Dear Madam Attorney General and staff,

My name is Shirley Stanton and I am a registered nurse. I attended the Mental Health Hearing on January 18 and regret that I didn't enter my testimony. I was employed at ECMC as a Unit Manager and worked in Behavioral Health for 23 years and retired in January 2014. While employed there, I managed various units including Adolescents, Adults, and Geriatrics. During this time, I witnessed situations and conducted Investigations for many minor incidents and sentinel incidents that occurred in and out of the hospital. To conduct these incidents, I was trained by NYS and worked with the Justice Department, the Commission of Quality Care, and the Office of Mental Health.

Some sentinel events included: sexual occurrences, deaths on the units resulting from suicide or assaults between patients. One patient, seriously injured during an assault died as a result of suffering a subdural hematoma. There were many incidents and with proper management and staff may have been prevented. Working with people with mental health has many facets that were touched upon along with a stigma that leads to fears to healthcare deficits. There is a huge component regarding safety for all patients on the unit and staff.

Focusing on staff safety, there was an investigation conducted by PERB and the NY Nurses Association (NYSNA) several years ago which you should look into obtaining. This investigation covered several incidents that involved staff who were injured by patients and the perceived thought that there was a lack of concern and action set in place to provide safety. ECMC accepted many patients admitted who had severe behavioral and anger issues. I myself was injured back in 2005 when a large adolescent male attacked my male staff. They were unable to calm the situation so I assisted and was injured to the point of being out of work for one year. Many other staff also injured and then were fearful to return back to work.

I retired in January 2014 and was happy to leave because I always had this in my mind that if I got reinjured, I could wind up in a wheelchair. Nothing seemed to change and from what I hear from

employees I stay in contact, they say it's even worse. This only touches the pile of items that lead to staff leaving the facility and shortages of staff calling in sick or being out on comp.

Along with the latter, the insurance companies dictate and oversee the guidelines of patients who are admitted and when discharge will take place. In the patient's record we had to ensure that if the patient was suicidal or had other concerns that required admission, the notes had to demonstrate that. If not, they were not admitted or they were discharged. I conducted utilization review with several insurance companies and provided the clinical data they required and the rationale of admission and if further symptomatology wasn't present, a doctor-to-doctor review was required.

I currently work with CINQ Care an entity who oversees several local primary care clinics. We focus on Medicaid and Medicare patients to enhance their care. What I see now is that there is a lack of cooperation between facilities. There needs to be changes made so that we can assist those in need and to prevent a future crisis and readmission back into the hospital. We should be able to share information and work together to provide quality healthcare. With this, HIPAA seems to be a barrier. In addition, if we worked together CINQ Care has contracted with local shelter to provide housing for patients. This week alone, a patient was discharged back to the street. This is disgusting!

The Berger Commission was set up in 2007 and concluded that there was an abundance of healthcare facilities and too many beds for patients across New York so they restructured hospitals and healthcare. With this decrease and merging, there is now less beds and options for patients to turn to and we are now in this predicament today. Other hospitals had to merge and offer services specific to that facility. As an example, ECMC became the leading mental health intake along with renal treatment and trauma. Then others were closed. Primary practices could not sustain their business of remaining open and had to align with hospital to maintain their careers.

Buffalo Psychiatric Center lost many beds where patients were discharged to for long-term care; this option was now limited. As a result, patients can become homeless and have no place to be discharged to. They wind up back on the streets and often are assaulted since they may not have the capacity to understand. I recently had one female patient who wound up living in a tent. She did not

want to adhere to the shelter's policies. Shelters are managed by rules which many patients have a hard time following. They are mandated to leave early in the morning and then cannot return until later in the day. They don't provide enough services as well to help their boarders.

Children's Psychiatric Center was in the new for some time as NY State agencies wanted to house adolescents with adult patients at Buffalo Psychiatric Center. Due to an outcry of the public, this was placed on hold. Residential Treatment Facilities (RTC's) where adolescents are referred to if they don't have a place to live for various reasons are limited so there is a delay in discharge. Then if a patient with behavioral issues or those that fall within the spectrum of autism, they fall between the crack. While managing the adolescent unit back in 2010-2011, we had an autistic male who resided on the unit for over one year until we were able to secure a facility that would accept him in Pennsylvania.

My son also was sadly neglected in 2019. He served in both Iraq and Afghanistan and was severely injured there losing both his legs and sustaining other lifelong injuries. PTSD and TBI can be overwhelming. He was arrested in North Tonawanda a few years ago and went to Veteran's Court and was unable to follow the court's contract and he wound up being sent to Marcie, a psychiatric prison. This occurred in June of 2020 when Covid was in full force. As a result, there was no therapy at the prison and I made several attempts with Mental Legal Services who support psychiatric patients. I was informed that they were not going to the prisons. My son would call me and state that many of the patients were there for years and no one was helping them with their case. While he was at the Buffalo Veteran's Hospital, the treatment team was difficult to work with. I could go on and on.

Healthcare today is not compensating staff according to their education or experience. As a result, several nurse and other professionals sign contracts with facilities willing to attract them by compensating them with high salaries and other incentives. This leads to the geographical area to be short. Professionals are attracted to higher salaries and I don't blame them but then this leads to disparity and lack of quality care. One example follows below.

My father was just discharged from a local hospital on January 18, 2023. The care he received at this facility is identified to be the place to go if you have a stroke. Well, the care was horrible. He will be 93

years old tomorrow and is educated and alert. He asked for answers to many questions regarding his medical care and tests and staff didn't take the proper time to educate him. Then, he was provided misinformation by various staff and I was present to hear it all, it was very confusing and he became quite upset. I am thankful for my background so that I could advocate for him. I spoke with one on the nurses on the unit and she told me that 70% of the nurses there were travel nurses! There is no buy-in for these people and the orientation is minimal. What I heard was, "I don't know that and it's not my job." Whose job is it? After my father was discharged, I found many inconsistencies regarding his medications. I called to try and find out what the correct medications were and no one could answer me. I was told someone from discharge planning would call me back; no one did! If hospitals are staffed like this anywhere, then there is gross negligence occurring. This is a vital piece of information that was not communicated. I didn't know when his last dose of medication was given and then there were pages of the discharge summary that said different things.

The latter is only some of the issues that I have witnessed during the practice in health care and psychiatry. Thanks to Governor Hochul for supporting this incentive to enhance mental health care! I would be more than happy to provide any additional information and assist in any way I can. My future goal is to seek my NP in behavioral health. I am going to be 70 years old but this is where my heart is and I'm willing to keep working towards this goal. Any incentive to assist with educational needs would be helpful. My vitae include a BSN in nursing and a Masters in Healthcare Management which I completed in 2019. I'm sure many others would step up to the plate to enhance the quality of care if they were provided the opportunity to. For any questions, please contact me at 716-510-7737 and thank you for your time.

Sincerely yours,
Shirley Stanton RN, BSN, MSHM