Committee on Mental Health, Disabilities and Addiction

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## THE COUNCIL

# COMMITTEE REPORT OF THE HUMAN SERVICES Division

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**COMMITTEE ON MENTAL HEALTH, DISABILITIES AND ADDICTION**

*Hon. Farah Louis, Chair*

#### February 22, 2021

**Oversight: New York City’s Mental Health Emergency Response**

**Int. No. 2210:** By Council Members Ayala, the Speaker (Council Member Johnson), the Public Advocate (Mr. Williams), Ampry-Samuel, Cornegy, Rosenthal, Adams, Louis, Cumbo and Kallos

**Title:** A Local Law to amend the administrative code of the city of New York, in relation to creating an office of community mental health and a citywide mental health emergency response protocol

**Administrative Code:**  Adds chapter 20 to title 17; adds sections 14-191 and 14-192 to chapter 1 of title 14

**Int. No. 2222:** By the Public Advocate (Mr. Williams), Council Members Cornegy, Rosenthal, Louis and Kallos

**Title:** A Local Law to amend the administrative code of the city of New York, in relation to creating a three-digit mental health emergency hotline

**Administrative Code:**  Adds section 17-2008 to chapter 20 of title 17

1. **Introduction**

On February 22, 2021, the Committee on Mental Health, Disabilities, and Addiction, chaired by Council Member Farah Louis, will hold a hearing entitled “Oversight: New York City’s Mental Health Emergency Response.” The Committee will hear Introduction Number 2210 (Int. No. 2210), A local law to amend the administrative code of the city of New York, in relation to creating an office of community mental health and a citywide mental health emergency response protocol, sponsored by Council Member Ayala, and Introduction Number 2222 (Int. No. 2222), A Local Law to amend the administrative code of the city of New York, in relation to creating a three-digit mental health emergency hotline, sponsored by Public Advocate Jumaane Williams. Among those invited to testify are representatives from the New York City Department of Health and Mental Hygiene (DOHMH), and other interested parties.

1. **Background**
   * + 1. *Mental Health Emergencies/Crises*

According to the National Alliance on Mental Illness (NAMI), a mental health crisis is “any situation in which a person’s behavior puts them at risk of hurting themselves or others and/or prevents them from being able to care for themselves or function effectively in the community.”[[1]](#footnote-1) Because mental illness is a brain disorder, and by its nature unpredictable, many things can lead to a mental health crisis.[[2]](#footnote-2) Contributing factors to a mental health crisis may range from internal stressors such undiagnosed, and therefore untreated, mental health disorders that require medical stabilization, to external and environmental stressors such as changes in home, school or work life, or personal loss or trauma and exposure to violence.[[3]](#footnote-3)

Untreated mental illnesses can disrupt a person’s mood and affect their ability to think rationally.[[4]](#footnote-4) Behavioral changes may range from social isolation to hyperactivity, indifference to hostility, to thought disturbances including difficulties in concentration or excessive fear and suspicion, all of which may result in the increased inability to cope with the stressors of daily life.[[5]](#footnote-5) Warning signs of a mental health crisis may include rapid mood swings and dramatic personality shifts ranging from sudden withdrawal and depression, to verbal threats or violent outbursts, or abusive behaviors to oneself or others, and overwhelming feelings of emotional pain, including powerlessness, frustration, guilt, shame, and rage.[[6]](#footnote-6)

The impact of the current COVID-19 pandemic on the mental health and well-being of individuals cannot be overstated. According to the New York State Health Foundation’s February 2021 report, “one third of all adult New Yorkers reported symptoms of anxiety and/or depression” at a rate more than triple what was previously self-reported during pre-pandemic periods.”[[7]](#footnote-7) Additionally, “the proportion of New Yorkers reporting poor mental health has remained high throughout the pandemic, reaching 37 percent of adult New Yorkers in October 2020.”[[8]](#footnote-8) While experiencing fear, worry, and stress during a national disaster is not an uncommon response, for those already at increased risk, COVID has served to “worsen emotional wellbeing” and “put people at increased risk for clinical-level disorders such as major depressive disorder, generalized anxiety disorder and substance use disorders.”[[9]](#footnote-9) Major societal disruptions to daily routines have resulted in “uncertainty about the future” and coupled with the isolation from family and friends, has served to exacerbate mental health stressors.[[10]](#footnote-10) Additionally, “exposure to interpersonal violence and abuse while sheltering with others” and the “increased stress of working remotely,” especially in households with children who are home from school, have led to “increased stress and fatigue” and for some, using “substances as coping mechanisms for pandemic related stressors.”[[11]](#footnote-11)

While mental health crises can arise quickly and be difficult to predict, appropriate and effective therapeutic interventions can significantly help to mitigate danger, interrupt negative symptomology, and move individuals away from crisis towards a pathway of biopsychosocial recovery.[[12]](#footnote-12)

1. *Current Mental Health Emergency Response in New York City*

Currently, the New York City Police Department (NYPD) officers and the Fire Department of New York (FDNY) Emergency Medical Technicians (EMTs) respond to nearly all mental health 911 calls, regardless of the severity of health needs, whether a crime is involved, or whether there is an imminent risk of violence.[[13]](#footnote-13) However, New York City does have other initiatives and programs geared specifically towards responding to mental health crises, which are discussed below.

1. *ThriveNYC*

In 2015, First Lady Chirlane McCray and Mayor Bill de Blasio launched ThriveNYC, which focuses on ensuring that every New Yorker has access to mental health support. [[14]](#footnote-14) In 2019, Mayor de Blasio officially established the Mayor’s Office of ThriveNYC to coordinate ThriveNYC programs, track progress, and support City agencies as they incorporate promoting mental health into their service to New Yorkers.[[15]](#footnote-15) In partnership with 12 city agencies and about 200 non-profits,[[16]](#footnote-16) ThriveNYC has implemented several initiatives to provide new services to vulnerable populations, strengthen crisis prevention and response, intervene early, and further develop the mental health workforce.[[17]](#footnote-17) ThriveNYC initiatives and programs dedicated to responding to mental health crises include Crisis Interventions Training, Co-Response Teams, Intensive Mobile Treatment Teams, NYC WELL, and Mobile Crisis Teams.[[18]](#footnote-18)

* + 1. *Crisis Intervention Training*

In 2015, ThriveNYC partnering with NYPD,[[19]](#footnote-19) implemented Crisis Intervention Training (CIT). Taught by Police Academy instructors and mental health experts, Crisis Intervention Training helps NYPD officers better recognize and respond to the behaviors and symptoms of emotional distress and mental illness.[[20]](#footnote-20) The four-day training aims to increase officers’ skills in de-escalation of crises[[21]](#footnote-21) and improve the safety of both the officer and the individuals encountered.[[22]](#footnote-22) The training includes role-playing, lectures, and conversations with individuals with mental illness who have had both positive and negative encounters with the police.[[23]](#footnote-23) Over 65 percent of all operational staff in NYPD patrol precincts across the City have now been trained in Crisis Intervention Team training.[[24]](#footnote-24)

* + 1. *Co-Response Teams*

Co-Response Teams (CRT), a collaboration between NYPD, DOHMH, and ThriveNYC,[[25]](#footnote-25) is a pre- and post-crisis intervention initiative.[[26]](#footnote-26) Co-Response Teams consist of two police officers, who have received Crisis Intervention Team training,[[27]](#footnote-27) and one behavioral health professional.[[28]](#footnote-28) These teams work 16 hours per day, 7 days per week, to serve community members presenting with mental health or substance use challenges, who are at an elevated risk of harm to themselves or others.[[29]](#footnote-29) These teams work to connect people to treatment and social service support[[30]](#footnote-30) and serve as a resource for police officers in the field who encounter persons exhibiting signs of mental illness.[[31]](#footnote-31)

* + 1. *Intensive Mobile Treatment Teams*

Intensive Mobile Treatment (IMT) teams provide intensive and continuous support and treatment to individuals right in their communities, where and when they need it.[[32]](#footnote-32) Full-service mental health treatment teams include psychiatrists, social workers, case managers, nurses, and peer specialists.[[33]](#footnote-33) IMT teams serve clients who have had recent and frequent contact with the mental health, legal, and homeless service systems, displayed recent behavior that is unsafe and escalating, and been poorly served by traditional treatment models.[[34]](#footnote-34) Currently, there are 11 IMT teams in New York City, with the capacity to serve 297 clients at any given time.[[35]](#footnote-35)

* + 1. *NYC WELL*

NYC WELL is New York City's free, confidential support, crisis intervention, and information and referral service for anyone seeking help for mental health and/or substance misuse concerns.[[36]](#footnote-36) Available 24/7 by phone, text, or online chat, NYC Well is staffed by trained mental health counselors and peer support specialists, people with lived experience with mental illness and substance use challenges.[[37]](#footnote-37) As of September 2020, counselors and peer support specialists had responded to more than one million calls, texts, and online chats since the helpline launched in 2016.[[38]](#footnote-38) When needed, NYC Well deploys Mobile Crisis Teams (discussed below) to provide mental health services.[[39]](#footnote-39) Many see NYC Well as an alternative to emergency services.[[40]](#footnote-40) Twenty-three percent of surveyed NYC Well users, including both those contacting the program on their own behalf and those contacting on behalf of someone else (e.g., a friend or family member), reported that, if not for NYC Well, they would have considered calling 911 or going to an emergency room.[[41]](#footnote-41)

* + 1. *Mobile Crisis Teams*

A mobile crisis team is a group of health professionals, such as nurses, social workers, and psychiatrists, who can provide mental health services, primarily in people's homes.[[42]](#footnote-42) There are about two dozen teams in the city and they are available in the Bronx, Brooklyn, Manhattan, and Queens.[[43]](#footnote-43) Mobile crisis teams can provide mental health engagement, intervention, and follow-up support to help overcome resistance to treatment.[[44]](#footnote-44) Depending on what services an individual is willing and able to accept, the teams may offer a range of services, including: assessment, crisis intervention, supportive counseling, and information and referrals, including to community-based mental health services.[[45]](#footnote-45) According to DOHMH, 72 percent of the mobile crisis visits completed last year led to referrals to voluntary behavioral health services in the community.[[46]](#footnote-46) If a mobile crisis team determines that a person in crisis needs further psychiatric or medical assessment, they can transport that person to a hospital psychiatric emergency room.[[47]](#footnote-47) Mobile crisis teams may direct police to take a person to an emergency room against their will only if they have a mental illness (or the appearance of mental illness) and are determined to be a danger to themselves or others.[[48]](#footnote-48) People referred to mobile crisis teams are free to turn them away, and accordingly, mobile crisis teams only made contact with the individual they were asked to help in about half of the 20,000 cases referred to them last year.[[49]](#footnote-49)

As discussed above, NYC Well is the single point of access for Mobile Crisis Team Services for NYC,[[50]](#footnote-50) and mobile crisis teams are not linked to 911.[[51]](#footnote-51) If a mental health professional or any individual wants to reach a mobile crisis team, they need to find the number for a specific team or contact [NYC Well](https://nycwell.cityofnewyork.us/en/).[[52]](#footnote-52) The City has 24 mobile crisis teams (19 for adults and five for children).[[53]](#footnote-53) When an adult mobile crisis team is called upon to check on someone, the team takes an average of 17 hours to arrive, according to DOHMH.[[54]](#footnote-54) In some cases, it can take up to two days for a team to show up, with no services available overnight.[[55]](#footnote-55)

1. *HEAT*

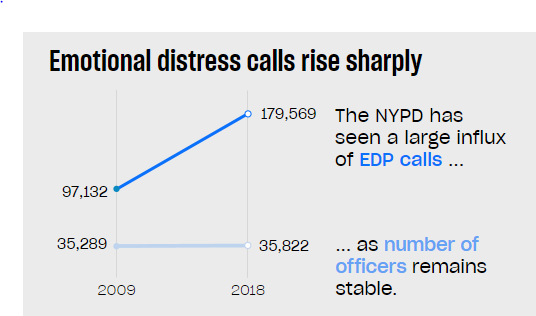
New York City also offers Health Engagement Assessment Teams (HEAT teams) which consist of one clinician and one peer, a person who has previously experienced a mental health challenge.[[56]](#footnote-56) HEAT teams proactively engage people with the most frequent 911 contact and connect them to care and other stabilizing support.[[57]](#footnote-57) HEAT teams are only used by police for areas of outreach that do not involve any active risk and, much like mobile crisis teams, HEAT teams cannot respond to 911 mental health crisis calls and they cannot transport anyone.[[58]](#footnote-58) Instead, HEAT teams are called by police, or local agencies such as the Department of Homeless Services.[[59]](#footnote-59)

1. *2021 Mental Health Response Pilot Program*

Beginning in February 2021, a newly-announced pilot program will ensure that newmental health teams of health professionals and crisis workers from FDNY Emergency Medical Services will be the default response to mental health emergencies in two high-need precincts.[[60]](#footnote-60) These teams will have the expertise to respond to a range of behavioral health problems, such as suicide attempts, substance misuse, and serious mental illness, as well as physical health problems, which can be exacerbated by or mask mental health problems.[[61]](#footnote-61) NYC Health + Hospitals will train and provide ongoing technical assistance and support for this pilot program.[[62]](#footnote-62) In selecting team members for this program, FDNY will prioritize professionals with significant experience with mental health crises.[[63]](#footnote-63) In emergency situations involving a weapon or imminent risk of harm, the new Mental Health Teams will respond along with NYPD officers.[[64]](#footnote-64) The pilot is modeled on successful, alternatives to police response programs in other cities, such as CAHOOTS (discussed below) in Eugene, Oregon.[[65]](#footnote-65)

1. *Criticisms of Current Approach*

For decades, but especially in recent years, many have vocally criticized the role of police in responding to mental health emergencies, or “Emotionally Disturbed Persons (EDP) calls,” as inappropriate, dangerous, inefficient, and ineffective.[[66]](#footnote-66) Between 2008 and 2018, mental health emergency calls doubled, increasing each year in every police precinct, reaching close to 180,000 calls in 2018 (see table below).[[67]](#footnote-67)



Source: NYPD Budget Hearing via The City

Some of these calls have ended tragically: Between 2016 and 2019, 14 individuals with mental illness were killed by police.[[68]](#footnote-68) Nationally, since 2015, almost a quarter of all individuals killed by police have had a known mental illness.[[69]](#footnote-69) Injuries also commonly occur from police encounters with individuals with mental or behavioral health challenges, though injuries are tracked less and receive less media attention than police-caused deaths.[[70]](#footnote-70) In most of the deaths or injuries that occur from police response to mental health emergencies, the officers on site are not trained nor prepared to appropriately respond to the erratic or unpredictable behavior that marks mental health crises.[[71]](#footnote-71) Accordingly, police presence at a mental health emergency often creates shame, fear, stigma, and trauma for the individual suffering a mental health crisis, which can exacerbate crises rather than defusing them.[[72]](#footnote-72) Mental health experts recommend engaging individuals experiencing mental health crises with respectful, empathetic verbal interventions that deescalate crises.[[73]](#footnote-73) Such skills are complex to build, and take many years to practice and train for – practice and training that most NYPD officers do not currently have.[[74]](#footnote-74)

Additionally, by having police, rather than mental health professionals, trained peers, and medical providers, respond to mental health emergencies, New York City has created a tragic holding pattern, wherein individuals with mental illness cycle between emergency rooms and jail.[[75]](#footnote-75) In 2019, approximately 16 percent of individuals incarcerated at Rikers Island were diagnosed with serious mental illness, up from 10 percent the year before.[[76]](#footnote-76) An analysis of 2017 911 calls show that of calls involving individuals with mental illness, 94,000 (54 percent) resulted in emergency department (ED) visits, which experts also criticize as ineffective in ensuring long-term care and breaking the ED-to-Jail cycle.[[77]](#footnote-77) The current reliance on police for responding to mental health calls is not only ineffective in helping individuals with mental illness, but it also creates potential for tragic outcomes, and overly relies on jails and hospitals, which are not equipped to provide long term behavioral health care.[[78]](#footnote-78)

1. *Mental Health Emergency Calls in Black and Brown Communities*

While the entire nation has been forced to confront systemic racism within policing, for Black and Brown individuals with mental illness, police response is even more problematic.[[79]](#footnote-79) In New York City, neighborhoods that are predominantly Black and Brown and poor neighborhoods are consistently more likely to experience a high volume of mental health emergency calls,[[80]](#footnote-80) and are also more likely to experience a violent interaction with police.[[81]](#footnote-81) An analysis of mental health response calls from 2018 shows that the ten precincts with the largest Black and Hispanic populations in New York City experienced 34,637 calls, while the ten precincts with the largest white populations in New York City experienced only 19,197 calls.[[82]](#footnote-82) Relatedly, precinct-specific data that shows large numbers of mental health 911 calls in poorer neighborhoods also reflect data that shows that poorer Black and Hispanic neighborhoods register a higher number of psychiatric hospitalizations, thus underlining the ED-criminal justice pipeline described above.[[83]](#footnote-83)

For police who are not properly trained in mental health response, and even for those who are trained, responding officers need to assess whether an individual is a potential threat to themselves or to the general public.[[84]](#footnote-84) While this individualized assessment is itself problematic for officers who are not the appropriate or experienced responders to mental health emergencies, it becomes even more problematic once race or ethnicity is layered into the assessment due to implicit bias and perceptions of “dangerousness,” which tend to reinforce racial inequities.[[85]](#footnote-85) According to mental health experts, such biased assessments—particularly, the intersection of race and disability and/or mental illness—can and do have violent outcomes for Black Americans.[[86]](#footnote-86)

1. *Access to Mental Health Care in Communities of Color*

Underlying the problematic police response to Black and Brown individuals with mental illness is the lack of access to affordable, culturally-sensitive care within Black and Brown communities and other communities of color.[[87]](#footnote-87) Across the country, an estimated 119 million Americans live in a “mental health desert” or “Mental Health Care Professional Shortage Area,” which means they are unable to access mental health care because there are too few mental health providers relative to the needs of the population.[[88]](#footnote-88) Most Americans living in mental health deserts are people of color and those in rural areas.[[89]](#footnote-89) This trend holds true in New York City, where, for example, in the Bronx, 91 percent of residents insured by Medicaid live in a mental health desert, most of whom are Black, Brown, and low income New Yorkers.[[90]](#footnote-90) Further, according to the United States Health and Human Services Office of Minority Health, Black Americans living below the poverty level are twice as likely to report psychological distress as those over twice the poverty level, yet less than half of Black adults who need mental health care for serious conditions receive it.[[91]](#footnote-91)

The lack of mental health access in communities of color is a deep, and complicated problem which extends beyond a simple lack of providers within communities of color.[[92]](#footnote-92) To start, Black are Brown communities are far more likely to be under- or uninsured than their white counterparts, which decreases access to affordable mental health care.[[93]](#footnote-93) Black and Brown communities are also less likely to receive culturally-sensitive, trauma-informed care, which is crucial to building trust between providers and communities.[[94]](#footnote-94) This is partially explained by the disproportionately white mental health workforce: according to the American Psychological Association, about 86 percent of psychologists in the U.S. were white in 2018 and about 15 percent were from other racial and ethnic groups.[[95]](#footnote-95) Growing the mental health workforce in communities of color requires sustained educational and outreach efforts, federal student loan forgiveness, better guarantees of federal insurance parity and livable wages for mental health workers, and increased efforts to incentivize Black and Brown Americans to attend and have access to mental health training and graduate programs.[[96]](#footnote-96)

Without access to culturally sensitive, affordable, and sustained mental health care within Black and Brown communities, mental health emergencies will continue to disproportionately prevail in communities of color, and police will continue to inappropriately intervene.[[97]](#footnote-97)

1. *Best Practices/Other Jurisdictions’ Approaches to Mental Health Emergencies*
   1. *CAHOOTS*

In 1989, the city of Eugene, Oregon launched CAHOOTS (Crisis Assistance Helping Out On The Streets), a community-based public safety system that provides mental health first response for crises involving mental illness, homelessness, and addiction.[[98]](#footnote-98) The program is staffed and operated by the White Bird Clinic, a non-profit Health Center.[[99]](#footnote-99) CAHOOTS was initially created to be a service capable of handling noncriminal, nonemergency police and medical calls.[[100]](#footnote-100) Today, CAHOOTS responds to requests typically handled by police and EMS.[[101]](#footnote-101)

When CAHOOTS is notified of a behavioral health crisis, a two-person team consisting of a medic (a nurse, paramedic, or EMT) and a crisis worker, who has substantial training and experience in the mental health field, are dispatched.[[102]](#footnote-102) Upon arrival, the team will assess the situation and provide crisis intervention, counseling, mediation, information and referral, transportation to social services, first aid, and basic-level emergency medical care.[[103]](#footnote-103) CAHOOTS responders cannot force anyone to accept their aid and they cannot arrest anyone.[[104]](#footnote-104) Moreover, CAHOOTS responders are not armed, and their uniforms usually consists of a White Bird T-shirt and jeans.[[105]](#footnote-105) The idea is that the more "civilian-like" the responders look, the less threatened their clients will feel.[[106]](#footnote-106) Only in rare cases do CAHOOTS staff request police or EMS to transport patients against their will.[[107]](#footnote-107) In 2019, out of a total of roughly 24,000 CAHOOTS calls, police backup was only requested 150 times.[[108]](#footnote-108)

CAHOOTS is notified of a behavioral health crisis by police dispatchers.[[109]](#footnote-109) Dispatchers are trained to recognize non-violent situations with a behavioral health component and route those calls to CAHOOTS.[[110]](#footnote-110) The police department and CAHOOTS staff collaboratively developed criteria for calls that might prompt a CAHOOTS team to respond.[[111]](#footnote-111) However, the criteria used as a guide rather than a rule.[[112]](#footnote-112) In addition, individuals, after calling the nonemergency police line or 911, can specifically request CAHOOTS.[[113]](#footnote-113)

When CAHOOTS began, it had very limited availability in Eugene, Oregon.[[114]](#footnote-114) Today, CAHOOTS operates as a 24-hour service in two cities, Eugene and Springfield, Oregon and responds to more than 65 calls per day.[[115]](#footnote-115) In 2017, CAHOOTS answered 17 percent of the Eugene Police Department’s overall call volume.[[116]](#footnote-116) The program saves the city of Eugene an estimated $8.5 million in public safety spending annually[[117]](#footnote-117) and another $14 million in ambulance trips and Emergency Department costs.[[118]](#footnote-118)

* 1. *Crisis Response Unit*

The Crisis Response Unit (CRU) is a partnership between Washington, Olympia Police Department (OPD) and Recovery Innovations International to provide free, confidential, voluntary crisis response assistance.[[119]](#footnote-119) Similar to CAHOOTS, the program provides outreach services to those in crisis, identifies each individual's circumstances and needs, and helps identify individuals with chronic mental health disorders, substance abuse and co-occurring disorders.[[120]](#footnote-120) Services provided include crisis counseling, conflict resolution and mediation, harm reduction, first aid and non-emergency medical care/connections, resource connections and referrals, and transportation to services.[[121]](#footnote-121) The Crisis Response Unit cannot restrain people against their will.[[122]](#footnote-122)

CRU teams, consisting of two behavioral health specialists, use police radios to identify and respond to calls.[[123]](#footnote-123) OPD works with the Thurston County 911 communications center (TCOMM 911) to identify calls that would be appropriate for CRU to respond to.[[124]](#footnote-124) Rather than dispatching CRU units directly based on specific criteria, TCOMM 911 shares all potentially eligible calls coming through 911 or Olympia’s non-emergency line over the shared police frequency.[[125]](#footnote-125) CRU can hear all the calls on the police frequency and may decide to respond.[[126]](#footnote-126) In addition, officers may refer calls to CRU if they determine a health-centered response is more appropriate.[[127]](#footnote-127) In addition to completing state training for behavioral health specialists, CRU members must spend time with police on patrol. [[128]](#footnote-128)

* 1. *Woodstock Music & Art Fair*

In 1969, more than 400,000 people descended on a 600-acre farm in Bethel, New York for the Woodstock Music & Art Fair, which lasted three days.[[129]](#footnote-129) Town officials expected no more than 50,000 people and were overwhelmed by the huge crowds.[[130]](#footnote-130) Security at Woodstock was limited[[131]](#footnote-131) and was provided by a communal pig farm known as the Hog Farm.[[132]](#footnote-132) Furthermore, it is estimated there were no more than a dozen police officers at the festival.[[133]](#footnote-133) Although the crowd at Woodstock experienced bad weather, muddy conditions, and a lack of food, water and adequate sanitation,[[134]](#footnote-134) there were no incidents of violence.[[135]](#footnote-135) Of the 80 arrests that occurred, the majority of them were made on drug charges.[[136]](#footnote-136)

Woodstock Music & Art Fair relied heavily on the medical staff.[[137]](#footnote-137) Volunteer doctors, EMTs, and nurses manned Woodstock’s medical tent.[[138]](#footnote-138) Even some Woodstock attendees with medical expertise and peers lent a hand.[[139]](#footnote-139) For example, Hog Farm members helped treat concertgoers who experienced bad side effects from using drugs.[[140]](#footnote-140) In total, staff treated at least 3,000 patients over three days.[[141]](#footnote-141) Two deaths did occur during the event.[[142]](#footnote-142) However, the vast majority of Woodstock attendees got through the three days safely, without violence, and excessive police present.[[143]](#footnote-143)

1. **Conclusion**

At today’s hearing, the Committee looks forward to hearing from the Administration, providers, community-based organizations, and advocates about how New York City can drastically change the way in which we respond to and address mental health crises and emergencies.

1. **Legislation**

**Int. No. 2210**

This legislation requires the establishment of an Office of Community Mental Health (“Office”) within DOHMH, to be headed by a deputy commissioner. This Office would create a citywide mental health emergency response protocol, and a mental health emergency response unit to respond to mental health emergencies within 30 minutes of receiving a mental health emergency call. This would establish that the mental health emergency response unit headed by the Office – and not the police – is the primary response to mental health emergencies. The legislation also requires the Office to identify gaps in mental health provision in New York City, including access to treatment, cost of services, utilization rates, and any racial, cultural, religious or economic barriers to accessing treatment, disaggregated by zip code, race, ethnicity, gender, and age. The Office would also coordinate between City agencies and community-based organization and mental health providers, and provide training to all relevant City agencies regarding the established mental health emergency response protocol. This legislation additionally requires NYPD, in conjunction with the Office of Community Mental Health, to train all members of service, 911 call operators, and new academy recruits in the mental health emergency response protocol. Finally, this legislation requires the Office to report monthly and annually about the emergency mental health calls received, and other work that the Office is conducting.

The bill would take effect 180 days after it became law.

**Int. No. 2222**

This legislation requires the Office to establish a three-digit hotline, staffed by mental health call operators, for individuals experiencing a mental health emergency. The Office would train call operators in the mental health emergency response protocol and conduct public outreach and education publicizing the three-digit hotline.

This bill would take effect on the same date that Int. No. 2210 would takes effect.

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| Int. No. 2210  By Council Members Ayala, the Speaker (Council Member Johnson), the Public Advocate (Mr. Williams), Ampry-Samuel, Cornegy, Rosenthal, Adams, Louis, Cumbo and Kallos    A Local Law to amend the administrative code of the city of New York, in relation to creating an office of community mental health and a citywide mental health emergency response protocol    Be it enacted by the Council as follows:  Section 1. Title 17 of the administrative code of the city of New York is amended by adding a new chapter 20 to read as follows:  Chapter 20  COMMUNITY MENTAL HEALTH  § 17-2001 Definitions. For the purposes of this chapter, the following terms have the following meanings.  Community mental health. The term “community mental health” refers to the provision, treatment, management and support of mental and behavioral illness within a community setting, including, but not limited to, hospital care, outpatient care, care provided by not-for-profit and community-based-organizations, emergency management, employment support, and housing support.  Mental health emergency. The term “mental health emergency” means  (1) a medical or behavioral health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical or behavioral health attention to result in a significant risk of serious harm to oneself or others; or (2) where a person’s actions, feelings, and behaviors can reasonably be expected to put them at risk of being unable to care for themselves or function in the community in a healthy manner; or (3) any other situation or circumstance designated as a mental health emergency by the office.  Office. The term “office” means the office of community mental health.  Public safety emergency. The term “public safety emergency” means a crime in progress, violence, or a situation likely to result in imminent harm or danger to the public, as defined by the office.  § 17-2002 Office of community mental health. a. Establishment of office of community mental health. The commissioner shall establish an office of community mental health. Such office shall be headed by a deputy commissioner who shall be appointed by the commissioner.  § 17-2003 Mental health response protocol. a. No later than December 31, 2021, the office shall develop a citywide mental health emergency response protocol and post such protocol on the department’s website. Such protocol shall establish guidelines:  1. for all emergency call operators, including, but not limited to, 911 call operators, to identify calls as potential mental health emergencies;  2. regarding the information that must be provided by a member of the public to establish that a mental health emergency is also a public safety emergency before authorizing the dispatch of a law enforcement officer; and  3. for all emergency first responders to utilize when responding to potential mental health emergencies, including the following circumstances:  (i) when the mental health emergency response unit responds without the assistance of the police department;  (ii) when the police department responds to public safety emergencies prior to the mental health emergency response unit, including guidelines for whether and how to engage with any member of the public suspected to be experiencing a mental health emergency,  (iii) when the police department and mental health emergency response unit staff are engaged in a joint response, including when and how to defer to office of community mental health employees on engaging with individuals suspected of experiencing a mental health emergency;  (iv) when emergency call responders should include the mental health emergency response unit during a 911 call; and  (v) how emergency responders should respond to a mental health emergency before mental health emergency response unit arrives at the scene.  b. Any changes to such protocol shall be posted on the office’s website within 24 hours of such change.  § 17-2004 Mental health emergency response unit. a. The office shall include a unit of mental health clinicians and peers that shall respond to all mental health emergencies.  b. The mental health emergency response unit shall respond to all mental health emergencies within 30 minutes of receiving a call identified by the mental health emergency response protocol as a potential mental health emergency. The office shall follow-up with any individual interacting with the mental health emergency response unit within 48 hours of such a response.  c. The office shall provide appropriate training, medical equipment, vehicles, and adequate staff to the mental health emergency response unit.  d. The office shall identify best practices concerning titles, uniforms, training, qualifications, and professional and personal experience of such staff.  e. The office shall determine the geographic locations necessary for such equipment, vehicles, and staff in order to achieve the response time set forth in subdivision a of this section.  § 17-2005 Coordination between city agencies and service providers. The office shall coordinate between city agencies and mental health service providers by:  a. incorporating city agencies and community-based-organizations involved in responding to mental health and public safety emergencies into the mental health emergency response protocol. Such agencies shall include, but not be limited to, the police department, the department of homeless services, the department of social services/human resources administration, the fire department bureau of emergency medical services, the administration for children’s services, the department of education, the New York city health and hospitals corporation, and other offices or units within the department;  b. training city agencies and community-based-organizations involved in responding to mental health and public safety emergencies, including the police department, in the protocols established pursuant to section 17-2003;  c. providing referrals to community-based-organizations or mental health providers for individuals seeking connection to care; and  d. monitoring the usage of the city’s emergency response infrastructure in order to improve community mental health services and reduce mental health emergencies through preventative care.  § 17-2006 Public outreach and education. The office shall conduct public outreach and education. Such outreach and education shall include, but not be limited to:  a. Publicizing the mental health emergency response protocol;  b. Conducting targeted outreach campaigns in neighborhoods facing barriers to access of mental health care and in which there are a disproportionate number of mental health emergency calls; and  c. Providing information and resources regarding access to mental health care, particularly free, low-cost, and insurance-covered mental health care.  § 17-2007 Reporting. a. Monthly reporting. Beginning February 1, 2022 and by the first day of each month thereafter, the office shall provide to the mayor and speaker of the council, and post to its website, a report on mental health emergency calls received and handled pursuant to the protocol, including but not limited to the following:  1. the number of potential mental health emergency calls received, in total and disaggregated by whether the call originated from 311, 911, or another source, and further disaggregated by the agency or agencies dispatched; and  2. the number of mental health emergency responses conducted, disaggregated by the responding agency or agencies, and further disaggregated by zip code, race, ethnicity, gender, age, and whether follow-up or referral services were provided to individuals.  b. Annual reporting. Beginning February 1, 2022 and by each February 1 thereafter, the office shall submit to the mayor and speaker of the council, and publish on its website a report on the activities of the office, including but not limited to:  1. an assessment of mental health service needs and gaps in care, including access to treatment, cost of services, utilization rates, and any racial, cultural, religious or economic barriers to accessing treatment, disaggregated by zip code, race, ethnicity, gender, and age; and  2. any changes to the mental health emergency protocol and the reasons for any such change.  § 2. Chapter 1 of title 14 of the administrative code of the city of New York is amended by adding new sections 14-191 and 14-192 to read as follows:  § 14-191 Mental health emergency response. The department and its officers and employees shall follow the mental health emergency response protocol established by the office of community mental health pursuant to section 17-2003.  a. The department shall not respond to a call designated by the mental health emergency response protocol as a potential mental health emergency call, unless the office of community mental health has notified the department that there is a public safety emergency pursuant to the emergency mental health response protocol.  b. Upon dispatch to a potential mental health emergency that is deemed by the office of community mental health to be a public safety emergency, the department and its officers shall follow the instructions of any employees of the office of community mental health emergency response unit present at the scene and refrain from engaging with an individual in mental health crisis unless instructed to do so by a member of the office of community mental health.  c. 911 call operators shall follow the mental health emergency response protocol established by the office of community mental health for identifying potential mental health emergency calls. In the event that such protocol identifies a potential mental health emergency call, the 911 operator shall connect the call to the office of community mental health emergency response established pursuant to section 17-2003.  § 14-192 Mental health emergency response training. The department, in conjunction with the office of community mental health, shall:  a. Provide training for all current members of service regarding the citywide mental health emergency response protocol established pursuant to section 17-2003 no later than July 1, 2022;  b. Provide training for all 911 call operators regarding the citywide mental health emergency response protocol established pursuant to section 17-2003 no later than July 1, 2022;  c. Provide training for all new academy recruits and new 911 emergency call operators regarding the citywide mental health emergency response protocol established pursuant to section 17-2003; and  d. Provide retraining for all members of service within six months of any changes to the emergency response protocol established pursuant to section 17-2003 or no later than every two years if no changes are made.  § 3. This local law takes effect 180 days after it becomes law.                SIL/D.A.  LS # 4045  1/22/21 12:15 pm |

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| Int. No. 2222    By the Public Advocate (Mr. Williams), Council Members Cornegy, Rosenthal, Louis and Kallos    A Local Law to amend the administrative code of the city of New York, in relation to creating a three-digit mental health emergency hotline    Be it enacted by the Council as follows:  Section 1. Chapter 20 of title 17 of the administrative code of the city of New York is amended by adding a new chapter section 17-2008 to read as follows:  § 17-2008 Mental health emergency hotline. a. Three-digit hotline. The office shall establish a three-digit hotline for individuals experiencing a mental health emergency. Such hotline:  1. Shall direct calls to a centralized call center operated by the office and staffed by mental health call operators;  2. Shall not direct calls to the 911 system unless the mental health call operator determines that there is a public safety emergency;  3. Shall be capable of receiving calls originating through the 911 and 311 systems; and  4. Shall be available for use no later than December 31, 2021.  b. Mental health emergency response protocol. In accordance with the mental health emergency response protocol established pursuant to section 17-2003 of this chapter, the office shall establish guidelines for call operators of the three-digit hotline established pursuant to subdivision a of this section, to identify calls as potential mental health emergencies.  c. Public outreach. The office shall conduct public outreach and education publicizing the three-digit hotline established pursuant to subdivision a of this section.  § 3. This local law takes effect on the same date as a local law amending the administrative code of the city of New York, relating to creating an office of community mental health and a citywide mental health emergency response protocol, as proposed in introduction number \_\_\_ for the year 2021, takes effect.                SIL.  LS # 5569  2/1/2021 3:00 pm |

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