORELLI: Perfect, thank you. I think there's a consensus on this side of the table that should you identify needs and additional resources for this purpose there would be an effort to give those. Last thing I want to ask about is when the PD refers people to outside clinicians, is that covered by the insurance policies of each respective contract, or-- how does that work? How does that work with respect to insurance reimbursements?

ASSISTANT CHIEF PONTILLO: So, generally, yes. Our Medical Division, for example, the psychologists we have, they will conduct assessments,

but they don't necessarily provide treatment. The treatment is left to the individual member of the service to pursue with their-- either their primary care physician or mental healthcare provider that they select through their insurance. Currently, there are seven different insurance programs available to members of the NYPD. Over 90 percent of PD members have Emblem Health, so most of the healthcare is through Emblem Health. For medical and primary care physicians it's through an Emblem provider. For mental healthcare Emblem has contracts that work out to Beacon Health, but through Emblem Health, a member of the service who has that insurance can get coverage. The coverages vary depending upon which plan you have and whether or not you have a rider and whether you're in network or out of network, and the landscape can get very, very complicated. As a matter of fact, that's one of the most common calls our Employee Assistance Unit gets is from people having difficulty understanding and navigating the healthcare system and we will provide that help. We will make the calls for them. We'll sit with them, we'll help them make an appointment and get a provider. We also have a network of

Department-- NYPD Department Surgeons and a network of Honorary Surgeons we have relationships with, and through that network through our Supervising Chief Surgeon and the Department Surgeons and our network of Honorary Surgeons, sometimes we can facilitate getting appointments or getting the appropriate healthcare.

CHAIRPERSON BORELLI: Are there any opportunities when a member of the NYPD would be denied mental health coverage because of a plan they chose? Or have a very high copayment?

ASSISTANT CHIEF PONTILLO: Theoretically, sure, depending upon their plan and what their treatment requires and whether or not medications are covered and to what extend and how many visits are covered, and whether it's in-patient or out-patient. There are a lot of permutations to it. So, it could. I'm not aware of any personally, but theoretically it could.

CHAIRPERSON BORELLI: It just seems that that should be-- considering we give police officers the power to hold people against their will, you know, the full power of the state to end a life, perhaps, I mean, it just seems that there should be

no financial impediments to a person seeking this type of mental health counseling. What about the leave policy for both the FDNY, actually, and the NYPD? Can-- does an employee have to take personal time to see a mental health clinician?

DIRECTOR SHMERLER: It depends on their role [sic]. Usually, a fire fighters or EMT will come in on their off time if that-- they're not capable of doing that, they'll get leave time to come in.

CHAIRPERSON BORELLI: Okay.

DIRECTOR SHMERLER: And those, they'll come in-house to the clinicians in the house, clinicians that we have in-house are culturally competent and know the job that they do. They're aware of it. They're usually referred by one of our peer counselors who has a relationship with that, so that really tries to build the trust.

CHAIRPERSON BORELLI: Is there--

ASSISTANT CHIEF PONTILLO: [interposing] Similar for NYPD. You know, it depends upon the unique circumstances. Members can seek healthcare on their own time and generally do. However, if a member is out sick or is, for example, some of our

counseling service programs that we provide are on job time. So you could use sick time in which case you're paid and you're off. You see your physician or some of our counseling programs are done on job time.

CHAIRPERSON BORELLI: Is there any opportunity through Thrive NYC for a police officers or fire fighter to receive free and relatively immediate mental health services?

FIRST DEPUTY COMMISSIONER TUCKER: Well, they can get the-- if they take advantage of the 24-hour hotline, and they can then get services through that, that process, right? Yeah.

CHAIRPERSON BORELLI: Thank you. That's all I have.

CHAIRPERSON RICHARDS: Thank you. Going to go to Council Member Levine followed by Levine. I also wanted to acknowledge we were joined by Council Member Miller and we're also joined by Council Member Alicka Samuel as well. So, Levine and then Gibson.

COUNCIL MEMBER LEVINE: Thank you, Mr. Chair. We need to attack this crisis on multiple fronts which is why we are pushing for more clinical resources in the Department and we want to remove

barriers to members of the Department accessing resources outside of the Department. And there are reasons that someone could pursue either channel. Someone in the Department has the advantage of maybe being embedded in the command, getting to know members of the Department, so it becomes a really normal type of service. We're looking to remove the stigma, and we think that could be a very effective tool for that. But we understand the sensitivity around confidentiality, and that some members of the Department might prefer to go to an outside provider like POPPA. In either case, it's so critical that the offices understand that their career will not be negatively impacted simply by asking for help, and you've spoken about this some today already, but I do want to give you a chance to confirm. If someone simply requests a meeting because they are suffering with a social worker or psychologist in the Department, or if someone seeks outside help from POPPA or another provider, does that in any way trigger a report to a superior, or is any information transferred that could affect that officer?

ASSISTANT CHIEF PONTILLO: No, so POPPA is confidential. If a member contacts POPPA and they

get service through POPPA, that is confidential. There could be some circumstances where there's an immediate threat to somebody's safety and have to be hospitalized, that may get more resources involved, but generally, no, that is confidential. Similarly, if somebody goes to their own physician and/or social worker or other clinician and seeks some treatment, that too is confidential. It's protected by HIPPA, and it's between that individual person and their practitioner.

COUNCIL MEMBER LEVINE: One of the intents of our bill in establishing the idea of an annual mental health check-up, which would be voluntary I want to emphasize, is that it begins to feel routine, and that there's no kind of red flags that emerge because someone gets a checkup. As I mentioned earlier, just like you'd get a physical. It doesn't mean you're necessarily sick, it just-- you're taking preventative action. Can you explain the exact protocols that would require a clinician then to report that a person is in danger to themselves that might then trigger the need to temporarily take the service weapon and possibly the badge?

ASSISTANT CHIEF PONTILLO: Sure. It could be something as overt as an attempt to take one's own life. It could be suicidal ideation where the person is expressing a desire to take their own life, or it could even be a medication or combination of medications that debilitate somebody to the point where, you know, if a side effect of the medication is that you cannot operate machinery, you probably can't drive a car or exercise the judgment that we need a police officer to have when they're on duty. So, again, it-- we will defer to our trained professionals, our medical staff, to make those determinations on a case by case basis. Ideally, we want to speak to the member involved. We want to speak to their physician. We may want to talk to family, friends, and coworkers depending upon the facts or circumstances. Sometimes, if the source of the stress is coming from home, then we probably would not want to bring in the family member because that could further aggravate the situation.

COUNCIL MEMBER LEVINE: And what about if it's the family member themselves who makes a report that they're concerned about the safety of their

loved one? How is that information transferred? What are the protocols there?

ASSISTANT CHIEF PONTILLO: So, it'll be handled similarly. So, I could just say general numbers. In 2018, when we look at people who reached out to the Employee Assistance Units-- and we don't track identities, but we do keep some empirical data for analysis purpose, because we want to know why people are calling and what services they need. We had almost 2,000 phone calls last year. Over 1,100 were from the person themselves doing a self-referral, and that ran the spectrum, everything from I'm in a very, very bad place and I need critical care right now to I'm having trouble navigating my insurance, can you help me figure out what insurance coverage I have and who to call, and we deal with all that. We also deal with a lot of those risk factors and stressors that could be contributing factors to suicide like financial issues, like marital difficulty, like bereavement and grief and a whole host of issues that people might be dealing with. So of the balance of the 2,000, we get a few hundred calls from other members of the service who are calling about somebody else, and we get some number

that come from family members calling about a family member they're concerned about, and we will begin irrespective of where that call originates from. We will begin that process to reach out to that person, get a hold of them, interview them, find out what their issues are, if necessary get them with a clinician, and/or get them through their insurance coverage to private care if that's the appropriate response.

COUNCIL MEMBER LEVINE: Some of the recent cases of death by suicide have been among retirees, and that leads me to wonder about your strategy for reaching people who are no longer coming to work every day. Can you have a presence at a pension office or some other venue where you know you'll have contact with retirees?

ASSISTANT CHIEF PONTILLO: Sure. So one of the things that we're looking at, you know, if and when we establish this outreach program where we have trained clinicians to include psychologists, social workers, and Employee Assistance Peer Counselors. Ideally, we'd want to have a team at the Police Pension Fund so when people go to retire, we can do kind of an end-of-career debriefing. Currently, when

people go down and file for retirement, part of the package they get when they leave is an informational brochure from our Employee Assistance Program that talks about retirement, talks about some of the stress of retirement, provides information about various peer support programs that they can participate in for retirees, and also invites them to contact the Employee Assistance Unit if they ever are in any trouble. And we do get calls every year, albeit from small numbers, from retirees who reach back to get assistance from us, and we will provide that assistance.

COUNCIL MEMBER LEVINE: But if you had adequate staffing, then this could be not just a brochure you hand someone upon retirement, but an actual in-person consultation, potentially.

ASSISTANT CHIEF PONTILLO: Certainly, if we had clinicians on site, we could do some type of interview or debriefing for people who are filing for retirement. We're currently working with the Police Pension Fund now to develop an outreach program to send out information to retirees. All retirees get a quarterly pension statement, and they also do periodic mailings on information about upcoming

events. So we're looking to include information about insurance coverage as well as about employee assistance services.

COUNCIL MEMBER LEVINE: Auxiliary Officers and other part-time personnel could face many of the same stresses that--

ASSISTANT CHIEF PONTILLO: [interposing] Sure, and we make the information available for them. So a lot of our outreach is really focused at the command level. So we have information centers that we put up. We've designed a whole series of informational brochures. We've created a series of videos that deal with suicide, stress, postpartum depression, grief, things as sublime as little tags for every keychain for Department vehicle has the Employee Assistance phone number on it. So, just a constant reminder, always available, and we've had some success stories. You know, recently we had a member of the service who took one of these brochures, folded it up, put it in his pocket; three days later at 2:00 a.m. and said, "I'm in a real bad way," and we got that person some in-patient care and, you know, hopefully made a difference.

COUNCIL MEMBER LEVINE: POPPA's come up a lot today. That's such an outstanding resource, in part because it's peer-led, and officers value the opportunity to speak to someone who's been there. What are the other nonprofits, or could you at least give a sense of the number of other nonprofits and outside providers beyond POPPA that you are working with?

ASSISTANT CHIEF PONTILLO: So, we work with a number of organizations locally. So for example, the American Foundation for Suicide Prevention, their Chief Medical Officer has been working with us for our Executive level training as well as some in-service training we're currently designing. The American Association of Suicidology [sic], they provide our training for the psychological autopsies. Through NYC Well and one of their organizations, they work with Vibrant. We're getting clinicians for the command-level training that we're currently doing. So we have that going on, and then through NYC Thrive and DOHMH doing the mental health first aid training. That's been ongoing. Like the Commissioner said, we've trained 8,000, primarily police communication technicians,

traffic enforcement agents and school safety agents, but now we're in the process of training uniformed members of the service. So that's ongoing. We, you know,-- recently, so because of this, as another-- let me just back up a minute. Our priority from the very beginning is to encourage members to get help. And like the Commissioner said when we did the executive training, the primary message, you know, we gave them information about the science around suicide, information about suicide and the NYPD, information about warning signs and intervention techniques and preventive measures and resources that are available, but we said your primary mission here is one of leadership, to set the tone, create the culture, and we want people to know the Department's number one priority is that you get help. If you need help, if you know somebody who needs help, get help. Whether it's through the Medical Division and through Employee Assistance, through POPPA, through your own private doctor, go into a New York City hospital, it doesn't matter. Wherever you are most comfortable, go and get help. That's the number one priority. So along those lines and looking to expand the availability of services that are available

outside the NYPD, because we recognize there is a stigma and there is a certain level of difficulty coming forward internally, so people are more comfortable going outside. We began, as the Commissioner said, you know, we looked at Project Cope from 2001-2002 and designed a program similar to that that would provide mental health, healthcare, to members of the service free of charge who needed it, in a confidential way, and from a known and respected healthcare provider that could deliver the services that our members need. So, along those lines we went down the path of conducting an emergency procurement. So the procurement rules under the City can be quite cumbersome, but we have the ability to do an emergency acquisition, and we did that. We were able to secure the funding. We solicited some healthcare providers who could provide the mental healthcare services that we needed, and we have reviewed the responses. There was only one who was capable of performing these services 24/7/365, having healthcare professionals available to treat our members, and that is New York Presbyterian. So we have sent them a letter of intent that we're accepting their proposal, and we think we can begin

that as early as next week. So we're working out the details now, but we will be promoting that internally, letting members know that another option they will have that will be confidential will be to go to New York Presbyterian, and they'll have a dedicated hotline and they'll have dedicated staff to deal with our members.

COUNCIL MEMBER LEVINE: Thank you very much, and thank you Mr. Chair. I'll pass it back to you.

CHAIRPERSON RICHARDS: Thank you. Going to go to Council Member Gibson.

COUNCIL MEMBER GIBSON: Thank you. Thank you, Chair Richards, Chair Ayala, and Chair Borelli, and Council Member Levine for leading the effort on introducing 1704. Good afternoon, gentlemen. Thank you for being here. And certainly I echo the sentiments expressed by my colleagues and Chairs, and first and foremost, our continued prayers to the Department, both the NYPD and the FDNY, and certainly any life that we lose by death at suicide is always a call to action. And really as a Department, as an Administration, looking at some of our internal mechanisms and how we can provide better services,

and really meeting officers where they are. and I appreciate our Deputy Chief really being honest and understanding that officers balancing both professional and personal lives is a real challenge, and when you look at policing in 2019, it's changed significantly from when many of you started in the Department, and so if you look at the recent deaths we've had, they have been different ranks, different ages, retired, and so obviously while there is no pattern or trend, but certainly the uniformed member of service is the common theme. So I appreciate a lot of the work and effort that has been already expended. I do know EAU very well and POPPA as well as the Chaplains Unit which we continue to expand on, but I wanted to ask specifically, you alluded to Thrive NYC mental health first-aid training and a number of other efforts that the Department is embarking on. I also think that in order for officers to feel completely comfortable, confidentiality and real confidentiality has to be a priority. And we know the culture that sometimes we create ourselves, whether we're here in the Council, any other agency, it's a culture that exists. We know about it, and so we know that although we always make every effort to

be confidential, the reality is it's not always confidential, and the talk amongst ranks and different officers is really there. And so breaking down that system and looking at this from a holistic perspective is really our overarching goal. So in addition to the Department of Health and Mental Hygiene and Thrive NYC, I wanted to ask are you engaging our external partners in our fraternal organizations, which we have a lot of, because many of them have a real intimate relationship with their members. They meet ongoing, and so working with our external partners like a Noble, or the Guardians, or any of the other organizations to really reach their members at that level. Has that been started? And if not, is that something you think would be productive?

FIRST DEPUTY COMMISSIONER TUCKER: Certainly. We do have an active involvement with our fraternal organizations. They are kind of key to so much of the culture in the agency. So yes, we do, and they are included in this whole effort to go forward, and they've been involved in the past when we came out with Are You Okay campaign. They were very much in the mix on that as well.

COUNCIL MEMBER GIBSON: I remember that.

FIRST DEPUTY COMMISSIONER TUCKER: So yes, and you know, it's interesting because that issue-- speaking with someone from Noble the other day, and that issue came up with respect to the peer process and who the folks are. So there is some sensitivity around that and making sure that whoever the volunteers are have a broad sense of-- that it covers the multitude of people in the Department, what the Department looks like. That was a particular concern, but beyond that, I think everything that we're doing really cuts across every aspect of the membership, and that obviously includes all of the fraternal.

COUNCIL MEMBER GIBSON: Okay, and I know my time is up, but I just wanted to, if I could, just very two quick questions. Chair Ayala, and I believe Council Member Levine already talked about it, but I know that oen of the challenging points in an officers' career is as they age out of the Department at age 63. Once they put in their papers there's a series of things that will happen, but we know that they are going to age out at some point. So before they get to the Police Pension Fund, what is the work that we're doing to work with them as they transition

out? And then the second question is, there's nothing greater than the support of a family, and while understanding that has to be very particular in how you attack it, but the family support, spouses and children and other relatives in an officers' lives can also prove very beneficial. Obviously, very case by case basis, if you understand what I mean. But what type of family support services are we also offering while respecting that individual officer's privacy, and then obviously as they transition out into retirement?

FIRST DEPUTY COMMISSIONER TUCKER: Well, with the outreach, you know, seminars are conducted by EAU as well for people who are about to age out or who are going to put in their papers and retire, not because of age, but just because of whatever their tenure is, 20 years or so. And so that is-- that'll be and is part of the normal process right now. As I said earlier in my testimony there are things that have been in place. Now we want to make sure that we build on those foundations. This would be one of those aspects. As it relates to people as they get closer to, notwithstanding the seminars, we are actually exploring what else-- you know, we talked

about how early we want to intervene and speak with someone. Is it a year out before they-- if it's aging out, a year before, a year and a half before, what does that look like? We haven't come up with a particular model yet, I don't think, but it is part of the conversation that's taking place.

CHAIRPERSON RICHARDS: Thank you.

COUNCIL MEMBER GIBSON: Thank you so much, Chairs.

CHAIRPERSON RICHARDS: Thank you. Going to go to last round of questions. Can you talk about Project Cope a little bit more? So, in your testimony you spoke of the initiative being started in the wake of 9/11, so and back then obviously you partnered with private hospitals to provide counselling sessions with private clinicians and a 24-hour hotline without charge to officers coping with trauma from the attacks. And I think in your testimony you also allude to an RFP being issue.

FIRST DEPUTY COMMISSIONER TUCKER: Yes.

CHAIRPERSON RICHARDS: Can you just speak a little bit more about that?

FIRST DEPUTY COMMISSIONER TUCKER: Well, as the Chief referenced just a moment ago, we are--

we sent them a letter of intent with respect to the services you just outlined. They are the only one that sort of fit the model that we-- when we did the initial grief procurement RFP. And so we hope to-- I mean, we have a-- we have the emergency procurement in place and we're acting on it, and we hope to have an agreement and begin services within a few weeks.

CHAIRPERSON RICHARDS: And this will be permanent?

FIRST DEPUTY COMMISSIONER TUCKER: Yeah, it'll be permanent so in as much as-- eighteen, is it 18?

ASSISTANT CHIEF PONTILLO: Eighteen months.

FIRST DEPUTY COMMISSIONER TUCKER: Eighteen-month procurement, so then we have to do a larger RFP and then, you know, we'll have other folks who may come in.

CHAIRPERSON RICHARDS: So, we won't have to worry about this ending, because after 9/11 it ended, so I just wanted--

FIRST DEPUTY COMMISSIONER TUCKER: [interposing] Well, I think you had lots of reasons why it ended because of what the initial purpose was,

but-- and the other thing that I think, you know, I think it's, you know, the notion that we're doing it for 18 months because of the procurement restrictions is actually not a bad thing, because this will give us a sense of--

CHAIRPERSON RICHARDS: [interposing] Right.

FIRST DEPUTY COMMISSIONER TUCKER: how many people access it, how many people use the services. That'll tell us something in and of itself in terms of efficacy of that particular model. Maybe we need to do something.

CHAIRPERSON RICHARDS: And just speak about your plan on the clinicians. So your plan would be, if this bill were to pass, to ensure that every precinct has clinicians. Have you come up with a plan on what that looks like yet?

FIRST DEPUTY COMMISSIONER TUCKER: Yeah, we do, I don't know if we have the particulars, but the goal is to create 58 teams of-- that would then-- and it's based on just geography, the number of boroughs we have, the eight boroughs and so forth. And then also-- so it would cover the transit district, PSAs and precincts, but also-- so all of

those folks, but then we have I think ultimately nine groups that would-- one of which would be-- in terms of the boroughs, we'd also have a group that would deal with the administrative officers like particularly headquarters as an example, the specialized units. So, but that's the goal, and then we have the clinicians and, you know, the psychologists, clinicians, and those folks who will be accessible and embedded in those areas, and to build that-- to build trust as I proposed [sic] the conversation we had earlier where people will become familiar with this team of people in their area. So, I think we're talking about enough teams that would provide services to on average a thousand officers. That's how we sort of roughed it out so you have a sense of how it would work.

CHAIRPERSON RICHARDS: And my last question is--

FIRST DEPUTY COMMISSIONER TUCKER: [interposing] And obviously, not every, you know, not every person in those-- in these, throughout the Department, will be taken advantage of. That's the advantage, we'd be taking advantage of it. So, 58 teams, 25 to start off with in the early stages. So

this protocol, the early part of what we're standing up would we start with the 25. We'll build to the 58, but we'll also learn as we go.

CHAIRPERSON RICHARDS: And then a last question I have is I want to know one provision of the bill requires the Department to make wellness information session available to officers annually. Does the Department agree that encouraging officers to sit down with someone who can help make sure that they're doing okay and that they know how to get more help if they need it is a valuable way to keep officers emotionally healthy?

FIRST DEPUTY COMMISSIONER TUCKER: Listen, I think so. It's in line with what we're proposing anyway, right? We want to make sure that any officers, any civilian who needs help has the ability to get that help.

CHAIRPERSON RICHARDS: So, Oleg, you support the bill?

FIRST DEPUTY COMMISSIONER TUCKER: And know it's available.

EXECUTIVE DIRECTOR CHERNYAVSKY: We look forward to working with you.

CHAIRPERSON RICHARDS: Yes, okay. Pick on Oleg; he didn't speak today.

FIRST DEPUTY COMMISSIONER TUCKER: Alright.

CHAIRPERSON RICHARDS: Alright, I'm going to go back to Borelli, and then we'll start to wrap up this panel.

CHAIRPERSON BORELLI: Thanks. Just final questions for the Fire Department. How many members of service utilized the Counseling Service Unit?

DIRECTOR SHMERLER: Approximately 2,500 to 3,000 a year actually come in for a session with--at least one session to see one of our licensed counselors, tens of thousands in the field with our peer counselors, tens of thousands of contacts each year.

CHAIRPERSON BORELLI: 2,500?

DIRECTOR SHMERLER: 2,500 to 3,000 actually come in each year to receive--

CHAIRPERSON BORELLI: [interposing] Does the Department track whether the visit was caused by job-related trauma or personal reasons, or?

DIRECTOR SHMERLER: We track it. The Department doesn't. I mean, our records stay with

us. So we have records of people coming in for trauma or family issues, substance abuse, whatever that is, but that stays in-house with us.

CHAIRPERSON BORELLI: In general terms, what is the percentage that come for job-related traumatic stress, versus something the general population might--

DAVID SHMERLER: [interposing] Yeah, I think the number one reason people come in is actually for marital reasons, but when you kind of dive down into marital reasons, it may be job stress, it may be substance abuse or other, you know, PTSD. But the number one thing we see the reason they say they're coming in is for marital reasons.

CHAIRPERSON BORELLI: And how does the Department basically inform members of the services available to them through the Counseling Unit?

DIRECTOR SHMERLER: Well, that's done every day with the teams that go out, the peer teams that go out to the stations and the firehouses. We do that online as well through Diamond Plate. Any chance we get, any opportunity we get to disseminate the services available, we let them know, and over a year-- it takes time. That trust has been built over

time, so it's really a sign of strength when someone says they need help. Fire fighters talk about it at the kitchen table. One of the things that we do with our EMS stations and firehouses, we educate them every day on different mental issues like depression or PTSD. We go to the stations in small groups talk about it, and we hope-- our hope is when we leave they're still having those conversations, and that again helps with stigma.

CHAIRPERSON BORELLI: And then since you're tracking the number of people, have there been more people seeking services in years-- compared to years past?

DIRECTOR SHMERLER: You know, it peaked about 18 months after 9/11. I don't have the exact number in my head, but that's when it was the highest, and then it kind of leveled out to 2,500 to 3,000, and it's been there for about, you know, 10 years. You know, it's pretty consistent. We have-- our hotline gets about-- that the hotline is when the office is closed after business hours and on weekends, and that gets about 2,000 calls a year, and 20 percent of those calls come from family members.

So, others, you know, the others are members of service.

CHAIRPERSON BORELLI: And are cadets notified at the Academy, EMS Academy, and any type of training program at that point of services available?

DIRECTOR SHMERLER: Oh, yes, education is done at Proby [sic] School and EMS Academies as every rank. As people move from rank to rank, education piece is there. At annual medicals once a year, we do education. At retirement we have education pieces. We're really concerned about our retirees. The outreach is more difficult there. So we see them at our annual medicals WTC. There's always a peer support personnel seeing them each and every year. The other thing that we have in about five locations monthly is a retiree breakfast where we-- it's a social gathering, but we have services that are available and someone from peer support and one of our counselors there just to let them know that they're not forgotten about. They spent 25 to 30 yeas serving this city. We will not forget them at CSU.

CHAIRPERSON BORELLI: Thank you.

CHAIRPERSON RICHARDS: Commissioner Tucker, do officers do-- members of service do an annual medical as well? No, they don't, okay. Alright, thank you all for coming out. Thank you for your work. We look forward to continuing our partnership with you on this. Thank you so much for the work that you're doing. The next panel: Nancy Carbone, Friends of Fire Fighters, John Petrullo, POPPA, BeatriZ Cornell [sp?] Comunilife Coalition for Behavioral Health, and Anitha Iyre, Vibrant Emotional Health. Let me just call this again: Nancy Carbone, Friends of Fire Fighters, John Petrullo, POPPA, Anitha Iyre, Beatriz Caranell [sp?], Comunilife Coalition for Behavioral Health. John Petrullo? Alrighty, thank you. You may begin.

NANCY CARBONE: Hello? Yeah. I'd like to thank this Council for the opportunity to speak on this very sensitive issue, and I offer my condolences to the police officers, the Police Department, and the City as a whole, because if we lose a police officer or a first responder, we've all lost. Friends of Fire Fighters has been in existence since immediately following 9/11, initially as a response to 9/11, but now serves fire fighters active and

retired and their families. Some of today's fire fighters were in grade school back in 2001, but now they're on the job that requires tremendous dedication and sacrifice. Our success with the firefighting community is largely based on our policy of absolute confidentiality and it has grown largely through word-of-mouth. We started in one firehouse in 2001, quickly grew to five firehouses by January of 02, and now-- that was actually in my car and in the firehouse kitchens, and we've grown to all five boroughs, and I think the driving force of the fire fighters themselves who asked me to start a nonprofit to start a counseling place outside of the Fire Department. There was a perception in 2001, less no now, but there was a perception, strong perception that CSU was not the place they wanted to go. They didn't feel it was confidential. Over the many, many years in the interim, we have actually now a good working relationship with CSU and that they now trust us, and the good reason, right reason, they didn't know who we were initially. They were a little cautious, but the current Fire Commissioner Dan Nigro was our Board Chair for three years prior to taking the position. So there's an understanding now of why

we exist. I think it's important to say that the City Councils that have supported us, we consider partners, and we hope to partner with more to ensure our continuation, but to say this is a delicate subject, it's an understatement. I think it's past time that we do open the door, stop whispering the word suicide. There is a stigma, of course, to getting help. There is no blame, but there are gaps, and the gaps that we'd like to close as Friends of Fire Fighters comes from understanding that there has to be a place for people to go that is separate from their job or their agency such as the Police Department or the Fire Department. So to that end, our main place is a firehouse, a circa 1870's firehouse in Brooklyn, that the fire fighters have built themselves. They've restored it to a firehouse. So when they come in they feel very much at home. When we've had events that invite the police officers, they say it is without exception; we need a place like this. I think a part of it is that they know that they have each other to speak to, so there's an understanding about what the job is about and the stressors, but also there are counselors there that are credentialed and licensed and able to

help them build a tool box of different things they can do to help them through very, very difficult times. There's no argument as to what they're up against in regards to the tragedies that they witness and are very much a part of and the toll that it takes. We also consider the family a very, very integral part to helping the fire fighter. The first responder goes home at the end of a tour and there's often times a disconnect. So if we aren't helping the fire fighter, we are not helping the family. I think it's also important to say on a personal note my grandfather chose suicide as an out, and so the ripple effect on the families lasts for generations. So, it's incredibly important to me that all gaps are closed. I offer Friends of Fire Fighters with my Board's support, my staff's support to help the NYPD so that we can be a center for them to drop in to now that they have help there for them as well. Thank you.

CHAIRPERSON RICHARDS: Thank you. Thank you so much for the work you do. Thank you.

JOHN PETRULLO: Hi, I'm John Petrullo, the Director--

CHAIRPERSON RICHARDS: [interposing] Press your button.

JOHN PETRULLO: I'm John Petrullo, the Director of POPPA. I just wanted to make myself available in case there's any questions about POPPA and what we do, and if you'd like I can give you a little history of POPPA, how it all started. POPPA wound up in this facility back in 1995 when we had 26 suicides, and one of the solutions was to have a peer group that would help the cops that would be independent of the Police Department. When it initially was set up, it was a suicide hotline for the cops to call. It's changed so much since then. It's no longer just a suicide hotline. We get less suicide calls now, but we do get a number of calls that back in the day we would never get, because the cops wouldn't pick up the phone to call. So now we have cops that call long before it gets to crisis. We're able to avail of mental health professionals by meeting with another peer. The peer-- difference between our peer and Department peer is that they're doing it on their time. It's confidential, and that helps us break that wall down, the stigma a little bit. When they call for help, they know that it's

not going to go anywhere, and that's been a huge part of the success. Through the years we've had about 150 officers that were talking about completing suicide which came through the program, and the majority of them were able to get better and get back to full duty. We have a lot of different programs that we now do. We do a two-day assist. We do that at least four times a year where we teach our officers and we allow them to bring in their families or friends, what to look for in somebody who may be suicidal. We've also increased it now where we're doing an outreach on self-care for them. Earlier in the year we did outreaches for-- up at the range we were able to reach roughly 20,000 of our officers giving them a presentation on suicide awareness, self-care. We've now started to incorporate meditation into it. We're going to be offering classes on meditation to police officers and their family just as another way for them to reach out to see if they can get some stress relief. We know that that's not the answer. That's not the only thing, but from the police officers we've heard from that do the meditation, they say they get a huge relief from it. We've also started a family program, and we've

targeted Staten Island. Thank you to Councilman Borelli for supporting us with that. We brought the police officers together with their families so that they can come together, have a better understanding of the stresses of police work, what the family members could look out for in their loved one, and also gave them a piece on how to nurture relationships. If we can keep them in better relationships, it may alleviate some of the stress where they may not bring the stress home with them. We've had-- roughly get about 400 to 500 calls into our active line using-- utilizing 200 of our Peer Support Officers. We have another 80 that are on the retiree team. So we also keep in mind our retirees. That's nationwide. We have retirees from east coast to west coast and we have peers involved that can go out and meet with them when they are out of state. So with that, that's just a summary of what we do, and if you have any questions, more than welcome to answer them.

CHAIRPERSON RICHARDS: Thank you. Thank you for what you do.

JOHN PETRULLO: Thank you.

JULIE LAWRENCE: Hi, good afternoon.

CHAIRPERSON RICHARDS: Push your button. Press the magic button. There you go.

JULIE LAWRENCE: Sorry. Good afternoon. I'd like to thank the City Council for inviting Comunilife to speak here today. My name is Julie Lawrence. I'm stepping in for Beatrice who had to go and run our afterschool program in Brooklyn, but thank you very much for having us here. Comunilife's Life is Precious Program, also known as LIP, opened 11 years ago and has centers in Brooklyn, the Bronx, Manhattan, and Queens, and is New York City's only suicide prevention program for at-risk Latina teens. The CDC Youth Risk Behavior Study stated that in 2017, 20.9 percent of Latina teens in New York City seriously considered suicide and that 13.1 percent attempted suicide, statistics that are higher than their peers. Today, I'm here to speak to you about how our experience in developing LIP can be a template for developing culturally and linguistically appropriate suicide prevention strategy for the Police Department and first responders. The recent spat of first responders who have committed suicide is a tragedy for which a strategy must be developed to abate it. We know that for every person who

completes suicide, there are many more who seriously consider suicide. We also know that first responders and the Police Department have their own culture and language. That language goes beyond English or Spanish, but includes how words and phrases are perceived. When we developed Life is Precious, we knew that there was an epidemic affecting our community and that we wanted to do something about it, but we did not know what the best way was. For this, we went directly to the Latinx community. We spoke with the teens, parents, educators and community leaders. We learned why they thought this happening, what services they thought should be provided, and most importantly, how to destigmatize and talk about the issue. We learned how the topic should be approached. Fast forward 11 years, LIP remains a community-informed program. New activities are developed based on the input from our teens and their families. New centers are opened in neighborhoods where our teens reside or go to school, and our social media web presence and awareness campaigns are developed with their help. Since our Life is Precious program opened in 2008, more than 350 Latina teens have taken part. They are

all in school or have graduated. Many have gone on to college. Most importantly, not one of our teens has completed suicide. Our takeaway for you today is that any strategies developed to help at-risk first responders must incorporate the language and culture of the first responders. This needs to be-- needs to include awareness and education and services that they can access. Thank you very much.

CHAIRPERSON RICHARDS: Thank you. Press your magic button. There you go.

DOCTOR ANITHA IYER: Good afternoon. My name is Doctor Anitha Iyer. Thank you, Council Member Ayala and the Committee on Mental Health, Disabilities, and Addiction for the opportunity to provide testimony regarding the emotional issue, important issue of mental health services and supports for first responders. Vibrant Emotional Health, formerly known as the Mental Health Association of New York City has provided direct services, public education, and advocacy services to New York City for over 40 years, and throughout its history has been engaged in suicide prevention activities for vulnerable populations. Vibrant currently administers the National Suicide Prevention

Lifeline which serves nearly two million people every year. Vibrant also partners with the Mayor's Office at Thrive NYC and the New York City Department of Health and Mental Hygiene to operate NYC Well, the City's multilingual, mental health, substance use, and crisis intervention services which is available to all New Yorkers via phone, text, and chat 24 hours a day, seven days a week. As research demonstrates, people in certain professions such as law enforcement officers and other first responders are at increased risk for suicide and they struggle without accessing the supports necessary to address their mental health and emotional needs. First responders experience unique stressors associated with their work, including exposure to traumatic events they might witness in the community such as death or severe injury of others as well as the stress associated with risks to their own person safety within the context of their work. They may work frequent shifts often with long hours and may work overnight or during other off hours, which may decrease their opportunities for adequate sleep and decompression time after their work hours. An illustration of the effects of these dynamics was reported in a 2016

study which found that 75 percent of police officers surveyed reported having experienced at least one work-related traumatic event, but fewer than half of those affected reported the effects of this experience in their work places. Behavioral Health Disorder such as depression, Post-Traumatic Stress Disorder and substance misuse have been demonstrated to be higher among first responders than the general population, and to increase among police officers following exposure to traumatic events including natural disasters such as Hurricane Katrina or terrorist attacks such as those that occurred on 9/11. In addition, suicidal ideation and suicide attempts have been demonstrated to be higher than the general population in an array of studies of police officers. For example, a literature review published in 2016 found that 25 percent of female officers experienced suicidal ideation or made an attempt. While the corresponding rate for male officers is just over 23 percent. Research has also identified a number of risk factors associated with behavioral health conditions and suicidal ideation or attempts including, but not limited to, high levels of job-related stress or burnout while on the job,

Significant mental or physical distress prior to active duty, exposure to work-related traumatic events, including those directly experienced by responders such as physical injury, exposure to long work hours while exposed to traumatic events without adequate time off to decompress, and personal challenges such as relationship difficulties or financial hardship. Research has additionally demonstrated an increased risk of having a suicide plan as well as increased rates of suicide attempts if one is a first responders. These risk-factors coupled with job-related access to firearms are of significant concern and point to the critical need to provide evidence-based interventions to reduce the rate of suicide attempts among this population. Some of the non-clinical interventions that have been demonstrated to be effective to reduce suicidal ideation among first responders includes psychological first-aid training which is a training that is intended to help people who have experienced disasters or other traumatic emergency events, peer support programs, and ensuring adequate support in stressful work environments and protection from over-work while encouraging and supporting help-seeking

behavior. There are effective clinical treatments for depression, anxiety disorders, substance misuse and Post-Traumatic Stress Disorder, all of which contribute to increased suicidal risk among first responders, but in order to connect first responders to treatment it is critically important to identify those who may be struggling with clinically significant symptoms and suicidal ideation. For this reason, the value of screening first responders on a routine basis for psychological distress, including suicidal ideation, cannot be understated. Public education must also be provided to ensure that police officers can recognize the signs that their partners in law enforcement may be experiencing emotional distress, have peer-level conversations to provide appropriate support, and promote help seeking, and can access treatment services and other supports that can reduce the risk of suicide. All first responders should be made aware of NYC Well and the 24/7 availability of its counselors to provide support, safety planning and connection to treatment services, including to mobile crisis response and emergency intervention when indicated. In the wake of the recent increase of suicides among New York City

police officers, Vibrant has partnered with Thrive NYC and the NYPD to provide suicide prevention trainings to police personnel during roll call, and as of the date of this hearing has provided 72 hearings with the intention of providing training to every police precinct in the city before the end of November. The trainings provide information about how to recognize the risk factors for suicide, how to identify warning signs that someone may be thinking about or planning suicide, how to engage with someone safely to help support them and help them connect with resources and information about resources, including those that are available internally within the NYPD and those that are available externally including NYC Well, which can serve as a confidential source of support and crisis intervention to first responders and all other NYPD personnel. As we are still reviewing the details of the proposed legislation that would require NYPD to provide mental health services and information to officers. We cannot comment specifically on it. However, Vibrant does generally support the provision of additional mental health resources for the New York City Police Department. Additionally, Vibrant supports the

proposed resolution to declare the third week of May of each year to be recognized as First Responder Mental Health Awareness Week. Vibrant looks forward to continued partnership with the Mayor's Office of Thrive NYC and with the NYPD to reduce the impact of suicide among New York City's first responder community. We are also grateful to the New York City Council for its leadership in supporting the mental and emotional wellbeing of first responders and all New Yorkers. Thank you.

CHAIRPERSON RICHARDS: Thank you for your testimony. Then I want to go to John for a few questions. Can you just speak to what are the advantages of members of service going to POPPA which provides services obviously outside the Department? and I want to thank you because I actually spoke to an officer the night of the suicide around the corner from my house, and he spoke of after 9/11 him coming and utilizing services at POPPA, and he really thought POPPA was a great route to go for officers due to his experience. I want to thank you and POPPA for the work that you do. And can you just speak to why peer-led counseling is very important and what are the advantages of having your organizations

really at the front line and what is your thoughts around the clinicians?

JOHN PETRULLO: Okay, thank you. One is the peer-based, and again, the peer connected with the volunteer is what gets it. When we go out and meet with one of the officer, the first thing we have to do is try to connect with them, and now they're looking at us saying why are you doing this, why are you here, why are you helping me? And they're thinking, well, do you have a nice cushiony job at 1PP, you got your weekends off. Just the opposite. These are cops that want to help somebody. So when they go out and explain to them that, no, I'm here on my time and you matter to me, that's what starts to break down the wall. Police culture as a whole is resistant to mental health. You know, the police are the helpers. They don't need the help, and as we know, and I know through my career there's times where you do need to get some help, and with that, we just afford them comfortability. And you know, in conjunction with everything else we're able to do for them, it makes it a much more comfortable route for them to take to get help.

CHAIRPERSON RICHARDS: Can you speak to your staffing? So, how much full or part-time staff do you have and how many volunteers?

JOHN PETRULLO: We have 200 volunteers that man the active help line. We also have an additional 80 that work on the retiree line. The retiree line is manned just by retirees. The active has a majority of active cops that man it. Running the office and the staff there's an admin person. I have a clinical person. We have a book-keeper, and we also have a cop assigned to us that takes care of all the scheduling on the lines and making sure it's programmed. We put a new cop on every 24 hours, so each cop that takes that line there, they're committed to it for 24 hours, any calls that come in.

CHAIRPERSON RICHARDS: And how many members of service did you service last year?

JOHN PETRULLO: Roughly about 400, 405 on the active line and then the 100-plus on the retiree line, everything ranging from a cop just needed to vent to we needed to get them into mental health facility [inaudible].

CHAIRPERSON RICHARDS: And how do you do outreach? Can you just speak to that?

JOHN PETRULLO: We do outreaches, and again, that's a compliment to the Police Department because they allow us access to the police officers. We were able to get up to the range, and again, talk to just about 20,000 cops. We do outreaches when the cadet or when the recruits come into the Academy. We get a period of time to talk to them. We also speak to the officers as they get promoted. We go to the promotion ceremonies, Sergeants, Lieutenants, and Captains, and we're able to reach them that way.

CHAIRPERSON RICHARDS: And can you speak to what have been some of the limitations you've been faced with, and how can the Council be helpful in ensuring that your organization is supported?

JOHN PETRULLO: We're firm believers and we've been talking about this for years doing the check-up once a year with them. We'd like to see that happen. And then thinking about how it would be implemented, if the Department does it, the feel is that the police officer is going to put down what the answer is that the Department wants to hear. If we do it in another way where it's done outside, if somebody like POPPA or another organization steps in

and takes that role, that'll help us get more honest answers.

CHAIRPERSON RICHARDS: And what's your budget annually? Are you provided with the budget, or is all--

JOHN PETRULLO: [interposing] We're a not-for-profit, so we work on that. We get an amount from the Police Relief Fund, which gives us our main operating money. We also get funds through the CMC or New York Cares now I think it's named. So we get an annual budget on the Police Relief Fund of about $400,000. We get it from the CMC, about another $300,000 to help us operate. Again, when we were here initially back in '96, the City Council came up with the money to help us get started. That has since gone away.

CHAIRPERSON RICHARDS: How much would that--

JOHN PETRULLO: [interposing] But we have other programs we're looking to do. When it was brought up when you were talking with the panel before, we do go out after critical incidents. We also get notified as EAU would. We go out and what we do is follow up afterwards, and we get them all in

for a debriefing. So, we just don't take the person that was involved in a shooting. We make sure we get the people that were there and just witnessed the horrific scene. Those officers are brought in. We have a mental health professional in peers, and they go to a formal debriefing where they get to talk about the incident. We know that that can help us take it, out of packing it down, and just off to the next job, and allow them to put it somewhere in a safer compartment, and if needed, we can hook them up with mental health services.

CHAIRPERSON RICHARDS: And you said,-- well, like I said-- not you, but I think in the last panel there were 26 suicides in 1995.

JOHN PETRULLO: 94 and 95, over the two year period.

CHAIRPERSON RICHARDS: Are you seeing much-- are you seeing a different environment now from then? Are you hearing or seeing more pressures on members of service now, or has this been very similar? Is this a similar story to 1994?

JOHN PETRULLO: This is different because the way they came in the cluster. That was something different. And it's all over the place as

far as amount of years on the job, and you know, how close they were to retirement and their commands. So that's kind of difficult for us to even put a finger on. When we get cops coming through, do we see stresses from policing today? Absolutely. They'll come in and be very frustrated that they don't have an outlet. They have to put up with a lot now, and that I think would be creating some of the calls we've received. I don't know about the suicides, what the contributing factors were there, but from our number of calls we get, we get some that are just dealing with job stress.

CHAIRPERSON RICHARDS: And has there been an increase or fluctuation in calls, or?

JOHN PETRULLO: Yes.

CHAIRPERSON RICHARDS: You have--

JOHN PETRULLO: [interposing] Based on--

CHAIRPERSON RICHARDS: [interposing] Can you go from last year to this year, how-- if you have the numbers?

JOHN PETRULLO: Yeah. This year, right now to-date, we're up to about what our call volume was last year in the entire year. Part of that is because of the outreach. When we do outreaches, our

call volume goes up. When we're able to get out there and we suggest, and we try to do it as much as we can-- we'd like to be out there as often as we can because the constant reminder is helpful. You know, when we have cops who are sitting in the group and they're doing okay today and they're not listening, and they're, you know, maybe looking at a paper or on a cell phone as we're talking, we get it. They're okay today, but six months from now things change, and now they're looking for that help, and they don't know where to go. So by being out there constantly-- I mean, we've done it where we'll go out and EAU will go out and it'll be a joint effort, but our concerns with that is that we don't want to be put in the same boat as the Department. The reason we're so successful is because we're separate from the Department, and with that, the Department does allow us to operate. We know there's a line there that neither of us won't cross, but they allow us to do a lot without interfering and wanting to know what's going on. We give them zero information on the police officers that call and that just get a referral. It's a little more detailed when it's

somebody that we have to put out of service, which means removing weapons.

CHAIRPERSON RICHARDS: And PD refers people to you, or no?

JOHN PETRULLO: From what I've heard, yeah, some people have said that their unit has referred over to us.

CHAIRPERSON RICHARDS: Alright, thank you for the work you do. Really appreciate it, and we look forward to working and being helpful, and offline we should have a meeting or something of that nature, but POPPA should start thinking about ways the Council could be helpful as we were back in '94, because we want to stem this epidemic. So thank you for the work you do, and all--

JOHN PETRULLO: [interposing] Thank you very much.

CHAIRPERSON RICHARDS: the volunteers and your staff. Thank you.

JOHN PETRULLO: Thank you.

CHAIRPERSON RICHARDS: Any questions from my colleagues? Diana Ayala?

CHAIRPERSON AYALA: Yeah, question for LIF [sic]. Does NYC Well have the ability to track

how many first responders are calling into the system?

ANITHA IYER: So, NYC Well can track calls from first responders, so long as they identify themselves as first responders when they reach out to us.

CHAIRPERSON AYALA: Do many people disclose that they're first responders?

ANITHA IYER: Based on the calls that we've received where individuals have disclosed that they are a first responder, police officers, or otherwise, it's a very small number. We can certainly get back to you with specific data on that.

CHAIRPERSON AYALA: And I have a question regarding some of the data that you put in your report. There was literature published in 2016 that found that 25 percent of female officers experience suicide ideation while only 23 percent of male officers experience it. Yet, the trend saying that-- you know, we're seeing higher trends of men that are committing suicide. What is the-- what do you think is the discrepancy there?

ANITHA IYER: So, there's generally a discrepancy in terms of ideation versus attempts

between men and women in the general population. This study was-- the study I cited was from Stanley [sic] and the references in the packet I provided. So, it's focused-- it describes ideation or made an attempt versus the 25 female suicide offices who also-- the report is about ideation or made an attempt. I don't have any further details about what that discrepancy could be, but in the general population as well there is a higher proportion of ideation among females and a higher amount of attempts among men.

CHAIRPERSON AYALA: Yeah, I'd be interested in finding out what the difference is, because if more women are considering it, and more men are actually completing it, then you know, something-- there's something really off about that, off-putting to me. So I would like to learn more. Thank you.

CHAIRPERSON RICHARDS: Thank you. Thank you all for the work that you do. Thank you so much. Alright, last panel: Oren Barzilay, Local 2507 FDNY EMS, Keevon Harper [sp?], Friends of Fire Fighters, Regina Wilson, Vulcan Society, Eric Knudson [sp?],

Friends of Fire Fighters, Amy Aindricks [sp?], Mercada [sp?].

UNIDENTIFIED: Eric Knudson, Lieutenant, had to leave. He had to report for work, and Keevon Harper also had to go to the firehouse, so thank you.

CHAIRPERSON RICHARDS: Okay, thank you so much, and thank you for the work that you do. Benjamin Sher? Oh, you're here, okay, great-- National Association of Social Workers, NYC Chapter. Regina Wilson, Vulcan Society, Amy Aindricks, Mecada [sp?], Oren Barzilay. You may begin.

OREN BARZILAY: Good afternoon, Council Members. Thank you for giving me the opportunity to speak on this vital issues that many first responders are dealing with. My name is Oren Barzilay, President of the FDNY EMTs, Paramedics, and Fire Inspectors Union. FDNY EMTs and paramedics are highly trained medical personnel whose work is an extension of a physician performed on the streets of our city. This happens during the heat of summer, in the freezing temperatures of a blizzard, in the highest crime-ridden neighborhoods. In the course of a shift, an EMT, paramedic or any first responder may find a teen laying in a pool of his own blood after

being shot. An EMT, paramedic or any first responder may be called to the scene of a baby in cardiac arrest. He or she will be summoned to revive a drug addict who stopped breathing. All this, along with dealing with the difficult environments of high patient acuity, all while operating a five-ton ambulance, lights and siren, through the most congested streets in the nation. Our members are exposed to violence, trauma, child/elder abuse, burn victims, and deaths are seen on a daily basis. The routine daily exposure to the above is medically proven to cause mental illness. The working conditions for the FDNY EMS professional are to say the least less than ideal. There's never enough funding to field an appropriate number of ambulances to meet the ever-increasing call volume. There is never enough staffing to ensure there are enough people to share the workload, making mandatory overtime a daily fact of life that pays far too low for the unpredictable situations that routinely define a normal day at work. The stresses of high call volumes, overtime, shift work, abuse of the 911 system, unstable and dynamic working conditions, maintaining skills proficiency, managing political

changes coupled with the draconian discipline system that treats the most minor infractions as major felonies has resulted in among all emergency services workers, EMTs, paramedics, and other first responders the highest rate of PTSD. PTSD is rarely a standalone issue. Other behavioral health disorders such as addictions and depressions are often associated with PTSD. These have direct relations with one another making them cold [sic] occurring issues. For EMTs and paramedics, this can manifest into many different ways, including a combination of a substance abuse and depression. For instance, an EMT or a paramedic who is dealing with depression may use alcohol to self-medicate. These combinations can result in destructive behavior, disruptions on the job, and translate into a divorce rate of 40 percent. The Department offers EMTs and paramedics help through our Counseling Service Unit. They, while making a valiant effort, are hand-cuffed by the Department policy. The practitioners that staff CSU are unable to grant time away from the job. As of July this year, the FDNY Counseling Service Unit has a psychologist on staff. However, our members are seen by a clinician, leaving them unable to file

claims; thus, workers' compensation will not accept the claim made by one of my members. If a member needs time to decompress, he must use his own leave balances. If he needs advanced care, he must file a claim with his insurance company. That claim is often denied, leaving the member no choice but to return to full-duty and re-enter the cycle that led to his PTSD in the first place. I look forward to working with this committee on improving the mental health of all first responders.

CHAIRPERSON RICHARDS: Thank you for your testimony. Thank you for your work.

REGINA WILSON: Good afternoon to the Chair and Council Members. My name is Regina Wilson and I am the Immediate Past President of the Vulc Society, a New York City Fire Fighter in Brooklyn, New York, and a member of the FDNY Ceremonial Unit. The Vulc Society is an African-American affinity group which is comprised of uniformed and civilian employees of the FDNY. Our organization has been in existence for 79 years and has played a vital role in some of the critical changes made in the Fire Department in regards to fair and equitable treatment for women and people of color. Our organization

mission is to support, educate, and serve our members in our community. I'm here today to address the issues of preventing suicide and promoting mental health for first responders. A study which was conducted by the Rudderman [sp?] Foundation and several articles written by Forbes, Fire Engineering, and Fire Rescue One reported that most fire fighters commit suicide in 2017 than they died of line-of-duty. In fact, the study found that 103 fire fighters and 140 police officers died by suicide in 2017 compared to 93 fire fighters and 129 officers line-of-duty death. It is reported that very little has been done to address PTSD, anxiety, and depression in responders even though they are five times more likely than civilians to suffer from these symptoms. First responders are constantly exposed to death and destruction and it can cause an avert toll in the long run. As a member of the Ceremonial Unit, we are exposed to continuous amounts of funerals, plaque dedications, street renamingings, and memorial service. As you know, the Fire Department just buried more than 200 of its World Trade Center illnesses, fire fighters. So we're still-- we actually have a World Trade Center related illness

funeral this week. As a member-- sorry. This elite unit is the very backbone of providing strength and comfort to our members in the Department who are dealing with the most traumatic parts of their lives and their family lives. We cannot overlook the need to focus on helping people who spend every day and sometimes every waking moment on all that they have to help others. Unfortunately, a lot of the suicides for first responders go unreported and not addressed by the media or press as much as line-of-duty death. I believe this creates a large difference in the way first responders who died are treated. It is also unfortunate that a lot of Departments do not have an adequate suicide prevention program that helps to really focus on the treatment of people dealing with depression and suicidal thoughts. These programs should also address the issue of proper mental health services and how each community and gender deals with mental issues-- mental health issues. As an example, in the African-American community, it has always been taboo to talk about seeing psychiatrist or therapist or speaking to any type of mental health professional at all. You are seen as crazy, unmanageable, and to your family and friends, just different. It is

important to help to break the stigma and provide a safe space and atmosphere for those that have grown up believing that getting help is for losers. As a remedy for the issue to the un-comfortability and relatability and speaking with mental health issues for women and people of color, I suggest peer-to-peer counseling or assistance with people who look like them. Begin with a diverse mental health counsel unit and continue mental check-ups. The Department begins to take the stigma out of the toughness we think that we should have as fire fighters and begin to feel comfortable to speak about how we feel with our own peers. Providing more awareness training for officers in the Department will help officers to identify the signs of suicide and depression and not just when they're going through flips which is in the beginning of their career, and begin to have the conversations with the members to help them to see that it's okay to get help. We need more in-depth training now to deal with the situations that have been masked for so many years. We ask today to provide the funding to help-- the help we need as first responders to continue to serve the city we love.

CHAIRPERSON RICHARDS: Thank you. Thank you.

BENJAMIN SHER: Chair Richards, Chair Ayala, Chair Borelli, and the rest of the City Council, thank you for allowing the National Association of Social Workers New York City Chapter to prevent testimony on Int. 1704. My name is Ben Sher, and I am the President of NASW NYC Board of Directors and a licensed Master Social Worker. The Executive Director of NASW NYC, Doctor Claire Green Ford [sp?] sends his regrets as she as well could not be here today. Prior to my current position I spent 21 years working at one of the largest providers of mental health services in metropolitan New York City. Ten of these years were spent in direct oversight of programs serving New Yorkers with serious mental illness. I have been a trainer and consultant on mental health symptoms, mental health risk factors, and resources for people for 25 years. I want to begin my testimony by offering my deepest condolences to the families and colleagues of police officers who recently lost people to suicide. Most of my interactions with first responders and the police has been when I was involved in emotionally disturbed

person's calls for the clients I served. These interactions were often not easy for all of the parties involved and demonstrated the inherent stress involved in being a metropolitan police officer. In all occasions I found the work of building relationships with local police precincts and officers assigned to cover the programs I supervised made the outcome of these calls most effective. These relationships gave me the opportunity to, within the bounds of confidentiality, reach out to officers I knew and elicit their support when our residents were troubled or beginning to destabilize. In preparing my testimony for this hearing, it was the concept of relationship building that stood out for me in helping to address the needs of police officers and other first responder in mental health information, training and support resources. Though our society has come a long way, there is still much stigma and misunderstanding about mental illness. It is much easier for a person to say they're experiencing a mental condition than depression, anxiety, Post-Traumatic Stress Disorder or the symptoms of suicidality. I believe the same stigma and even shame about mental illness is increased in

the New York City police force and in first responders where officers are trained to be in control, and having problems is a sign of weakness. Officers are trained to be tough and to bear through hard times. Emotions are suppressed and to show signs of sadness, worry, stress, or trauma are to be marginalized and ignored. While we typically think of first responders when in the midst of crisis, we at the times forget when the crisis subsides, when the story is no longer trending, there are those who are impacted beyond the latest Twitter feed. There are those who go from one emergency to another, hardly having time to process one traumatic event before responding to the next. We overlook the fact that those who are one day witness the despair of a family who lost their child to drugs, the devastation of the person who lost their home to a fire, or have to deal with the ongoing mental and emotional toll years after tragedies such as what our first responders, their loved ones, and all of those who were impacted by the terrorist attacks on 911 live with every day. According to Asa-- Doctor Asa Don Brown [sp?], who is also a first responder, on psychology today, there's ample evidence to suggest

that many first responders deny or resist seeking mental healthcare due to longstanding stigmatization. Research literature suggests that for many there's an underlying fear of being subjected to ridicule, prejudice, discrimination, and labeling. In fact, in 2016, the Badge of Life, a police suicide prevention program revealed that nearly 108 law enforcement officers across the country took their own lives. According to the Fire Fighter Behavioral Health Alliance, an estimated 113 fire fighters and paramedics took their own lives in 2015. The statistics are real. The untimely death of fire fighters, police officers, correction officers, probation officers, EMTs and countless other first responders is present. As the largest professional body of social workers, we beg you to consider the barriers in organizational culture within our first responder organizations that may reinforce these stereotypes and strengthen the system of silence. One in five people in America will experience a mental health condition in their lifetime. First responders are not immune to this statistic. Therefore, I applaud the City Council for taking the steps to prevent suicide and address the mental

health concerns of first responders. At the same time, NASW cautions the Council to be sensitive to the cultural needs and experiences of the first responders as they develop this legislation. Social workers, through their code of ethics are required to provide culturally sensitive services to populations that have different experiences. Working with first responders would be part of building that culture awareness. We implore you to use every resource at your disposal to support our first responders. We ask that training on destigmatizing treatment and help is done for everyone in every rank. We ask that this is ongoing and not a one-time check-off box as training done. We ask that comprehensive services and options are provided and accessible to first responders both in and outside of their agencies. We ask that these services and supports are also extended to their families because they sacrifice for us, too. Thus, the important aspect of relation building and understanding culture will be key in developing legislation for Int. 1704. Social workers, the nation's largest provider of mental health services are uniquely posed to support this work. Social workers are trained and the person

environment perspective. We're expected to understand the person in the context of the psychosocial behavioral, familial, economic, education, political, spiritual, and other forces that may be affecting their lives. NASW NYC stands ready to help work with the City Council develop models of care and educational resources grounded in its expertise in mental health while working within the understanding of population that needs time, support, patient understanding to make these interventions successful. NASW NYC has over 5,000 members and a national organization that counts 120,000 social workers at its core. We want to support all efforts to address the risk of suicide and mental health issues amongst first responders, and we understand the assessment and care by which this must be done. We stand ready to be resource from development to implementation of this legislation. Thank you for allowing us to testify today.

CHAIRPERSON RICHARDS: Thank you all for your testimony, and let me just ask the EMTs and obviously the Vulcan Society first. So, I'm-- huge emphasis obviously was put on PD today because the rashes of deaths by suicide. Would you support

companion bills that look very similar to this? Do you support clinicians? Are you saying the services are not technically there the way FDNY framed it today? Can you just speak to that? Well, yeah--

OREN BARZILAY: We definitely need more than clinicians. They're there just to listen. They-- it doesn't go any further than that.

CHAIRPERSON RICHARDS: So for your members?

REGINA WILSON: It looks different.

CHAIRPERSON RICHARDS: It looks different.

OREN BARZILAY: It certainly is different for my members.

CHAIRPERSON RICHARDS: Yeah, yeah. And what would you want done if that's the case?

OREN BARZILAY: Well, the first biggest issue that we have is the stigma and the confidentiality.

CHAIRPERSON RICHARDS: And are people taken off the jobs or is there perception of that, or how does that look for--

OREN BARZILAY: Well, if you are diagnosed there is the risk of you being sidelined. You're restricted, and then that makes it even worse

because now you're going to get a pay cut. When you disclose that you need some time off, they will do it for you, but when you go on a light duty position or modified duty position, you're now getting a pay cut, which will add to your stress.

CHAIRPERSON RICHARDS: And how often would you say that happens?

OREN BARZILAY: Our members are very rarely come forward saying that they have this problem due to those issues that I just mentioned.

CHAIRPERSON RICHARDS: And for the Vulcan Society, if you could speak.

REGINA WILSON: We believe that-- the CSU unit has provided a lot of great accessibility to talk to the counselors, but I think our main issue is that there's not enough counselors. I think CSU spoke about going around to all the different firehouses, but there's over 200 firehouses, and they don't even have that many counselors. So, you cannot provide that type of service that they speak of when you have lack of staffing, especially peer to peer counselors. They just started this year to ramp it up after the Vulcan Society brought it to their attention, and we also wanted to make sure that we

reiterated to them that there is a need of people of color to be in these units, because if you want people to have a level of comfort and you want them to have a level of understanding, you have to have people in there that looks like them, that can relate to them, that understands their history, their past, and can be more relatable to the things that they're doing. So, for-- I think our issues are different. I feel that EMS is always treated a lot different than fire and the amount of resources that we get are so far less for EMS, and as well for the Fire Inspectors. So, I think a revamp and equality for all of us if we're considered family has to be made and make sure that we're all receiving the same level of care. And also, the fire fighters themselves are not coming as forward in the rates that they could as well, because they don't feel like they are getting the adequate amount of care that they need because it's not-- it's not something that's always talked about, and it's not an ongoing and pervasive issue that we're dealing with every day in the firehouse. So, we're looking for that type of treatment because we have a lot of issues dealing with as Oren talked

about in reference to domestic violence and drug abuse and DWIs and alcohol abuse going on.

CHAIRPERSON RICHARDS: Thank you. And NASW, could you speak to do you support the goals of the bill, the bill that we introduced today? Do you think it's a step in the right direction?

BENJAMIN SHER: Absolutely, I think that NASW would completely support-- actually, completely supports this bill and would do anything we can in our resources to help support it. And if I just had one minute, I do want to address Council Ayala's questions earlier about suicide. You are absolutely 100 percent correct about the fact that men are less socialized to talk about their problems than women are. One of the other reasons why there are more completed suicides amongst men, is because men use more lethal means to end their lives. So there's more likely, unfortunately, to be the side effect of death as a result of that. Whereas women have used more means that might not result in ultimate demise. So I just wanted you to know that. So, thank you.

CHAIRPERSON AYALA: So that means that they may have attempted it, but were not successful because of the way that they attempted.

BENJAMIN SHER: Right, or that men may have been, you know, may have sort of had the same issues, but because they're more likely to use a lethal means to kill themselves, the result is that they end up dying.

CHAIRPERSON AYALA: I appreciate that.

CHAIRPERSON RICHARDS: Alrighty, well thank you.

OREN BARZILAY: Can I?

CHAIRPERSON AYALA: Sorry, I have one more--

OREN BARZILAY: [interposing] Can I just add something to what Regina said? One, I thank you for bringing some stuff to light. Just to show you the disparity that she's talking about, on the fire side, there's multiple fire fighters on the counseling service unit, there's only one paramedic assigned to the EMS side. The Department talk about our members getting debriefed after critical incidents. That's not necessarily true. Unless you're asking for it, you're not getting it. So, if you're walking out with a burned child who is not breathing, unless you're asking for somebody to talk to, it's not necessarily always there for you.

CHAIRPERSON AYALA: Is that just for EMTs or is that also-- are you witnessing that in the Fire Department itself?

OREN BARZILAY: I'm witnessing it, and I'm sorry, Regina. I'm witnessing it my members.

CHAIRPERSON AYALA: With your members. So--

OREN BARZILAY: [interposing] Soon as you're done with that patient, you're back in service.

CHAIRPERSON AYALA: Got you. And that was kind of something that I was talking to my colleagues about is that I was very impressed, highly impressed with the level of service that the Fire Department and the services they offer their members. However, it's quite clear that there's a discrepancy in that level of service kind of being more uniformed policy that stretches across all of the different agencies and categories. So, I think that that's something that we should definitely look into and maybe have a conversation with the Administration about, because there's no reason why one-- you know, there should be a disparity in the way that services are being provided, especially if we're seeing success in the

Fire Department, then we shouldn't be, you know, recreating the wheel. We should be replicating some, you know, those practices. But again, I apologize, I had a question about, you know, the EMTs and it just slipped my mind. You're absolutely right, you should be, you know, an equal part of that conversation, and we will follow up with FDNY and with the Administration about that.

OREN BARZILAY: And this is in no way, shape or form taking a shot at anybody that works at the counseling services.

CHAIRPERSON AYALA: [interposing] No, no, I get it. It's not.

OREN BARZILAY: They do a great job. But there is--

CHAIRPERSON AYALA: [interposing] No, no--

OREN BARZILAY: [interposing] There is a disparity of treatment over there.

CHAIRPERSON AYALA: But that's why I think it would be that disparity would kind of, you know, disappear if we had a uniformed policy for how we provide mental health services to all of our first responders and that I should look. I mean, obviously, there are differences in the Department,

right, that would sway it a different way, but I think that there are ways that we could do this that looks a little-- that resembles, you know, what the other Departments are doing. But I thank you so much for coming here to testify today.

OREN BARZILAY: Thank you.

CHAIRPERSON RICHARDS: Alrighty, thank you so much for coming out. We look forward to continuing to work with you. I wanted to thank my counsels for the great work that they did: Casey Addison, Daniel Attis [sp?] for the work that they did as well for this hearing. We look forward to passing these bills and working with the Administration and FDNY and NYPD, and obviously our EMT buddie to make sure that this is a uniformed process, and I think you made a great point that it shouldn't look different, that everybody should get the same services. So, thank you so much. Thank you all for coming out. This hearing is now closed.

[gavel]

C E R T I F I C A T E

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

Date October 20, 2019