Mayor's Office of ThriveNYC

Committee on Mental Health, Disabilities, and Addictions
February 22, 2021

Testimony of Susan Herman, Senior Advisor to the Mayor and Director of the Mayor's Office of ThriveNYC

Good morning, Chair Louis and members of the Committee on Mental Health, Disabilities, and Addictions. My name is Susan Herman and I am a Senior Advisor to the Mayor and Director of the Mayor's Office of ThriveNYC. I am joined by several colleagues: Dr. Myla Harrison, Acting Executive Deputy Commissioner of the Division of Mental Hygiene at the Department of Health and Mental Hygiene; Chief Terri Tobin, Chief of Intergovernmental Operations at the NYPD; Dr. David Prezant, Chief Medical Officer for the FDNY; and Dr. Rebecca Linn-Walton, Assistant Vice President, Behavioral Health at NYC Health + Hospitals. Thank you for the opportunity to testify.

First, I would like to extend a warm welcome to Chair Louis. We enjoyed a close and productive partnership with former Chair Ayala, and we are very much looking forward to working with you as you take over chairing this important committee.

The Mayor's Office of ThriveNYC, created in 2019, is the first Mayoral office devoted to promoting access to mental healthcare for New Yorkers. We currently oversee 30 programs designed to close critical gaps in mental healthcare through innovation. Our programmatic budget as well as data about the reach and impact of our work are all on our website.

In addition, we promote cross-agency collaboration and help shape mental health policy in the City. This work includes chairing the Crisis Prevention and Response Task Force of over 80 experts from the nonprofit sector, elected leaders, and City government. We also chair the Mental Health Council, which includes the leadership of over 30 City agencies working together to maximize the City's mental health-related initiatives.

PROGRESS ON MENTAL HEALTH CRISIS PREVENTION AND RESPONSE SINCE 2014

Over the last seven years, the City has made great progress strengthening how we prevent and respond to mental health crises. We appreciate that the City Council has been a critical partner in this effort. The legislation we are discussing today should be viewed in the context of what we have seen work and the progress already underway.

I would like to begin by discussing crisis prevention. Many mental health crises can be prevented if people are able to access and stay connected to needed care. Yet for decades, too many New Yorkers have gone without mental health treatment or support when and where they have needed it. There are 17 federally designated mental healthcare shortage areas in New York City. Like food deserts, these are neighborhoods without sufficient access to mental healthcare. One way we have worked to increase access to care is by changing the mental healthcare landscape.

Thrive programs have added hundreds of new service locations across the City, over 70% of which are in the federally designated mental healthcare shortage areas.

We have partnered with 13 City agencies and nearly 200 community-based organizations to add new, onsite support in over 200 high-need schools, 100 shelters for families, 45 centers for older adults, every precinct and PSA in the City, and all runaway and homeless youth residences. We also support 57 mobile treatment teams that bring intensive, ongoing clinical care to people with serious mental health needs, right in their communities.

We have also expanded access to services through NYC Well, the City's comprehensive mental health helpline that serves as a gateway to care thousands of times every week. Starting out as a suicide hotline, NYC Well now answers calls, texts and chats for a wide range of behavioral health needs. It offers immediate support, referrals for ongoing treatment, and when appropriate, deploys mobile crisis teams to respond to urgent concerns in person. In 2020, NYC Well answered an average of 6,200 requests for support every week.

These new services build on a strong foundation. Apart from its partnership with ThriveNYC, the Department of Health and Mental Hygiene spends nearly $500 million annually for people with mental health concerns, substance misuse, and intellectual and developmental disabilities. Among other services, this includes supportive housing, crisis respite centers, mobile treatment, and school-based mental health services.

NYC Health + Hospitals, apart from its partnership with ThriveNYC, invests about $800 million every year in acute inpatient and outpatient behavioral health services. The Department of Homeless Services street outreach teams and Safe Havens increasingly connect people to behavioral healthcare. And, NYC Care, our citywide guarantee of health care, includes behavioral health services.

The City has made significant progress over the last seven years. A lot of new work began in 2014 with the Task Force on Behavioral Health and the Criminal Justice System, which brought together over 300 advocates, practitioners, academics, and government officials to develop recommendations to reduce the number of people with behavioral health needs who cycle through the criminal justice system. All of these recommendations are now underway-- including new support for people awaiting trial or detained in the City's jails, Crisis Intervention Training for police officers, and Support and Connection Centers (formerly known as Diversion Centers), which offer short-term stabilization services to people with mental health and substance use needs. The East Harlem Support and Connection Center, which opened a year ago, gives police officers an alternative to avoidable emergency room visits or enforcement interventions.

The City's collaborative work on mental health crises continued through the recommendations of the Crisis Prevention and Response Task Force, approved by the Mayor in 2019.

Even with the COVID-19 pandemic and a fiscal crisis, we have brought many of these recommendations to life. While we could not add more ACT mobile treatment teams as we had

planned because of the State's cap on Medicaid, we have added 4 new Intensive Mobile Treatment Teams-- fully funded by the City-- bringing the total capacity of all the mobile treatment teams functioning in the City to almost 4,000 clients at any given time. These teams continue to make a profound difference in people's lives. For example, during the first 3 months of the fiscal year, we could see that of those clients who began receiving IMT services while homeless – many of whom were experiencing street homelessness – 47% moved into permanent housing during their engagement with IMT and 90% of clients stayed connected to treatment for 12 or more months. Mobile treatment teams serve people who otherwise might never have been connected to either housing or treatment – and they are no doubt helping to prevent crises.

The result? Right now, with all of the new services in place, New York City provides more mental health support – to more people, in more places, and in more ways – than ever before.

STRENGTHENING CRISIS RESPONSE IN 2021

Now I would like to discuss crisis response.

Not all crises require an emergency response. Some mental health crises require an urgent, but not an immediate response. For that reason, we have also enhanced our mental health urgent response infrastructure. Mobile Crisis Teams include clinicians and peers who provide in-person assessments and connection to care for people experiencing behavioral health crises. These teams are deployed about 20,000 times a year by NYC Well, public hospitals and healthcare providers. Because of the Crisis Prevention and Response Task Force, they will soon be able to respond to people within a few hours during the day and early evening, every day of the year. This reflects great improvement from only a year ago when most responses were the next day and weekend calls resulted in significant delays.

As more New Yorkers become aware of this service and experience it, we hope to see more and more people turning to NYC Well and Mobile Crisis Teams – rather than 911.

As we enter 2021, following several years in which more mental health services have been available to New Yorkers, and we are both preventing and responding to crises more effectively, we are beginning to see the tide turn.

Mental health emergencies are declining. From 2008 to 2018, the number of mental health 911 calls in New York City nearly doubled, increasing every year and in every precinct. In 2019, the total number of calls dropped for the first time in a decade, by 5% or over 8,000 calls. In 2020, the number of calls fell by another 6% or over 9,000 calls. And, according to a recent evaluation of NYC Well, more than 20 percent of surveyed NYC Well users who contacted NYC Well for themselves reported that they would have considered calling 911 or going to an emergency room if not for NYC Well. They knew they had another option.

To continue this positive momentum, in November 2020, the Mayor announced that for the first time in our history, health professionals will be the default response to 911 mental health crisis calls.

This new health-centered approach – called B-HEARD (the Behavioral Health Emergency Assistance Response Division) – will be a critical step forward in the City's commitment to treat mental health crises as public health problems, not public safety issues. Currently, NYPD officers and FDNY/EMS Emergency Medical Technicians (EMTs) respond to all mental health crisis calls to 911. This is regardless of the severity of the mental health need, or whether a crime is involved, or whether there is an imminent risk of violence—all 911 mental health calls get this joint response. Beginning in Spring 2021 in Northern Manhattan (specifically, the 25, 28, and 32 precincts in East and Central Harlem), the new Mental Health Response Teams of Health and Hospitals social workers and FDNY EMTs will be the new primary response to mental health emergencies. In emergency situations involving a weapon or imminent risk of harm, NYPD officers and EMTs will continue to respond as before.

Mental Health Response Teams will have the experience and expertise to de-escalate crisis situations and respond to a range of behavioral health problems, such as suicidal ideation, substance misuse, and serious mental illness, as well as physical health problems, which can be exacerbated by, or mask, mental health problems.

This pilot has been shaped by a steering committee that includes FDNY, NYC Health + Hospitals, the Department of Health and Mental Hygiene, NYPD and the Mayor's Office of ThriveNYC. We have been intentional about its design. We have consulted cities across the country that are undertaking similar work and have met with members of the Crisis Prevention and Response Task Force, advocates from Correct Crisis Intervention Today (CCIT-NYC), and elected officials to hear their thoughts.

First, we think it makes good sense to build on the tremendous capacity and decades of experience within FDNY's Emergency Medical Services, which currently responds to over 150,000 mental health emergencies every year. EMTs will be able to arrive on the scene within minutes and have expertise to assess and treat many health issues.

Second, Health and Hospitals, the largest public hospital system in the country, is the City's behavioral health safety net, operating psychiatric emergency departments, as well as inpatient and outpatient behavioral healthcare. H+H also manages several Mobile Crisis Teams and assertive community treatment teams or ACT teams that offer ongoing mobile treatment to people with serious mental illness in their communities.

EMS and H+H both have deep experience running emergency operations. These are the right partners to create the right teams of experienced EMTs and social workers. And they are the right partners to provide the appropriate training and supervision for these teams.

Third, in introducing this entirely new service to NYC, we have ensured that we are integrating lessons learned in other jurisdictions. Our model builds on the most established program in the country: CAHOOTS (Crisis Assistance Helping Out On The Streets) in Eugene, Oregon. CAHOOTS, a program of a community-based clinic, handles cases sent by their 911 system. Designed to address a wide array of physical and mental health problems in non-violent situations, CAHOOTS teams of paramedics and social workers responded to approximately 24,000 calls last year.

New York City will be the largest city to rollout this kind of an approach. To inform our pilot, we have also spoken to large cities such as Denver, Chicago, and San Francisco that are just beginning this work, as well as nearby Ulster, Albany, and Orange counties. All of these programs are dispatched out of 911. There are many similarities with our model: Every model is using a social worker or clinician and an emergency medical responder (an EMT or a paramedic). No team exceeds three people. No team is directly providing medical transports to hospitals; each is calling ambulances to provide transport where needed.

Denver and San Francisco are basing their teams within the emergency medical services function of their fire departments, as we are, and contracting out for social workers to add to their teams. Chicago is pursuing a hybrid model: they plan to hire some mental health professionals directly through their health department and contract with community partners to hire others. They want to test both approaches. None of these team will respond to 911 calls that involve violence. While there is some variation in how cities define "violence," the presence of a weapon automatically excludes these new teams from responding in every city we have spoken to -- including the CAHOOTS model in Oregon.

The design of New York City's pilot differs from models elsewhere in several key ways. Some cities are integrating pre-existing mobile crisis teams into their 911 system. In New York City, Mobile Crisis Teams respond to urgent situations, not emergencies. In some cities, peers are part of the crisis response team in addition to mental health clinicians. Denver and San Francisco's models are overseen by their local public health authorities; however, in both of these cities, their health authority includes the entire public hospital system. In New York City, our public hospital system is a separate entity – Health + Hospitals. There are also some limitations on the kinds of situations teams respond to – for instance, in San Francisco, teams are only dispatched to public locations.

In big cities nationwide – health-centered approaches to mental health emergencies – are new. Denver's began in June 2020, San Francisco's in November 2020, and Chicago is aiming to begin in summer 2021. There are few established best practices yet in large cities; we are all designing these initial pilots carefully and learning from one another.

Fourth, we wanted to ensure that the teams in the pilot phase are based in communities with sufficient operational infrastructure to support rapid implementation and a range of community mental healthcare options. We needed to select a single 911 radio dispatch zone – usually two or three contiguous precincts – where everyone is on the same radio frequency, making dispatch

easier. We chose zone 7 – which includes the 25, 28, and 32 precincts or East Harlem, and parts of north and central Harlem because of the high volume of mental health calls. Zone 7 had 9,058 mental health 911 calls in 2019; and 7,446 calls between January and November 2020, the most in the City. H+H has hospitals, clinics, and a psychiatric emergency program in this zone, and the new East Harlem Support and Connection Center, which offers short-term stabilization services, is there as well. Furthermore, EMS has facilities nearby that could be quickly adapted to serve as a base for operations.

We have been hard at work – operational protocols are nearly finalized, the training is designed, and hiring is underway. We will launch as soon as everyone is hired and trained. Once we launch, we will monitor this pilot to ensure we can scale as quickly as possible. Specifically, we will gather detailed data on metrics such as: the percentage of mental health 911 calls selected for the new teams; the number of times the new teams are dispatched; the time from dispatch to arrival on scene; the kinds of locations to which the teams are dispatched; and how calls are resolved.

This pilot represents an important change in how New York City responds to mental health crises, and it is imperative that we get it right. We want to make sure the protocols are correct, the training is sufficient, and the staffing levels are right – before we expand.

Given the work currently underway, the City shares a commitment to the spirit of Intro. No. 2210, which would create an office of community mental health and a citywide mental health emergency response protocol. However, we think it is premature to mandate citywide implementation of a different model. There is too much to learn from the pilot to decide now to use a very different approach.

The City also has concerns with Int. No. 2222, which would create a three-digit mental health emergency hotline. As I mentioned earlier, a recent independent evaluation of NYC Well made clear, many New Yorkers are already turning to this helpline instead of calling 911 or going to an emergency room. Staffed by trained counselors and peers, NYC Well can provide immediate crisis counseling and suicide prevention as well as dispatch Mobile Crisis Teams to provide in-person assessments for people experiencing a behavioral health crisis. The City has invested in capacity at NYC Well, refined its services, and conducted significant outreach to New Yorkers to encourage them to contact this helpline.

In addition, last summer the FCC enacted rules to establish 988 as the 3-digit phone number to connect people in crisis with suicide prevention and mental health crisis counselors. By July 2022, all phone service providers will connect 988 calls to the existing National Suicide Prevention Hotline. In NYC, NYC Well answers National Suicide Prevention Hotline calls. As such, we believe existing infrastructure already accomplishes many of the aims contemplated in Int. No. 2222.

We have not found an alternative three-digit number in any jurisdiction in the country that dispatches emergency responses. We teach our children from a very young age to call 911 in any

kind of emergency – whether it is a safety problem, a fire, or a health crisis. You shouldn't have to think hard about who to call in an emergency. If it's an emergency, call 911.

I thank this Committee for your ongoing partnership and commitment to continuing to strengthen mental health crisis prevention and response in our city. We are happy to answer any questions you have.

Testimony to the New York City Council Committee on Mental Health, Disabilities, and Addiction

Oversight Hearing on New York City's Mental Health Emergency Response
February 22, 2021

February 24, 2021

Distinguished Members of the Committee on Mental Health, Disabilities, and Addiction:

The New York State Health Foundation (NYSHealth) appreciates the opportunity to submit written testimony on the status of mental health in New York City. We offer information from our recent research on the mental health impact of the coronavirus pandemic on New Yorkers to highlight priority populations.

A wide body of research shows that people commonly experience fear, anxiety, and stress during and after a disaster.[1,2] It is not surprising that the coronavirus pandemic is therefore taking a toll on the mental health of New Yorkers. In addition to anxiety about the coronavirus itself, many New Yorkers are struggling with the societal changes resulting from the pandemic, such as isolation from community, uncertainty about the future, or new childcare responsibilities.[3,4,5,6] Furthermore, job loss—experienced by more than 1.7 million people across New York State in April 2020—is associated with anxiety, depression, suicide, and increased substance use. [7,8,9,10,11] The financial strain caused by this widespread job loss also decreases New Yorkers' ability to afford mental health care and increases other risk factors for poor mental health. [12,13]

NYSHealth's Work to Improve Mental Health
NYSHealth is a private, independent foundation that works to improve the health of all New Yorkers, especially the most vulnerable. Our grantmaking and research has provided us with experience in and knowledge of mental health needs and services across New York State. In particular, we have supported work to expand access to mental health care via telemedicine and to provide mental health support for frontline workers in the wake of the COVID-19 pandemic.

NYSHealth has recently funded multiple projects to bring mental health services to at-risk New Yorkers. For example, NYSHealth funded the Headstrong Project and the Military Family Center at NYU Langone Health to expand their telemental health resources for veterans as well as the Stop Soldier Suicide intervention and outreach program to expand the program across the New York City region. NYSHealth also supported the Physician Affiliate Group of New York, Bassett Medical Center, and Vibrant Emotional Health to provide mental health training and services to health care workers and other essential workers.[14]

New Research on the Mental Health Impact of COVID-19 in New York State
NYSHealth would like to provide the Committee with new research that sheds light on the mental health burden of living through the COVID-19 pandemic in New York State. Although this is a State-level analysis, it can support the City in its continued efforts to design programs and target resources, as well as provide data when working with State and federal partners. Findings highlight growing mental health needs across New York, which may result in mental health crises and the need for a robust community-based mental health emergency response.

The data presented here are from a recently published NYSHealth analysis based on the COVID-19 Household Pulse Survey, which is administered by the U.S. Census Bureau in collaboration with multiple federal agencies. The survey provides near real-time data on household experiences, including measures of mental health, during the coronavirus pandemic.

- In May 2020, more than one-third of adult New Yorkers reported symptoms of anxiety and/or depression in the prior week (defined in this analysis as experiencing poor mental health) (see ***Figure 1***). That rate is more than triple what was self-reported nationally using similar measures during recent pre-pandemic periods.[15]

- The proportion of New Yorkers reporting poor mental health has remained high throughout the pandemic, reaching 37% of adult New Yorkers in October 2020 (see ***Figure 1***).

- Compared with all racial and ethnic groups, New Yorkers of color generally reported the highest rates of poor mental health throughout the survey period. In October 2020, 42% of Hispanic and 39% of Black New Yorkers reported symptoms of anxiety and/or depression in the prior week (see ***Figure 2***).

- Although all age groups were affected, in October 2020, young adult New Yorkers (ages 18–34 years) reported the highest rates (49%) of poor mental health (see ***Figure 3***).

- Low-income New Yorkers experienced the highest rates of poor mental health across the survey period, compared with all other income groups. Reported symptoms of anxiety and/or depression increased across all income brackets from May to October 2020 (see ***Figure 4***).

- In October 2020, nearly half of New Yorkers (47%) in households that lost employment income since the start of the pandemic reported symptoms of anxiety and/or depression in the prior week. This rate is 1.7 times higher than among households that did not experience income loss (see ***Figure 5***).

For more details about these findings, please see NYSHealth's full report, available here: https://nyshealthfoundation.org/resource/mental-health-impact-of-the-coronavirus-pandemic-in-new-york-state

Responding to the Need for Mental Health Services and Mental Health Emergency Response in New York City

Although both New York City and New York State have taken vital steps to increase access to mental health care during the pandemic, more work is required to fulfill unmet needs. In October 2020, approximately 21% of adults in New York State with symptoms of anxiety and/or depression reported that they needed counseling or therapy from a mental health professional in the prior four weeks, but did not get it.[16] Additional services are needed especially in New York City, which is home to a higher proportion of New Yorkers at risk for poor mental health

outcomes during the pandemic, including people of color, low-income residents, and families who have recently lost income.

Demand for telemental health services, like mental health hotlines, has soared in New York City during the pandemic. Telemental health has provided a socially distant and safer health care option for many people seeking care throughout the pandemic. It has also helped to bring services remotely to the approximately 2.6 million New York City residents who live in federally designated mental health professional shortage areas, or areas with too few mental health providers and services for a given population.[17]

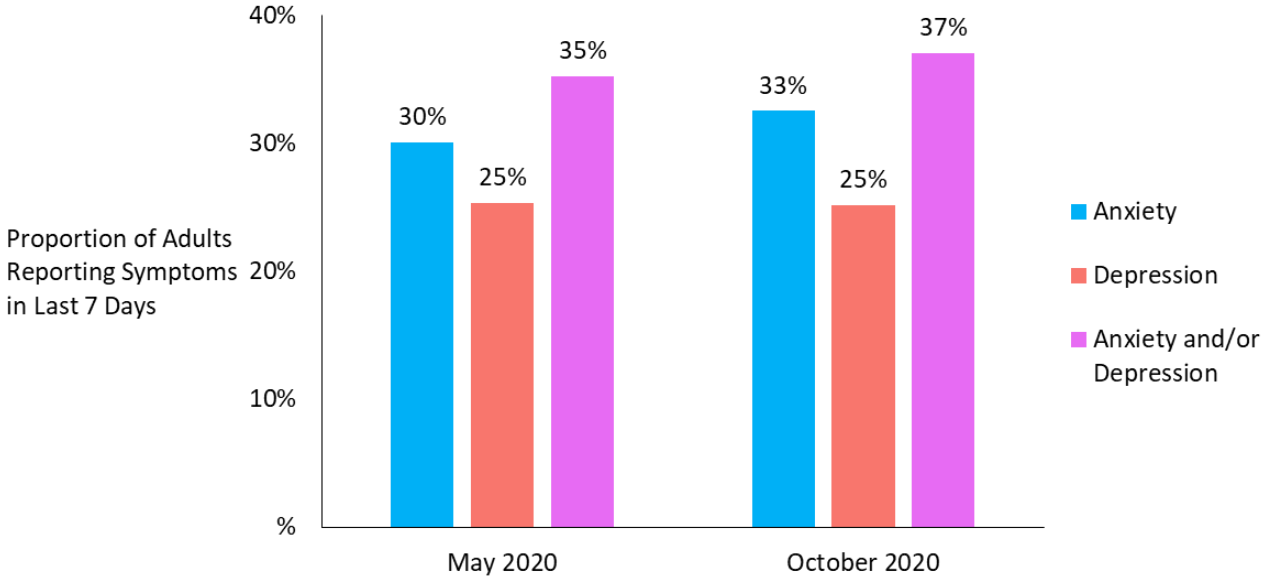
The need to expand upon existing hotline services is clear. For example, NYC Well—New York City's support, crisis intervention, and referral service—answered more than 40% more inquiries the first week of April 2020 than it did the first week of January 2020.[18] Demand steadily grew for the rest of the year, with NYC Well answering more than 80% more contacts the first week of November 2020 than it did the first week of January 2020.

Conclusion

NYSHealth applauds the Committee for bringing the critical issues of mental health services and mental health emergency response to the forefront during this critical moment. As New Yorkers continue to cope with the ramifications of an enduring pandemic, accessible, affordable, and culturally appropriate services provided by mental health professionals are needed more than ever. We look forward to continuing our partnerships with the City and other organizations to promote the emotional wellbeing of all New Yorkers.

Appendix

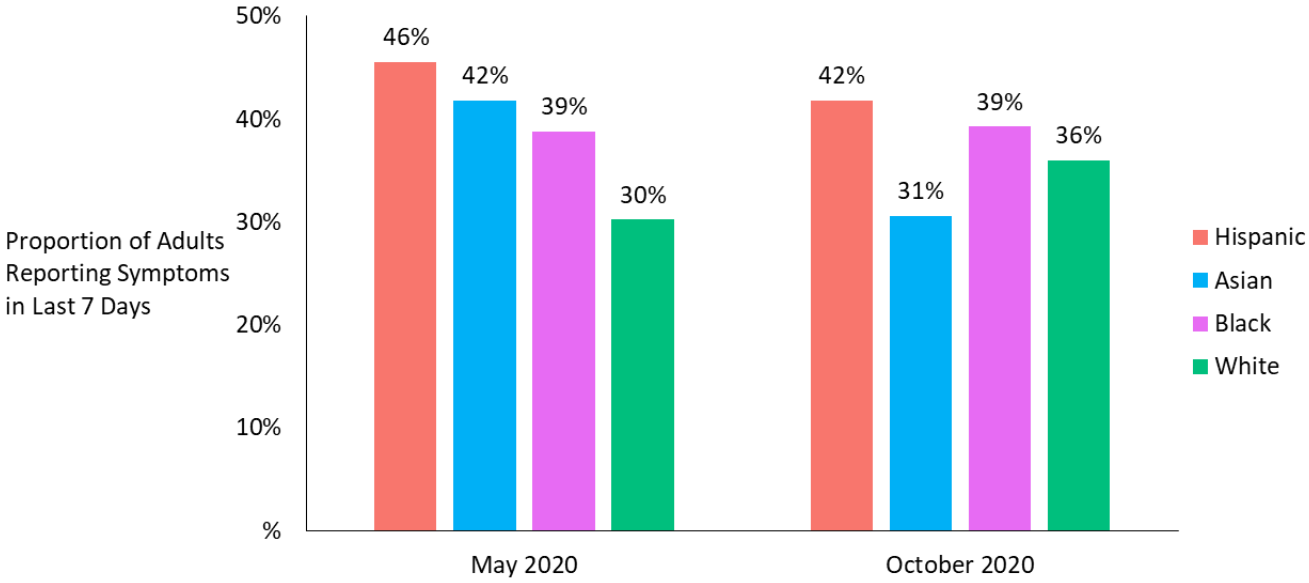
Figure 1. Proportion of Adult New Yorkers Reporting Symptoms of Anxiety or Depression During COVID-19



Note: Only adults who responded to mental health questions are included in the denominator. Data for May are the average of the following weeks of data: May 7–12, May 14–19, May 21–26, and May 28–June 2. Data for October are the average of the following weeks of data: September 30–October 12, October 14–October 26. See full report for the survey questions and scoring.

Source: NYSHealth analysis of U.S. Census Bureau Household Pulse Survey.

Figure 2. Proportion of Adult New Yorkers Reporting Symptoms of Anxiety and/or Depression during COVID-19, by Race and Ethnicity

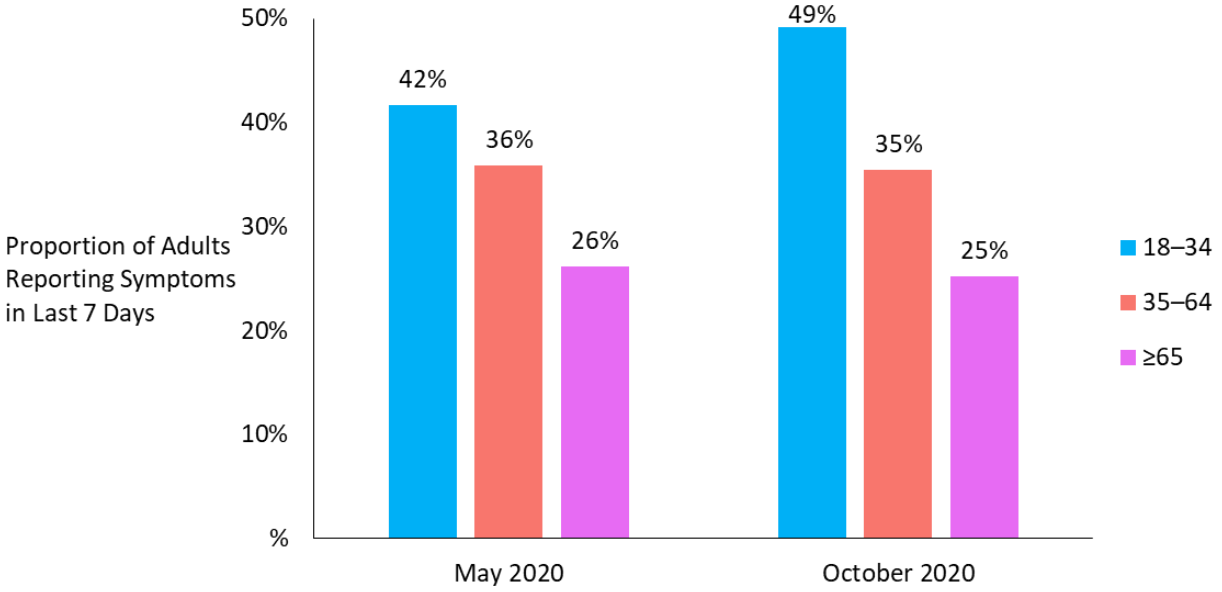


Note: Only adults in each race or ethnicity category who responded to mental health questions are included in the denominator. We categorized adults with an ethnicity of Hispanic identified in the data as Hispanic. We categorized adults with an ethnicity of Non-

Hispanic as Black, Asian, or white, according to their race code identified in the data. Adults with a race identified in the data as "other or two or more races" were excluded from analyses by race/ethnicity because of low sample sizes. Data for May are the average of the following weeks of data: May 7–12, May 14–19, May 21–26, and May 28–June 2. Data for October are the average of the following weeks of data: September 30–October 12, October 14–October 26. See full report for the survey questions and scoring.

Source: NYSHealth analysis of U.S. Census Bureau Household Pulse Survey

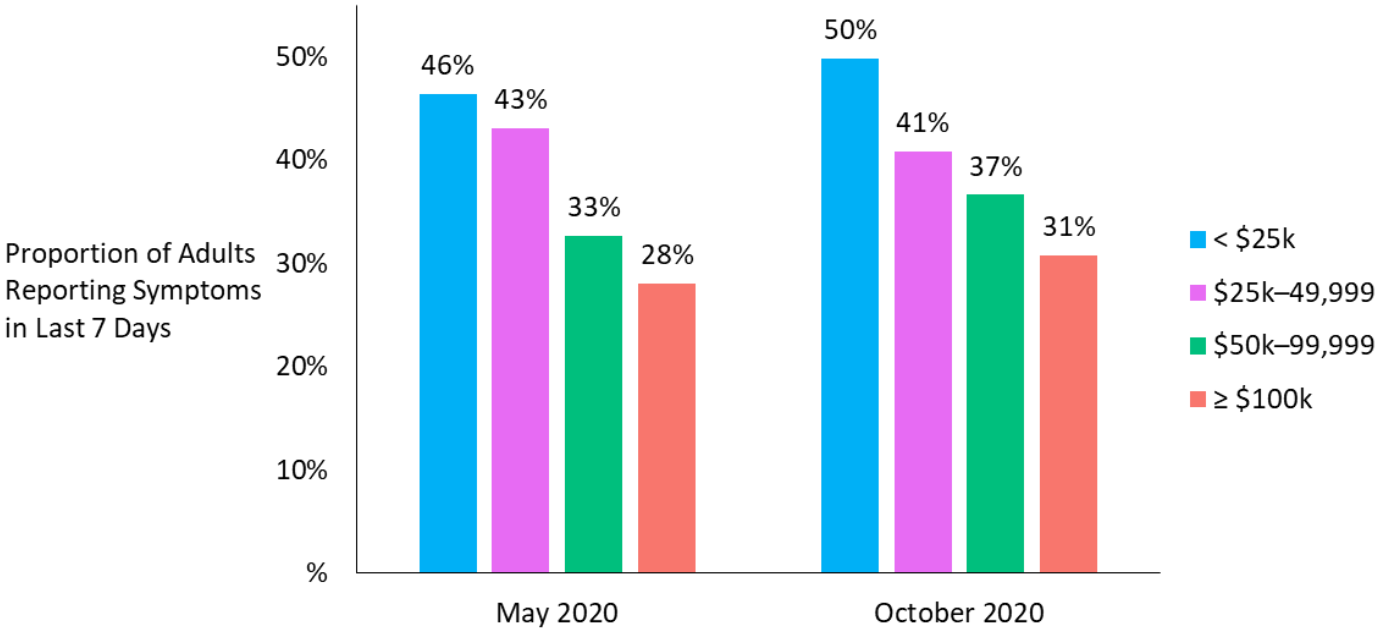
Figure 3. Proportion of Adult New Yorkers Reporting Symptoms of Anxiety and/or Depression During COVID-19, by Age



Note: Only adults in each age category who responded to mental health questions are included in the denominator. Data for May are the average of the following weeks of data: May 7–12, May 14–19, May 21–26, and May 28–June 2. Data for October are the average of the following weeks of data: September 30–October 12, October 14–October 26. See full report for the survey questions and scoring.

Source: NYSHealth analysis of U.S. Census Bureau Household Pulse Survey.

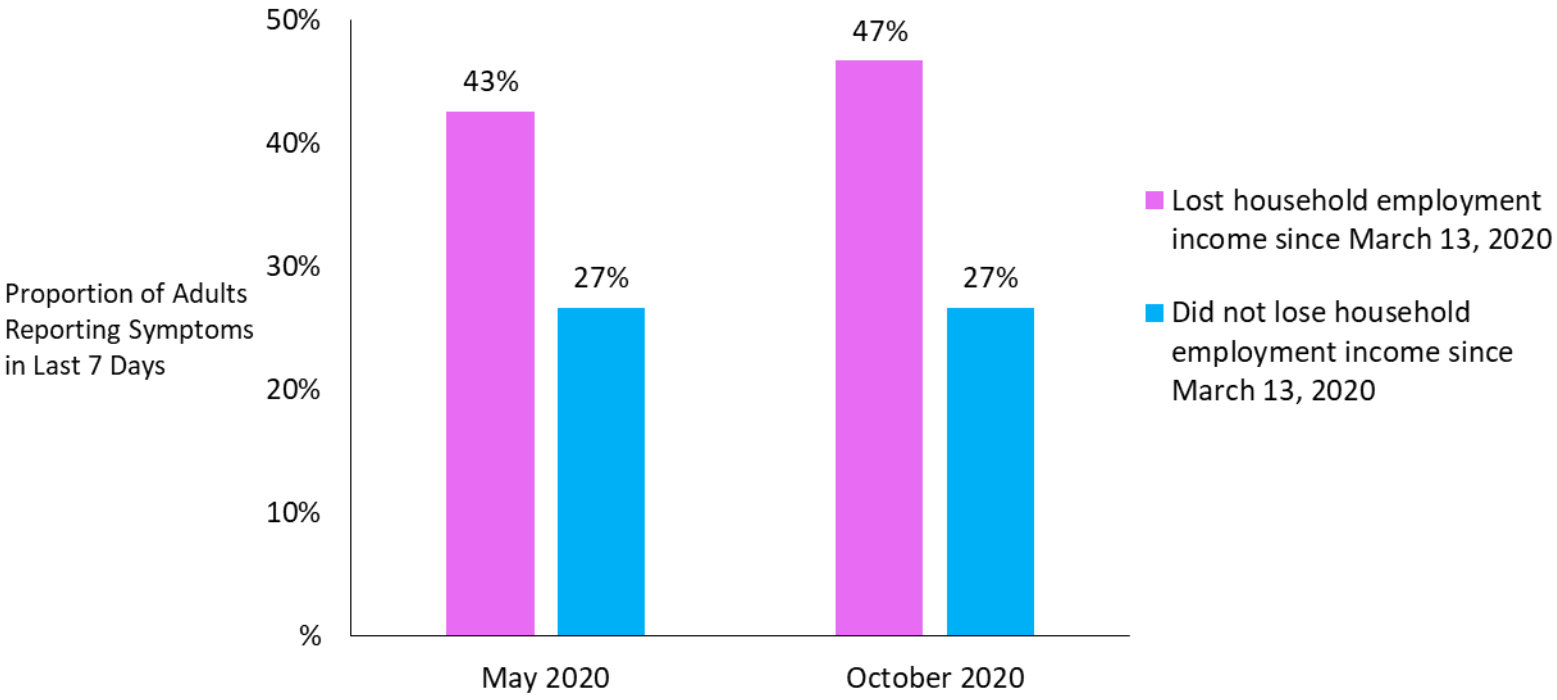
Figure 4. Proportion of Adult New Yorkers Reporting Symptoms of Anxiety and/or Depression During COVID-19, by Household Income



Note: Only adults in each income category who responded to mental health questions are included in the denominator. Household income is defined as total 2019 household income before taxes. Data for May are the average of the following weeks of data: May 7–12, May 14–19, May 21–26, and May 28–June 2. Data for October are the average of the following weeks of data: September 30–October 12, October 14–October 26. See full report for the survey questions and scoring.

Source: NYSHealth analysis of U.S. Census Bureau Household Pulse Survey

Figure 5. Proportion of Adult New Yorkers Reporting Symptoms of Anxiety and/or Depression During COVID-19, by Household Employment Income Loss



Note: Only adults in each household employment income loss category who responded to mental health questions are included in the denominator. An adult is considered to have lost household employment income if they or anyone in their household experienced a loss of employment income since March 13, 2020. Data for May are the average of the following weeks of data: May 7–12, May 14–19, May 21–26, and May 28–June 2. Data for October are the average of the following weeks of data: September 30 October 12, October 14–October 26 See full report for the survey questions and scoring.

Source: NYSHealth analysis of U.S. Census Bureau Household Pulse Survey.

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Testimony

New York City Council Committee on Mental Health, Disabilities and Addiction

January 22, 2021

Hawa Bah
Mother of Mohamed Bah
Justice Committee Member

My name is Hawa Bah. I am the mother of Mohamed Bah, a son who gave me great pride. I lost my son at the hands of the NYPD on Sept. 25, 2012.

Thank you to the members of the City Council who are here this morning and thank you for having us testify – family of those killed by police.

In 2012 Mohamed was depressed and didn't sound like himself. I flew all the way from Guinea to help him. I tried to get him into different programs, but everyone told me – you have to call 911 if you want medical help.

On September 25, 2012, I called 911, but the NYPD came first.

They forced their way into my son's home even though I begged them not to. They shot him eight times and killed him, execution-style – and then they lied about what happened.

Since 2012 I have been fighting for Mohamed and to prevent more of our children from being killed by police. I have fought for police reform in Albany and City Hall and we have won changes to some laws.

I went all the way to trial in my civil suit for Mohamed and the jury found that Officer Mateo used excessive force and Lt. Licitra failed to supervise. But they were not fired, both of them are still NYPD.

Mateo and Licitra should be fired and the NYPD must not be part of any mental health response, especially in Black communities.

I want to tell you the many reasons why I oppose the bill number 2210.

I have been fighting to remove police from mental health response for years.

But Intro 2210 will not solve the problem, it will send us backwards.

1. **Sending NYPD and a mental health team together will not work. We have to remove police completely. Even the 911 system must be removed from the NYPD's control.**

I am against what you call co-response teams, or any police response when someone needs medical care. The NYPD cannot be involved in responding to people who are experiencing emotional distress. New Yorkers who are experiencing a mental health emergency need care, not criminalization. When it is the NYPD, if you are Black or Brown, they do not come to help. They only come to harm and kill.

The NYPD always treats Black people and other people of color who are in crisis as dangerous and violent. When I called 911, I told them I want an ambulance, but they treated Mohamed like he was dangerous and sent the police. If this bill was the law when Mohamed was sick, it would

have been "public safety emergency", the police would still have come, and he would still have been killed.

If people are sick, they need care from people who want to help and know how to. Sending the police will only make them more scared and escalate the situation.

Any bill that is trying to solve the problem has to remove police from these situations or our Black children and other children of color will still be killed by police, or arrested or brutalized.

2. There needs to be accountability for officers who hurt or kill people or break protocol, but this bill doesn't ensure that.

The officers who killed my son are still in the NYPD and now they are even fighting the CCRB investigation, so they don't have to face any consequences for what they did.

The bill doesn't do anything to make sure that if officers don't follow protocol and hurt people, that they will be fired.

The bill doesn't seem to understand that the NYPD is not like any other agency. They have too much power and we need to remove them from these situations.

3. The bill doesn't help us prevent crisis – it ignores that there are almost no mental health services specifically for Black people in this city.

You can't prevent mental health emergencies without good mental health programs that work for Black communities. **We need services that are tailored for Black people.**

We need a bill that will help people like Mohamed so they don't get to a crisis, not a bill where police will still come if someone like Mohamed goes through a crisis.

The City Council should defund the NYPD so that money can go to the services we need. We need jobs, housing, education and health services that treat us with dignity, not more training and money for police.

4. If you want to create a system that will work, you have to listen to families like mine whose children have been killed by police and people who have suffered mental illness and been targeted by the NYPD.

The bill doesn't say anything about getting input from people like me and people like my son and any bill or City program that moves forward must be something that we support and are consulted about.

Today I am here to say Intro 2210 will not save the lives of people like my son, Mohamed Bah and that Mateo & Licitra should be fired.

I want to make sure any bill that wants to solve the problem does that – but Intro 2210 creates problems instead of solving them.

I pray that you will listen to me and other families and that you will oppose Intro 2210

City Council Committee on Mental Health, Addictions and Developmental Disabilities

Oversight Hearing: New York City's Mental Health Emergency Response

February 22, 2021

Chair Louis and distinguished members of the City Council, thank you for the opportunity to testify today. I'm Nadia Chait, the Associate Director of Policy & Advocacy at The Coalition for Behavioral Health. The Coalition represents over 100 community-based mental health and substance use providers, who collectively serve over 600,000 New Yorkers annually.

A key concern for our members is the criminalization of individuals with mental health and substance use challenges. Too often, when an individual is having experiencing a crisis, the response is police, when what individuals need is care. Both Intro 2210 and Intro 2222 take important steps to change this response and ensure that individuals who need care don't receive a public safety response.

We are also deeply committed to reducing mental health and substance use crises by connecting individuals to the appropriate level of care in the community. Intro 2210 and 2222 both take important steps to improve crisis response, however additional action will be necessary to reduce the volume of crisis calls. All too often, individuals seeking mental health or substance use care encounter waitlists and other barriers. The right level of care is not always available, so individuals who need a high intensity of service are sometimes unable to receive that, resulting in unmet needs that can lead to a crisis.

Intro 2222

We strongly support a three digit emergency hotline for individuals experiencing a mental health emergency, as proposed in Intro 2222. For this hotline to be fully successful, we encourage the following:

- **The Three Digit Hotline Should Be 988.** The FCC began the process of creating 988 as a national mental health hotline in July 2020, and federal legislation codifying this was passed in October 2020. The legislation allows states to add a surcharge to phone bills to pay for costs and services associated with 988. At the state level, the Office of Mental Health is currently working on the 988 implementation and identifying areas where services will need to be increase. We encourage the city to work with the state and federal government to make the city's three digit hotline 988.
- **Significant Public Outreach will be Necessary.** A key component of the bill is the public outreach and education campaign. While a three digit number is clearly easier to remember than a 10 digit hotline, it's still a new number. It took years for individuals to get used to 911 and 311. Public outreach should include ads on subways, buses, radio and television. These campaigns can also serve to reduce stigma around mental health and encourage individuals to seek care.
- **Collaboration with 911 and 311.** It will take time for New Yorkers to know to call 988. Additionally, many New Yorkers do not have the knowledge to determine what type of

emergency they are seeing. The bill will ensure that 988 operators are capable of receiving calls originating through 911 and 311, which is critical. We encourage the bill to go farther and mandate significant training and new protocols so that 911 and 311 operators know which calls to transfer to 988 and are able to differentiate between a mental health or substance use emergency and a public safety emergency.

Intro 2210

Mental health emergencies should have a mental health response. Intro 2210 will put NYC at the forefront in developing this response and ensuring that individuals in crisis receive a care response. Too many New Yorkers have died in tragic circumstances, when they or their family members called 911 for help, and instead received an overwhelming police response that ended in the death of a New Yorker with mental illness. This legislation will save lives by creating a care response. By creating this model on a citywide scale, Intro 2210 ensures that all New Yorkers will have access to a care response, rather than just select neighborhoods.

We strongly support the inclusion of peers as stated in the legislation. Peers, who have lived experience with mental illness or substance use disorder, are often the most effective response to a crisis, and can connect with individuals in ways that clinicians are not necessarily able to.

For the newly created mental health unit to meet its potential, the City will need to invest in the full array of services that support individuals in crisis. Many individuals in crisis do not need to go to the hospital, but do need care that can be provided outside of their home. Respite centers, such as the two Support and Connection Centers, can provide this effectively. However, there are currently only two of these centers in the city, which will not be sufficient.

We thank the Committee for your attention to this important issue. The Council has identified two important ways to improve the response to individuals facing a mental health crisis. We look forward to working with you on this critical issue.

CCIT-NYC

CORRECT CRISIS INTERVENTION TODAY

FIGHTING TO TRANSFORM RESPONSES TO MENTAL HEALTH CRISES

TESTIMONY

NYC COUNCIL BILL 2210 - 2021

NYC COUNCIL BILL 2222 - 2021

Greetings. My name is Christina Sparrock and I'm a member of the steering committee of Correct Crisis Intervention Today (CCIT-NYC). I have had direct experience with police officers during a mental health crisis. I am a Mental Health Advocate and a Peer Specialist. I am also a Certified Public Accountant.

"Nothing about us without us" has been a core demand by people in the disability community and other marginalized groups for decades.[i] It's a simple concept to understand; that people who have the most at stake in the outcome of a program or policy should be engaged in the design, implementation, and ongoing evaluation of the program's effectiveness. Council bill 2210 violates this principle as it was drafted without any community or peer input.

CCIT-NYC'S Extensive Advocacy to Transform New York City's Response to Mental Health Crises

CCIT-NYC has been advocating to transform the way New York City responds to mental health crises since 2012. Our efforts led to the formation of two mayoral task forces, which resulted in the specialized Crisis Intervention Team (CIT) training of several thousand police officers and other policies designed to improve outcomes for people who experience a mental health crisis. Sadly, after the training program, people in crisis, particularly those of color or Black, continued to be killed by police.

Concerned that the Mayoral task force planning efforts did not adequately include the user voice in shaping public safety policies, CCITNYC organized a Peoples' Crisis Planning session on January 18, 2019 that included over 80 people, most of whom were individuals or family members of people who had experienced a violent or fatal interaction with police officers. This one-day session produced several recommendations to reform the mental health crisis response system, such as:

1. including the deployment of trained peers -- those with lived mental health experience -- and health workers instead of the police;

2. using an alternative health emergency number in place of 911; and
3. ensuring peers are included in all planning initiatives.

This work was described in a CCIT-NYC report[ii] that was shared widely with elected officials and city planners.

In September 2019, the Public Advocate published a plan[iii] to improve the mental health crisis response system that incorporated nearly all of our suggestions, including the need for inclusion of the peer perspective, which stated:

> In order to develop a truly comprehensive plan on this issue, the City must include peers on all advisory councils and bodies relating to mental health crisis response. Additionally, the families of directly affected people must have their voices in this conversation (emphasis added).

In 2020, CCIT-NYC issued a detailed description of a **crisis response program** modeled after the CAHOOTS program in Eugene, Oregon. This proposal was also shared widely with the council and Public Advocate's office and, like the Public Advocate's report included specific provisions for an **oversight body** that would include **peers**, providers, and representatives nominated by elected officials, and relevant government agencies.

The oversight body would actively monitor the crisis response pilot by retaining an independent research entity to collect and evaluate data, publish regular reports, organize planning sessions, and offer recommendations for ongoing program improvement. While of course protecting the identity of individuals receiving mental health services, the work would be open for public review via livestreaming meetings and by posting all reports, public feedback, and other critical data on a user-friendly web portal.

CCIT-NYC'S Concerns with Int. 2210

Role of the Police. Our main concern with the bill is the extensive inclusion of the police as responders, as opposed to the peer-led mental health crisis response team. Police respond to criminals, and people experiencing mental health crises are not criminals. In addition, the police patrol guide explicitly states that a person experiencing a mental health crisis is an "Emotionally Disturbed Person" (EDP) or deranged. This translates to the police treating people experiencing mental health crises as inherently dangerous, when in fact, people living with severe mental illness are over ten times more likely to be victims of a violent crime[iv], and people experiencing a mental health crisis are 16 times more likely to be shot by and killed by police, compared to those without mental illness[v]. In fact, in the past 5 years in New York City, 16 individuals experiencing mental health crises were killed by police -- of whom 14 were Black or other people of color.

Whether police are involved in a mental health crisis is dependent on whether the crisis is also determined to be a "public safety emergency." The bill defines "public safety emergency" far too broadly, thus allowing for police involvement in potentially all calls. The bill's definition of "public safety emergency" includes such vague terms as some undefined "crime" being in progress, the similarly undefined term "violence," and an act which is likely to result in imminent harm or danger to an undefined "the public." The intention of the bill may have been to eliminate police as responders to mental health crises, but it clearly enables precisely the opposite, an entirely unacceptable outcome.

Role of DOHMH. Another critical concern is the proposed role of the Department of Health and Mental Hygiene (DOHMH). DOHMH should not be the entity to actually provide crisis response services. Rather, as the CCIT-NYC proposal suggests, and as is the case with CAHOOTS, DOHMH should contract with peer-driven, community-based organizations that offer quality care to individuals experiencing mental health crisis, are well connected with these individuals, are culturally competent, and have the trust of people living with disabilities. In addition, a Mental Health Council, consisting of at least 51% peers, together with representatives of community-based organizations which are aware of the systemic failures of the police, should be working alongside DOHMH to vet, and then contract with, the community-based agencies. DOHMH should also not be solely responsible for establishing the citywide mental health crisis response protocols and guidelines, but rather should be guided by the Mental Health Council.

Racial Equity. Also of great concern is the fact that the proposed crisis response program does not use a racial equity framework to inform its design and performance. Moreover, the proposed program is to exist in isolation, divorced from a comprehensive public health system that is based on crisis prevention and does not address health and recovery outcomes.

Emergency Response Time. The Mental health emergency response time of 30 minutes poses a great health risk for the person experiencing the mental health crisis, as well as an increased chance of police involvement. It is outright discrimination for emergencies experienced by individuals with psychiatric disabilities to be responded to with far less speed than the emergencies of those who do not have disabilities. Notably, EMS from response time for life-threatening medical emergencies was a mere 8:32 minutes, and even non-life-threatening medical emergencies were responded to in only 10:04 minutes.[vi] Mental health crisis response times must be the same as the response times for all other public health crises.

Emergency Medical Technicians. CCIT-NYC is greatly concerned with an undefined "mental health clinician" responding to mental health crises. Mental health clinicians

largely practice a clinical model where people are diagnosed, medicated and possibly stabilized, but they are often completely detached from the individual experiencing the crisis. Peer trained as crisis responders, on the other hand, have great empathy and can easily build rapport based on their lived experience. Peers can often de-escalate a mental health crisis by using strengths-based language. A person-centered approach, cultural competency, and treating people with respect – all of which peers bring to the table -- make people feel validated and also address the disproportionate incidence of disability among people of color.

In addition to peers, CCIT-NYC strongly recommends that the mental health crisis response teams consist of emergency medical technicians. Oftentimes, physical problems such as elevated insulin levels or urinary tract infections can look like mental health crises, so the expertise of an EMT can be crucial in appropriately responding to crises.

Consultation with peers and other advocates. Additionally, as discussed above, the bill seems to have been drafted without any consultation with subject experts, community-based providers, and, most critically, peers who have firsthand experience with the mental health system and encounters with crisis responders. In the future, we truly hope there is nothing about us without us.

Aspects of Int. 2210 CCIT-NYC Supports

While the concerns above must be addressed in order for the bills to benefit New Yorkers, we wish to point out the aspects of the bill that CCIT-NYC supports and should be kept in amended bills:

1. Establishment of peers as part of the mental health crisis response team.
2. Establishment of an emergency hotline number which is separate from 911, but is capable of receiving calls from 911 and 311.
3. A start-up date as soon as December 31, 2021.
4. Monthly and annual reporting, starting after the first month of operation.
5. "Follow up" by the Mental Health Emergency Response Unit with any individual with whom the unit interacts.
6. A training mandate for the Mental Health Emergency Response Unit.
7. "Monitoring" of the usage of the city's emergency response infrastructure.
8. The stated goal of reducing mental health emergencies "through preventative care."
9. Outreach targeted to neighborhoods "facing barriers to access of mental health care and in which there are a disproportionate number of mental health emergency calls."
10. Dispatch of police for a mental health emergency that can only occur if the Mental Health Emergency Response Unit summons the police after determining there is also

a public safety emergency, and once dispatched, the police "shall follow the instructions of" the Unit and "refrain from engaging with an individual in mental health crisis unless instructed to do so by a member of the [Mental Health Emergency Response Unit]."

11. Trained regarding the mental health emergency response protocol is mandated for all police, as well as "new academy recruits," as is re-training.

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[i] Nothing About Us Without Us: Disability Oppression and Empowerment, University of California Press, 1998.

[ii] Responding to a Psychiatric Emergency: A Vision for Public Health Reform in New York City. Community Access, February 2019.- https://www.communityaccess.org/storage/images/Miscellaneous/Responding_to_a_Psychiatric_Emergency_-_Discussion_Paper.pdf.

[iii] Improving New York City Responses to Individuals in Mental Health Crisis. Public Advocate for the City of New York, Jumaane D. Williams, September 2019 - https://www.pubadvocate.nyc.gov/reports/improving-new-york-citys-responses-to-individuals-in-mental-health-crisis/.

[iv] Mental Health Myths and Facts, 2014- Mental Health.gov: https://www.mentalhealth.gov/basics/mental-health-myths-facts.

[v] Role of Law Enforcement in Mental Illness Crisis Response, July 24, 2020- Research weekly: NAMI Pierce County-https://namipierce.org/research-weekly-role-of-law-enforcement-in-mental-illness-crisis-response/.

[vi] NYC Analytic: End-to-End Detail, NYC 911 Reporting (nyc.gov)- https://www1.nyc.gov/site/911reporting/reports/end-to-end-detail.page.

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February 22, 2021

Testimony of

Ruth Lowenkron, Disability Justice Director

on behalf of

New York Lawyers for the Public Interest

before the

Council of the City of New York

Committee on Mental Health, Disabilities, and Addiction

regarding

NYC COUNCIL BILL 2210 - 2021

NYC COUNCIL BILL 2222 - 2021

Good morning. My name is Ruth Lowenkron and I am the Director of the Disability Justice Program at New York Lawyers for the Public Interest (NYLPI). Thank you for the opportunity to present testimony today regarding Int. 2210-2021 and Int. 2222-2021.

The City must ensure that individuals who experience a mental health crisis receive appropriate services which will de-escalate the crisis and ensure their wellbeing and the wellbeing of all other New Yorkers. Only those who are trained in de-escalation practices should respond to a mental health crisis, and the most appropriate individuals to respond are peers (those with lived mental health experience) and health care

providers[1]. Police, who are trained to uphold law and order are not suited to deal with individuals experiencing mental health crises, and New York's history of its police killing 16 individuals who were experiencing crises, and seriously injuring two others, in the last five years alone, is sad testament to that. Eliminating the police as mental health crisis responders has been shown to result in quicker recovery from crises, greater connections with long-term healthcare services and other community resources, and averting future crises[2].

The scores of people experiencing mental health crises who have died at the hands of the police over the years is a microcosm of the police brutality that is being protested around the world today. Disability is disproportionately prevalent in the Black community and other communities of color[3], and individuals who are shot and killed by the police when experiencing mental health crises are disproportionately Black and other people of color[4]. The City Council simply cannot stand by while the killings continue. Now is the time for major transformations. Now is the time to remove the police as responders to mental health crises. Lives are literally at stake.

Correct Crisis Intervention Today – NYC (CCIT-NYC), which has over 80 organizational members including NYLPI, has developed the needed antidote. Modeled on the CAHOOTS (Crisis Assistance Helping Out On The Streets) program in Eugene, Oregon, which has successfully operated for over 30 years without any major injuries to respondents or responders, the CCIT-NYC proposal is positioned to make non-police responses available to those experiencing mental health crises. The proposal avoids the pitfalls of the City Council' legislation which NYLPI discusses below, and similarly avoids the even greater pitfalls presented by the City's Thrive pilot proposal. Hallmarks of the CCIT-NYC proposal are:

- teams of trained peers and emergency medical technicians;
- teams run by culturally competent community organizations;
- response times comparable to those of other emergencies;

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[1] Martha Williams Deane, *et al.*, "Emerging Partnerships between Mental Health and Law Enforcement," Psychiatric Services (1999), http://ps.psychiatryonline.org/doi/abs/10.1176/ps.50.1.99?url_ver=Z39.88-2003&rfr_id=ori%3Arid%3Acrossref.org&rfr_dat=cr_pub%3Dpubmed&#/doi/abs/10.1176/ps.50.1.99?url_ver=Z39.88-2003&rfr_id=ori%3Arid%3Acrossref.org&rfr_dat=cr_pub%3Dpubmed.

[2] Henry J. Steadman, *et al.*, "A Specialized Crisis Response Site as a Core Element of Police-Based Diversion Programs," Psychiatric Services (2001), http://ps.psychiatryonline.org/doi/10.1176/appi.ps.52.2.219?utm_source=TrendMD&utm_medium=cpc&utm_campaign=Psychiatric_Services_TrendMD_0.

[3] Mayor's Office for People with Disabilities, "Accessible NYC" (2016), https://www1.nyc.gov/assets/mopd/downloads/pdf/accessiblenyc_2016.pdf.

[4] CCIT-NYC, Testimony before the Committee on Public Safety (June 9, 2020).

- 24/7 operating hours;
- calls routed to a number other than 911; and
- oversight by an advisory board of 51% or more peers.

The full text of the CCIT-NYC proposal can be found at http://www.ccitnyc.org/who-we-are/our-proposal/.

CONCERNS WITH INT. 2210 AND INT. 2222

Inappropriate Role of Police. Notwithstanding a goal aligned with NYLPI's and that of CCIT-NYC to eliminate police as responders to mental health crises, the proposed legislation will achieve the precise opposite. **The bill must be amended to prevent the extensive inclusion of police as responders.** The legislation permits police involvement in a mental health crisis when that crisis also constitutes a "public safety emergency." Thus, the narrower the definition of "public safety emergency," the fewer police will be involved. The currently proposed definition of "public safety emergency" is far too broad. The terms goes so far as to include any "crime in progress," irrespective of the severity or dangerousness of the crime. Similarly, the term includes any type of "violence," again without respect to the severity or dangerousness of the violence. In addition, an act which is likely to result in harm to some unspecified "the public" is likewise considered a "public safety emergency." **The term "public safety emergency must be greatly narrowed.**

Inappropriate Role of DOHMH. NYLPI also objects to the proposed role of the New York City Department of Health and Mental Health (DOHMH). **DOHMH should not be the entity to provide crisis response services**. Instead, **DOHMH should contract with a peer-driven, culturally competent community organization** to provide such services -- as CCIT-NYC recommends in its proposal, and as CAHOOTS has been doing for nearly three decades. The City should not merely substitute one bureaucracy for another, but rather should turn to the community which commands the respect of those who might experience a mental health crisis.

Need to Involve Peers. The bill must **ensure that all aspects of crisis response reform – from its creation to its implementation to its oversight – include peers**. NYLPI suggests following the CCIT-NYC proposal to **create a council consisting of 51% or more peers** and which would work together with DOHMH to contract with the community organizations, guide the organizations, and assess their work.

Need to Improve Pubic Health. Although the bill has the stated goal of reducing mental health emergencies via "preventative care," in fact, the crisis response program stands on its own, with no connection whatsoever to a much-needed comprehensive public health system. **The bill must fund mental health services to ensure that mental health crises do not occur in the first place.**

Unacceptable Crisis Response Times. Without explanation**, the bill proposes a mental health crisis response time of 30 minutes**. **This is entirely unacceptable**. Such a delay could literally be the difference between life and death, and is surely why the City's current average response time for life-threatening emergencies is a mere 8:32 minutes[5]. **The City must adhere to federal and state constitutional provisions and federal, state, and local non-discrimination statutes, and respond to the crises experienced by people with mental disabilities in at least the same amount of time it responds to crises experienced by other individuals**.

Inappropriate Involvement of Mental Health Clinicians. Although NYLPI is pleased that the bill contemplates a peer as part of the "mental health emergency response unit," **the choice of some undefined "mental health clinician" to complement the peer is inappropriate**. Mental health clinicians deliver services in a "medical model" that is typically limited to diagnosis and medication. Notably, the very successful CAHOOTS model does not include any variety of mental health clinician. Rather than mental health clinicians, **the legislation should mandate emergency medical technicians who could appropriately handle such physical problems as elevated insulin levels or urinary tract infections, which all too often are masked by mental health crises**.

PROVISIONS OF INT. 2210 AND INT. 2222 WHICH NYLPI SUPPORTS

While the above concerns must be fully addressed in order for New York City to have truly reformed its response to mental health crisis, NYLPI notes the following provisions of the bills of which it is supportive:

- Establishment of peers as part of the mental health crisis response team;
- Establishment of an emergency hotline number which is separate from 911, yet is capable of receiving calls from 911(and 311);
- A start-up date as soon as December 31, 2021;
- Monthly and annual reporting, starting after the first month of operation;
- "Follow up" by the Mental Health Emergency Response Unit with any individual with whom the Unit interacts;
- A training mandate for the Mental Health Emergency Response Unit;
- "Monitoring" of the usage of the city's emergency response infrastructure;
- The stated goal of reducing mental health emergencies "through preventative care;"

[5] NYC Analytic: End-to-End Detail, NYC 911 Reporting (nyc.gov) - https://www1.nyc.gov/site/911reporting/reports/end-to-end-detail.page.

- Outreach targeted to neighborhoods "facing barriers to access of mental health care and in which there are a disproportionate number of mental health emergency calls;" and
- Dispatch of police for a mental health emergency that can only occur if the Mental Health Emergency Response Unit summons the police after determining there is also a public safety emergency, and once dispatched, the police "shall follow the instructions of" the Unit and "refrain from engaging with an individual in mental health crisis unless instructed to do so by a member of the [Mental Health Emergency Response Unit]."

Thank you for your consideration. I can be reached at (212) 244-4664 or RLowenkron@NYLPI.org, and I look forward to the opportunity to discuss how best to eliminate the police as first responders to individuals experiencing mental health crises.

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About New York Lawyers for the Public Interest

For over 40 years, New York Lawyers for the Public Interest (NYLPI) has been a leading civil rights advocate for New Yorkers marginalized by race, poverty, disability, and immigration status. Through our community lawyering model, we bridge the gap between traditional civil legal services and civil rights, building strength and capacity for both individual solutions and long-term impact. Our work integrates the power of individual representation, impact litigation, and comprehensive organizing and policy campaigns. Guided by the priorities of our communities, we strive to achieve equality of opportunity and self-determination for people with disabilities, create equal access to health care, ensure immigrant opportunity, strengthen local nonprofits, and secure environmental justice for low-income communities of color.

NYLPI's Disability Justice Program works to advance the civil rights of New Yorkers with disabilities. In the past five years alone, NYLPI disability advocates have represented thousands of individuals and won campaigns improving the lives of hundreds of thousands of New Yorkers. Our landmark victories include integration into the community for people with mental illness, access to medical care and government services, and increased accessibility of New York City's public hospitals. Working together with NYLPI's Health Justice Program, we prioritize the reform of New York City's response to individuals experiencing mental health crises. We have successfully litigated to obtain the body-worn camera footage from the NYPD officers who shot and killed individuals experiencing mental health crises.

Testimony of Jim Mutton
Director of NYC Operations
Concern for Independent Living, Inc. (www.concernhousing.org)
Steering Committee Member of Correct Crisis Intervention Today NYC (www.ccitnyc.org)

New York City Council Committee on Mental Health, Disabilities, and Addiction
Oversight - New York City's Mental Health Emergency Response
Monday, February 22, 2021 at 10:00 a.m.

Thank you members of the New York City Council Committee on Mental Health, Disabilities and Addiction for allowing me to submit written testimony in regard to proposed legislation **Int. 2210-2021 Creating an office of community mental health and a citywide mental health emergency response protocol** and **Int. 2222-2021 Creating a three-digit mental health emergency hotline.** My name is Jim Mutton and I am Director of NYC Operations at Concern for Independent Living, Inc. and governing member of Correct Crisis Intervention Today NYC. I currently oversee seven multi-dimensional supportive and affordable housing programs in Brooklyn and the Bronx, serving many hundreds of individuals recovering from mental illness, homelessness and related traumas, alongside affordable households, their families and young children. I also volunteer my time and expertise to CCIT NYC which is currently focused on implementation of a peer-run crisis intervention program to respond to individuals in mental health crisis.

I am excited to see proposed legislation to create an office of community mental health and a citywide mental health emergency response protocol, but concerned about the level of police involvement that remains in the model and the absence of community involvement in the proposed operation. Since 2014, CCIT NYC has worked closely with the NYPD under a learning collaborative to train over 20,000 police officers, sergeants and captains in best practices of crisis intervention, in the hope that this knowledge would enable the NYPD to better respond to individuals in mental health crisis. The effort has not been successful. Since the training began, seventeen people have been killed by the NYPD and three others critically injured, while crisis calls top 200,000 per year. My housing directors often have a need for external support for individuals in mental health crisis and I can tell you that the NYPD do not want this responsibility. This is a health issue and not a criminal justice matter 99% of the time. There is clearly a need to move away from a model that uses police officers as first responders to mental health crisis and embrace a nationally recognized model of crisis intervention that employs other professionals. Our pilot proposal believes a trained peer with lived experience and an EMT would be the right alternative in NYC. There is mounting evidence that peer led approaches result in successful long lasting outcomes, without trauma or injury. Having a peer on the team is essential, as a person with lived experience, a person who has "been there," can best relate to the fear of an outsider responding in a moment of crisis, and can prove that recovery works. An EMT worker is needed as many crisis calls may involve physical health issues which are masked by the mental health crisis.

I fully supports the creation of a new three-digit emergency hotline number, in accordance with the planned efforts to introduce a 988-type number on a national scale. Families, loved ones and concerned citizens of those in mental health crisis are fearful of calling 911 as they are typically afraid of the result. Our pilot also proposes the establishment of a new number dedicated to mental health crisis calls such as “WEL” or 988, which anyone can call. The calls would go to the city-run NYC-WELL hotline and would be staffed by trained operators who would send the calls to the mental health crisis response teams. We believe that such an alternative could become an efficient and well-used alternative to our 911 system when responding to mental health crises.

Thank you for your consideration.

PUBLIC HEARING OF
THE COMMITTEE ON MENTAL HEALTH

STATEMENT OF MICHAEL MATOS
BROOKLYN RESIDENT

Monday, February 22, 2021

Good Afternoon, my name is Michael Matos, born and raised New Yorker and a concerned citizen.

I'd like to first thank the council for the opportunity to speak on this incredibly important issue. For a long time, the topic of mental health crisis has often been a neglected subject of conversation, so it gladdens me to see legislation being drafted to address it.

In my experience as a first responder with the U.S Coast Guard, I've learned the extreme importance of utilizing the right resources when handling life threatening situations. In matters of mental health emergency response, our current system is ineffective and proven dangerous.

Officers of the NYPD lack the training, qualifications and judgement to recognize and address mental health crises as they occur. As many before me have mentioned, the countless instances of fatal encounters between those enduring such crises and the NYPD prove that change must be made.

No one reaching out for help while enduring a mental health emergency wants to be deemed a "threat to officer safety" upon first contact.

I'd like to thank Chair Louis and all additional sponsors of 2210-2021 for pushing this bill forward. However, we must relieve the NYPD of this responsibility and ensure their response is refocused to address matters which they are trained and funded for, violent crime.

I'd also like to express my support for 2222-2021 and applaud Public Advocate Williams for sponsoring this groundbreaking bill. The establishment of a three digit hotline dedicated to mental health emergency response is an excellent example of our commitment as a community to effectively handle this ongoing issue. This hits home for myself and the love I have for my military veteran community, where mental health emergencies are unfortunately all too common.

Over the past year, there have been numerous situations where I wish such a hotline existed in which I could utilize to assist my friends who've experienced such emergencies, without them fearing of being mistaken for an active threat.

Thank you for your time.

Testimony before the New York City Council Committee on
Mental Health, Disabilities, and Addiction Hearing
February 22, 2021

Presented by:
Cal Hedigan, Chief Executive Officer
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Community Access expands opportunities for people living with mental health concerns to recover from trauma and discrimination through affordable housing, training, advocacy, and healing-focused services. We are built upon the simple truth that people are experts in their own lives

www.communityaccess.org

Thank you Chair Louis and to the other members of the committee for convening this hearing. As the CEO of Community Access, I lead an organization that has long been in the forefront of efforts to transform our system of care into one where the voices of people living with mental health concerns are centered and play a vital part of the design, delivery and evaluation of services. Our 350 person strong staff work daily to support thousands of New Yorkers living with mental health concerns through supportive housing, mobile treatment teams, training, supported education, advocacy and other healing-focused services. Community Access is also proud to be a founding member of the Correct Crisis Intervention Today in NYC Coalition (CCIT-NYC)[1].

I want to start by acknowledging the work of the Council Members, the Public Advocate, and the staff who have worked to introduce these bills. The goal of each - to eliminate the role of police in responding to mental health crisis calls in New York City - is one that I fully support, and I am prepared to do my part to make this vision a reality in our city. The inclusion of peers as members of the proposed mental health crisis teams in Intro 2210 is a critical ingredient in system transformation. That said, in terms of the proposed legislation, there are some problematic elements that I would like to draw your attention to.

Intro 2210 does not go far enough to remove police entirely from the equation of crisis response. This is a result of the definition of the term "public safety emergency" being too broad. As written, almost anything could be defined as a "public safety emergency" which would lead to the New York Police Department (NYPD) being dispatched—contrary to the very goal of these reforms. Given how many times police responses to mental health crisis calls have resulted in violence or death, the importance of eliminating police as first responders cannot be overstated. A narrower definition of a public safety emergency is needed, such as the one developed for purposes of the CCIT-NYC pilot proposal last year[2]:

> *The mental health crisis response team may ask for police involvement only when the following Exception applies: the person is taking action which is causing serious bodily harm to self or another person or the person wields a weapon to credibly threaten imminent and serious bodily harm to self or another specific person and no other non-police de-escalation measures can safely be taken. Items such as a pocket knife or scissors do not constitute such a weapon.*

During the development of the CCIT-NYC pilot proposal, the coalition held a forum with peers and impacted communities to develop the criteria for when, if ever, police might need to be dispatched to mental health crisis calls. A similar undertaking is needed here. Relying on the overly broad definition of "public safety emergency" in the bill will only result in over-deployment of NYPD and will not meet the reform agenda of the proposed legislation.

[1] http://www.ccitnyc.org/

[2] http://www.ccitnyc.org/wp-content/uploads/2013/08/9.10.2020-CCITNYC-Pilot-FInal.pdf

The two pieces of legislation before this committee today are the result of years of advocacy by New Yorkers who have been harmed by the current emergency response system, where law enforcement officers are the default first responders for people experiencing mental health crises. This flawed system has cost people their lives. Over the last five years, 16 people experiencing mental health crises - 14 of whom were Black or other persons of color - have been killed in police encounters[3]. People who live with mental health concerns and have been harmed in police encounters, as well as their family members, have led the charge, along with advocates and leaders in impacted communities, to transform how New York City responds when a person is experiencing a mental health crisis. These voices have coalesced in a call for the removal of the police and the creation of health-only crisis response teams.

It is for this reason that I was so concerned to see that the perspectives of peers and impacted communities have not been incorporated into every component of these bills. It is critical that peers and impacted communities be at the center of all aspects of these reforms: the development of the proposed Office of Community Mental Health, the establishment and development of the emergency response protocols, any training that is to occur at the NYPD and other relevant agencies, the staffing at the mental health call center that will operate the new three-digit hotline, and in all other arenas where decisions are being made about how to improve the mental health crisis response system. As written, these bills do not incorporate those whose expertise is necessary to realize deep transformation in how our city responds to and supports people experiencing mental health crises.

There are a number of other concerns I have, including the absence of a community advisory or oversight body – comprised of at least 51% people living with mental health concerns - to oversee the development and implementation of the work of the proposed Office of Community Mental Health, the apparent intent to allow the NYPD to control how to train their own officers (a model that has been tried and has failed repeatedly[4]) and the lack of Emergency Medical Technicians (EMTs) in the proposed teams. While I believe that the Department of Health and Mental Hygiene (DOHMH) is a more appropriate home for the proposed Office of Community Mental Health than the NYPD, I remain concerned about how people living with mental health concerns, community leaders and community-based organizations will be called upon for their expertise, and have their input meaningfully implemented in that context. Housing the proposed Office of Community Mental Health within an independent entity that includes a broad representation of stakeholders should be considered.

I am proud of the work Community Access and the CCIT-NYC Coalition have done to prioritize this issue and move the conversation towards a health-only response that puts the needs of people experiencing mental health crises first. These bills contain elements that could be part of the road to a police-free mental health crisis response system, but require significant changes such as those I have outlined here in order to realize that intention.

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[3] https://www.communityaccess.org/ccit-nyc-in-remembrance

[4] https://gothamist.com/news/nypd-abruptly-halts-training-program-meant-help-police-de-escalate-encounters-people-mental-health-crisis

Thank you for hearing my testimony today. I look forward to working with the members of this committee, the Public Advocate, and agency partners to advance policy changes that will save lives.

Hearing of the New York City Council's
Committee on Public Mental Health, Disability & Addiction
Statement by Sonny Barrott
Monday, February 22, 2021

Good Morning, Speaker Corey Johnson, and other members of the City Council.

My name is Sonny Barrott. I am a born and bred Brooklynite and former NYC public school student and Hunter College undergraduate with my B.A. in Psychology. I live in the 39th District of Brooklyn and I would like to address the Committee on Mental Health.

Firstly, I support both Bills being discussed today on the floor Intro 2222-2021 and Intro 2210-2021. We need both bills to address the outcry for social change, greater mental health awareness, city wide police reform and education nationwide. The NYPD who has a long-standing history of racist group think tactics- where group members modify their opinions of the public to match what they think the group consensus thus creating an increase in racial disparities among B.I.P.O.C and P.O.C mental health crisis calls turning deadly.

I would like to site the case of 32 yr. Old Dancer and Personal Trainer Kawaski Trawick, who had a long history of mental health illness and struggled with drug addiction. While standing in his kitchen on the night of April 14th, 2019 was fatally shot and killed by Two police officers who had passed the current departments citywide training on how to handle crisis situations. While Kawaski was holding a bread knife and stick uttered his last question/declaration of cognizance “why are you in my home?” went unanswered and was fatally shot. Understand that no man deserves to die alone.

In the Declaration of Independence Thomas Jefferson wrote "We hold these truths to be self-evident, that all men are created equal, that they are endowed by their Creator with certain unalienable Rights, that among these are Life, Liberty and the pursuit of Happiness." I pray that every man even the ones who are afflicted by mental Illness can be seen as independent American Citizen who should hold these same truths.

Thank You.

Riders 4 Rights

February 24, 2021

Written testimony regarding the bill creating a non-police emergency response for mental health emergencies.

This bill was discussed in the Committee on Mental Health on February 22 at 10:00am.

Creating a non-police emergency response for mental health emergencies
Deadline February 22, 2021
https://council.nyc.gov/testify/

Bill Int 2210-2021

Background:
Sponsored by Council Members Diana Ayala, Speaker Corey Johnson, Public Advocate Jumaane D. Williams, Alicka Ampry-Samuel, Robert Cornegy, Helen Rosenthal, Adrienne Adams, Farah Louis, and Majority Leader Laurie Cumbo, this bill would create an Office of Community Mental Health within the Department of Health and Mental Hygiene to develop a Citywide Mental Health Emergency Response Protocol, wherein mental health emergencies are responded to by a Mental Health Emergency Response Unit, rather than the police. The Office would train relevant City employees regarding the protocol, including the NYPD officers, 911 call operators, and new academy recruits.

Testimony:

We are writing in support of Bill Int 2210-2021, creating a non-police emergency response for mental health emergencies. Proper care for New Yorkers requires the total removal of police from mental health calls, unless specifically requested by trained mental health professionals. While this bill presents a few imperfections without the parallel adoption of a dedicated mental health response line [Bill Int 2222-2021], it is a powerful and necessary step to protect the needs of those with mental health challenges, and to divert money away from policing toward solutions with the expertise, care, and material strategies to address them correctly. We are submitting this comment in support of its passage, and of 2222-2021.

Police are under-trained and under-equipped to respond to the specific needs of a person in mental crisis. In fact, police training runs in direct opposition to the needs of a mental health call; police training *encourages* officers to disregard the needs and the express wishes of a person in crisis. Even in cases where police officers do have de-escalation training or other mental health training, police officers are not experts in identifying mental health crises. The

mere presence of officers that arrive armed and uniformed, can be escalatory by nature to a person in crisis. This is true especially in communities with known and universally acknowledged histories of abuse and mistreatment by police: BIPOC communities, poor communities, LGBTQIA+ communities, immigrant communities, disabled communities, and the unhoused. Those in crisis must be met on their own terms, not with the enforcement of carceral systems. *This is better and safer for everyone involved*, first and foremost the person in crises but also EMTs, mental health professionals and, yes, officers.

One mental health professional, a psychotherapist and life-long New Yorker based in Brooklyn shared the following in June of last year:

> *As a therapist and supervisor at an outpatient community mental health center...I probably oversaw 50 hospitalizations between my own caseload and the therapists I supervised. We did this collaboratively with our clients, who almost always knew they were in danger and that they would be safer hospitalized. Because of the strength of the client-therapist bond, there was trust and a sense of safety; we knew them, we cared about them, and we were there to guide them toward mental health.*
>
> *Protocol around getting people to the hospital was - you guessed it - calling 911. After calling, two to four armed officers would arrive to transport our client.*
>
> *Here is a list, in no particular order, of things that happened often when officers arrived:*
>
> *They made disparaging remarks to the client and/or staff*
> *They hit on me*
> *They escalated the situation*
> *They tried to talk the client out of where they were going. Specific examples I recall hearing include: "You don't look like the type who would put a gun to your head" "It can't be so bad" "What do you have to complain about" "Just go home and have a drink"*
> *They cracked jokes, ignoring the client in need*
> *They handcuffed completely innocent people in one of the most vulnerable moments of their lives. (I witnessed this a few times and it was unconscionable.)*
>
> *Here is a list of things that NEVER happened:*
>
> *They had to use a weapon.*
> *They had to use force of any kind*
>
> *To be clear, the mental health system in this country is broken in a thousand small and large ways. But I can count on one hand the times that an officer was helpful, and I could fill a book with the ways they were harmful. Let's put trained professionals in the role of dealing with this, shall we?*

This is also obviously a resource question as well. We urge the City to invest substantially in the Office of Community Mental Health, reflecting the prioritization of this office in the FY22 City budget. The more we invest in police the more New York City is employing them to solve problems they are not equipped to solve. Over the past forty years, as other social services have been defunded, the New York Police Department has exponentially grown in budget and scope. This solves none of the problems that New Yorkers are facing; instead, it creates an automatic response: criminalize and incarcerate problems of mental health, problems of housing insecurity, and poverty.

As New Yorkers, we have talked to friends and strangers alike in bodegas, on subways, on the sidewalk, as the individuals themselves knew they needed mental health help and did not know where to turn. Many times these individuals voiced fear; fear of stigmatization, fear of incarceration, fear of losing autonomy. We need to fund social workers and mental health professionals with this training to do this work throughout our city.

Policing response to mental health is not an issue exclusive to New York City though. The failures of the operating ethos of police response to mental health crisis is shown throughout the country. This overwhelming pattern throughout the country supports the need to discharge police from the responsibility of responding to mental health calls. Without an effective mental health system, communities have relied on the criminal justice system to provide mental health care and as a result, every year over 2 million people with mental illness are booked into America's jails and prisons.[1] The 2019 report, *Crisis Response Services for People with Mental Illnesses or Intellectual and Developmental Disabilitie*s, by the Vera Institute of Justice compiles a thorough analysis of community-based responses to mental illness across the United States. Their findings are effectively summarized succinctly:

> *Police themselves have been saying for years that they are asked to do too much. Why do we continue to ask them to respond to crisis calls that health professionals could address more safely and effectively?*

We can look to other parts of the country to learn from pre-existing community programs that are working effectively to respond to mental health crises without police.

In Eugene, a program called CAHOOTS moved mental health crisis calls from local police to mental health professionals. That program responded to an average of 17% of emergency calls in the city, and is estimated to have fielded 24,000 calls since its inception, in a city of under 200,000. "A November 2016 study published in the American Journal of Preventive Medicine estimated that 20% to 50% of fatal encounters with law enforcement involved an individual with a mental illness. The CAHOOTS model demonstrates that these fatal encounters are not

[1] Steadman, H.J., Osher, F.C., Clark Robbins, P., Case, B., Samuels, S. (2009). "Prevalence of Serious Mental Illness Among Jail Inmates", Psychiatric Services, June 2009, https://ps.psychiatryonline.org/doi/pdf/10.1176/ps.2009.60.6.761 from 2017 report by Divert to What? Community Services That Enhance Diversion, The National Alliance on Mental Illness.

inevitable."[2] CAHOOTS responders are specially trained in mental health intervention and medical care, and arrive unarmed and plain-clothed. Only 12.5% of cases required additional assistance beyond the response team, most of it medical, and only 0.6% required eventual police or physical intervention. The program costs $2.3M and saves approximately $8.5M each year.[3]

People should not be losing their lives because a system is ill equipped to respond to their needs. Police officers killed Patrick Warren Sr. in Texas while responding to a mental health call by the family on January 10, 2021. Police officers killed Walter Wallace Jr. while responding to a mental health call in Philadelphia, Pennsylvania on Oct. 26, 2020. Christian Hall was killed by the police on December 30, 2020 while also having a mental health crisis. Meanwhile there are countless more individuals who have been killed by police when in a mental health crisis. A fellow member of Riders 4 Rights shared:

> "My friend lost one of his friends having a mental health episode because police shot him. This is a massive failure of police not knowing how to respond to a situation, becoming frightened, and going to the only thing they know how to do: fire a weapon."

Our stance is unequivocal: Police have no business intervening in mental health crises. Their presence in these matters is harmful and their removal is critical. But the removal of police from mental health crisis calls needn't be a pro- or anti-police question. All the available evidence tells us that this approach saves money, saves resources, and saves lives.

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[2] "What Is CAHOOTS?" (*White Bird Clinic*, November 8, 2020) <https://whitebirdclinic.org/what-is-cahoots/>

[3] *Ibid*.

Testimony New York City Council Committee on Mental Health, Disabilities and Addiction
January 22, 2021

Christine Henson

Justice Committee Member

My name is Christine Henson. I am the mother of Andrew Henson, who has autism and limited speech abilities. When he was 16-years-old, Andrew was assaulted by NYPD officers who were working with EMTs. Andrew is a survivor and I count myself lucky that he is alive today.

I'm here to oppose intro 2210 and make sure you understand that it is not going to work to have the NYPD show up along with mental health response teams. My son's experience is evidence that the NYPD is not fit to provide the care our loved ones need.

Shamefully this bill will continue to put families like mine in dangerous situations where we could lose our loved ones with disabilities.

My son needed an evaluation and more services for his disability. Instead, the EMT that was supposed to take care of him and the NYPD brutalized him.

On October 9, 2018 I had set up a meeting with the principal to update Andrew's Individualized Education Plan. During the discussion, the principal recommended that Andrew receive a speech evaluation at BronxCare, the principal arranged for an evaluation to happen on the same day.

The principal then instructed a staff person to call an ambulance to transport us to BronxCare. Prior to the ambulance arriving, two NYPD officers arrived and came into the school to speak with the administrators. When Andrew and I stepped out of the school to board the ambulance, we noticed more than two dozen NYPD officers present around the ambulance. I asked why the police officers were there, but no one gave me a response.

After stepping off the ambulance, Andrew told me he wanted something to eat. I was going to take him to get food, but the EMT grabbed Andrew to prevent him from moving. The NYPD followed the lead of the EMT and within seconds officers rushed over to grab Andrew's arms. None of the officers explained why they were putting their hands-on Andrew. They surrounded my son and piled on top of him.

The security guard choked and twisted his neck, I saw his body go limp while five officers held his arms behind his back. They forced my son on his knees and his face onto a bench. And blocked me from him. The officers ignored my screams that he had special needs.

My son needed medical attention and care that was gentle, not criminalization, abuse, trauma and a near death experience.

My son's experience is exactly what will happen if intro 2210 is passed. This bill ensures that the NYPD will show up along with the mental health response team in many, if not most cases, just as they showed up along with the EMTs in my son's experience.

This bill should not be allowed to pass. It does not honor the families who have lost loved ones to the police who were in emotional distress and it does not honor families like mine.

We also have to remove 911 from the control of NYPD, or else Black and Brown communities will keep being criminalized. Retraining is not enough. If 911 stays with the NYPD, the default will always be to send police.

I ask that you put yourself in my shoes, especially if you are a person of color. I live in fear that Andrew will be brutalized again, or worse, killed. If this bill passes, I will still live in fear. Mental health emergencies can happen to anyone. Our loved ones can have special needs. Do you truly believe they will be safe if the NYPD continues to be sent? We need to break this pattern

and stop criminalizing Black and Brown people who are struggling with mental health and disabilities.

I am the choir
My father was bi-polar all my life
I am on psych meds
I am in recovery
Helping M
Then all residents in my building including myself being the prey of a predator

6:16am Mary Conway-Spiegel gets in elevator to leave building and walk the dog. As Conway-Spiegel turned the corner to return home, walking west on 17th street underneath scaffolding she sees Dr. M with his white Labrador (dog) walking towards her. Mary kept walking assuming that because an Order Of Protection is in place and Dr. M is aware of the order it is his responsibility to avoid Mary and any family member listed on the order. Dr. M and Ms. Conway-Spiegel pass, M stops gets in Mary's face and lunges.
Mary immediately walks a few steps west and then north towards Cafeteria into the middle of the street asking Dr. M to, "please leave me alone." Conway-Spiegel continues walking in the middle of the street towards 136 West 17th Street - Dr. M went immediately back to 136; Mary waits till Dr. M is inside the elevator and out of sight and enters the building. Conway-Spiegel calls 911 at 6:33am

All of the above is explained the police. The fact that Dr. M was monitoring the building-wide, internal security cameras one of which is placed inside the elevator cab and purposely stalked Conway-Spiegel with the intention to harass. The police took Mary's statement and called their supervisor, Officer S Once the supervisor arrived the supervisor and 4-6 other officers on the scene spent at least 45 minutes to an hour with Dr. M inside the building hallway getting his side of the story.
According to building security - onsite inside the building lobby while the supervisor and the other officers were listening to Dr. M - Dr. M claimed he didn't recognize Conway-Spiegel because of her mask. He also stated that, "if you recognized him why didn't you walk away from him instead of walking towards him because he wasn't wearing a mask."

TOTAL NUMBER OF TIMES LAW ENFORCEMENT (NYPD/SHERIFF) HAVE BEEN ON–SITE AS OF 1/10/21 = 24

Testimony provided to the New York City Council
Committee on Mental Health, Disabilities and Addiction
in Response to the Introduction of Int 2210-2021 and Int 2222-2021 – February 22, 2021

Integrating Behavioral Health Supports in Emergency Response Services

NADAP is a community-based social service agency with six offices in the New York Metropolitan area.

One of our service areas is care coordination for individuals with medical and mental health conditions. We provide care coordination to about 5,000 people each year with the majority having co-occurring medical and mental health disorders. About half have both a mental health diagnosis and a substance use disorder.

We work with clients who are non-compliant with treatment. Often, their mental health conditions become exacerbated with the use of substances resulting in crises and emergency services involvement.

Every day, first responders encounter New York City residents who are in crisis. Often, there are underlying factors influencing both the behavior that initiated the call to 911 and the behavior observed by first responders upon encountering the person for whom the call was made.

The underlying factor is often a mental health condition, diagnosed or undiagnosed, or a substance use disorder. Sometimes those behavioral health conditions contribute to what first responders see as violent criminal behavior, and an individual's inability to follow directions and comprehend what is happening to them.

Family members are sometimes hesitant to call 911 for a family member in crisis with a behavioral health problem fearing that the emergency response could lead to incarceration or physical harm to their loved one.

To better manage the emergency situation, first responders need to quickly assess the situation, including any underlying conditions, to choose an appropriate course of action.

NADAP supports the Council's bill to create an Office of Community Mental Health and a city-wide mental health emergency response protocol to add support services to first responders to ensure vulnerable New Yorkers receive needed services with an appropriate response.

We ask that City Council consider the following components in the bill:

- Training for emergency call staff and first responders on assessing and managing behavioral health factors when responding to emergency situations,
- Utilization of brief assessments to identify mental health and substance use disorders,
- Use of video technology to add behavioral health care specialists when responding to emergency calls,
- Feedback and involvement from people with behavioral health disorders to help inform policy decisions,
- Establishing an advisory panel to provide input into the bill and establishment of the Office,
- Utilization of community resources for training and behavioral health services.

Testimony provided by Gary Stankowski, Chief Operating Officer, NADAP, gstankowski@nadap.org

TESTIMONY OF:

Joyce Kendrick, Attorney-in-Charge,

Mental Health Representation Team

BROOKLYN DEFENDER SERVICES

Presented before New York City Council

Committee on Mental Health, Disabilities and Addiction

Oversight Hearing on the City's Mental Health Emergency Response

February 22, 2021

My name is Joyce Kendrick and I am the Attorney-in-Charge of the Mental Health Representation Team of the Criminal Defense Practice at Brooklyn Defender Services (BDS). Over the last twenty years, I have represented thousands of clients living with mental illness in misdemeanor and felony cases in Brooklyn courts. I want to thank the Committee on Mental Health, Disabilities and Addiction, and in particular Chair Farah Louis, for holding this important hearing on the City's response to mental health emergencies.

BDS provides multi-disciplinary and client-centered criminal, family, and immigration defense, as well as civil legal services, social work support and advocacy in nearly 30,000 cases in Brooklyn every year. Our Mental Health Representation Team works to support people living with serious mental illness (SMI) who have been accused of a crime in Brooklyn, representing clients at competency evaluations, hearings and other court appearances during the pendency of their case. In addition, these specialized attorneys regularly consult with others in the criminal defense practice to advise on mental health concerns in their cases and provide internal expertise to all of BDS' criminal defense attorneys. We are also proud of having played an important role in the creation of the Brooklyn Mental Health Court in 2002. The Brooklyn Mental Health Court

works with defendants who have serious and persistent mental illnesses, linking them to long-term treatment as an alternative to incarceration. BDS continues to collaborate with this court to advocate for its expansion to meet the needs of more people, including people with intellectual disabilities and people who have previous criminal legal system involvement.

Emergency Response

For too long, our City has relied on policing and jails to address issues of mental illness and substance abuse. Individuals experiencing a mental health crisis are more likely to be engaged by police than medical providers.[1] Across the country, jails and prisons have become the largest provider of health care, including mental health care. New York City is no exception.

Instances where the police respond to mental health crises often end in abuse or even death, such as in the case of the NYPD killing of Kawaski Trawick in his own home.[2] A 2015 report from the Treatment Advocacy Center found that one in four people killed by police had untreated SMI and that one in every ten calls to police were related to a person with untreated SMI.[3] People experiencing mental health crises who survive their encounters with responding police are often criminalized and subjected to other forms of misconduct. According to the United States Department of Justice's Bureau of Justice Statistics, roughly one out of every four people in jail met the threshold for severe psychological distress within the prior 30 days, as compared to just 5% of the general population.[4] According to the American Psychological Association, at least half of all incarcerated people live with a mental illness.[5] Similarly, people who are unhoused and/or struggling with substance use disorder are more likely to encounter the police and be incarcerated[6]—without having their needs met.

Policing is demonstrably ableist in application; officers respond to people with disabilities with disastrous consequences. Police kill people with autism, people who are deaf or cannot follow verbal commands, people who are neurodivergent, and other people with special needs at much higher rates than the general population; studies show that between 30% and 50% of all people

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[1] National Alliance on Mental Illness, Jailing people with mental illness, 2019, Available online: https://www.nami.org/Learn-More/Mental-Health-Public-Policy/Jailing-People-with-Mental-Illness

[2] https://www.propublica.org/article/it-wasnt-the-first-time-the-nypd-killed-someone-in-crisis-for-kawaski-trawick-it-only-took-112-seconds

[3] Fuller, Doris & Lamb, H. & Biasotti, Michael & Snook, John. (2016). Overlooked in the Undercounted: The Role of Mental Illness in Fatal Law Enforcement Encounters. 10.13140/RG.2.1.1655.9128

[4] Jennifer Bronson, Ph.D, Report: Indicators Of Mental Health Problems Reported By Prisoners And Jail Inmates, U.S. Dept. of Justice, Bureau of Justice Statistics, available at:https://www.bjs.gov/index.cfm?ty=pbdetail&iid=5946.

[5] Collier, L. (2014, October). Incarceration nation. *Monitor on Psychology*, *45*(9). http://www.apa.org/monitor/2014/10/incarceration.

[6] NIDA. 2020, June 1. Criminal Justice DrugFacts. Retrieved from https://www.drugabuse.gov/publications/drugfacts/criminal-justice (last accessed February 1, 2021).

killed by the police have a disability.[7] This stark disparity is also reflected in the numbers of people who are arrested by police and incarcerated. According to another study by the Bureau of Justice Statistics, roughly 40% of people in jail and 32% of people in prison reported having at least one disability.[8] Simply put, building NYPD response into plans to address mental health crises ensures further disparate impacts and harm to people with mental health needs.

Int 2210-2021 – Creating an office of community mental health and a citywide

BDS supports the spirit of Int 2210-2021 in relation to creating an office of community mental health and a citywide mental health emergency response protocol. Families and caretakers of people living with mental illness often feel that they have nowhere to turn when their loved ones are in the midst of a mental health crisis. They recognize that calling 911 to report a mental health crisis will likely trigger a response by NYPD and potentially place their loved one in danger.

For years, BDS has called for a non-police response to mental health emergencies and the expansion of mobile crisis teams.[9] We are hopeful that this program will be successful and remove the burden from caretakers who have too often struggled to access mental health support and care for their loved ones due to fear of police escalation during a crisis.

We respectfully offer the following recommendations to strengthen the legislation and continue to shrink the scope of NYPD response to mental health emergencies:

1. ***Remove NYPD from all mental health responses and create accountability measures for inappropriate NYPD responses***

The proposed legislation allows NYPD to respond in cases that are indicated to be a "public safety emergency" though indicates that NYPD officers should "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." As written, the definition of public safety emergency[10] is too broad and may result in police being dispatched to almost any call.

Allowing the NYPD to continue responding to these calls—even with additional training—does not address the real danger that police pose to people experiencing mental health crises, nor does it prevent the criminalization of mental illness. Police are not mental health experts or medical professionals, nor should they be tasked with filling this role. The legislation specifically assigns to the NYPD the responsibility of training police officers to respond to people in emotional crisis and collaborate appropriately with the Mental Health emergency response teams. We disagree

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[7] Abigail Abrams, "Black, Disabled and at Risk: The Overlooked Problem of Police Violence Against Americans with Disabilities," Time Magazine (June 25, 2020) https://time.com/5857438/police-violence-black-disabled/.
[8] Jennifer Bronson, Ph.D., Laura M. Maruschak, BJS, and Marcus Berzofsky, Dr.P.H., Special Report: Disabilities Among Prison and Jail Inmates, U.S. Dept. of Justice, Bureau of Justice Statistics, available at: bjs.gov/content/pub/pdf/dpji1112.pdf
[9] See our prior testimony on this topic at www.bds.org/policy
[10] 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.

that more resources should be allocated to the NYPD for this training when the purpose of this bill is to limit the NYPD's role in responding to New Yorkers in emotional distress.

Additionally, the bill lacks any real measures for accountability for the NYPD. The spirit of this legislation is to remove NYPD from mental health responses, recognizing the traumatic and sometimes fatal consequences of NYPD response and escalation. While this bill includes a mechanism for reporting on which agencies report to a mental health emergency, it remains unclear what will happen if NYPD inappropriately responds or escalates. There must be clear accountability measures for wrongful police response included in any legislation intended to protect people experiencing a crisis when emergency services are requested.

2. ***Include stakeholders in the Office of Mental Health emergency response planning process***

Int 2210-2021 requires the City to establish an Office of Mental Health and develop a citywide mental health emergency response protocol. The establishment of this protocol must include stakeholders including people living with serious mental illness, people who have experienced NYPD response to a crisis, community mental health providers, and public defenders.

While the legislation calls for the inclusion of many City organizations in the response procedure—including DOHMH, NYPD, ACS, and others—there is no requirement for the City to include people living with serious mental illness or their loved ones. It is critical that people who have lived experience with the current emergency response system be able to share their stories and help shape what comes next. Additionally, because the NYPD is still included in the response to some emergencies under this proposal, BDS encourages the Council to include public defenders, community mental health practitioners, and mental health advocates who have a unique perspective on the impact of police response to people in crisis.

Int 2222-2021 - Creating a 3-digit mental health emergency line

BDS supports Int 2222-2021 which would create a specialized 3-digit mental health emergency line staffed by mental health professionals, in addition to allowing calls for mental health emergency response to be routed to mental health providers through both 911 and 311.
The existing mistrust of NYPD will not be eliminated by the creation of an emergency mental health team. Families and social workers report calling 911 to ask for EMTs to respond to an emotional health crisis but receiving a police response, which escalated a crisis. The creation of another line—and the ability to call 311—will ideally give people in crisis and their loved ones a sense of safety when seeking help. Additionally, a trained mental health provider may be able to provide a brief crisis intervention while on the phone, assess for suicidality, offer supportive counseling, and help someone regulate their emotions and return to a pre-crisis state. A call to a 3-digit emergency mental health line may provide an opportunity to for people in crisis to avoid hospitalization or arrest, stay in their homes, and be connected to community-based care.

Additional Recommendation

Creating a comprehensive plan for emergency response to mental health emergencies is crucial for the City, but this initiative must be coupled with increased support for people living with serious mental illness – including expanded respite centers, access to culturally competent mental healthcare, and the creation of additional supportive housing units.

Provide more respite centers and crisis beds for people with mental illness

Many of the people we serve would not have become court involved if there was a safe place they could go to stay, access medications, and get the support of mental health professionals while addressing a short-term crisis or mediating a concern with a family member or caretaker. While crisis respite centers are available, restrictive policies often prevent people who are court involved, suicidal, or deemed to be acting erratically to access beds. People with SMI could be invaluably served if there were safe, well-known respite centers where adults with mental illness could stay when experiencing a crisis that does not require hospitalization.

In current practice, when NYPD responds to a mental health emergency the person in crisis is handcuffed and transported to a hospital for evaluation or a police precinct. **The establishment of a mental health response team must be coupled with additional resources to meet the needs of people in crisis outside of the emergency room or a jail.**

The Governor has included funding for a stabilization centers in his budget proposal and the City has discussed the need for these services for many years. These centers must be opened, fully funded, and equipped to meet the needs of people who choose to access care in crisis, are ready to engage in treatment and need help to stabilize as they engage in care, as well as individuals who transported by a mental health response team or NYPD. We believe these spaces should be accessible in areas with the highest rates of emergency mental health calls and operated by trusted, community-based organizations, so people in crisis can remain in their own neighborhoods near their support systems.

Close treatment gaps for individuals with serious mental illness

We recognize a need for high quality, trauma informed therapy and psychiatry services for adults with SMI. Inadequate community-based mental health and substance use treatment funnel people struggling with mental illness into handcuffs, jails and prisons. For these individuals, time in City jails frequently exacerbates preexisting mental illness, as behavioral health needs are all too often met with violence and isolation rather than appropriate care. After serving time in jail or prison, people who return to their communities frequently lack adequate healthcare infrastructure and affordable and supportive resources. These inadequacies lead to people falling through the cracks and too often tragic results – either irreversible sickness and death or the churning cycle of incarceration, lapses in treatment, homelessness, and recidivism.[11]

[11] The National Commission on Correctional Healthcare has recognized these dangers. See Nat'l Comm. On Corr. Healthcare, About Us, https://www.ncchc.org/about (recognizing that improving the quality of care in jails and prisons not only "improve[s] the health of their inmates," but also "the communities to which they return").

In order to ensure that every New Yorker is able to access the care they need, we ask that the City expand evidenced-based treatments available to people with severe mental illness before they are engaged in the criminal legal system. This includes expanding access to Assertive Community Treatment (ACT) and Forensic Assertive Community Treatment (FACT) teams, investing in community based mental health treatment programs in low-income communities, and frontline workers—including Health Home care navigators and NYC Well phone-based counselors—on available mental health care options for New Yorkers with severe mental illness.

Increase access to culturally competent, trauma informed providers

Cultural competency is a major barrier to services for many New Yorkers with mental health needs. The existing outpatient mental health programs are not equipped to address the extreme trauma and hardship faced by the people we serve. Receiving mental health care has cultural barriers and stigma for many of our clients. For people who do not speak English, are LGBTQ, have been incarcerated, or do not see their race or ethnicity reflected by providers, receiving mental healthcare that is affirming and culturally competent can feel impossible. For clients with complex trauma histories, the available low-cost mental health clinics do not have the competency or scope of services needed to treat our clients.

We urge the City to invest in free and low-cost mental health services that are designed for people who have experienced hardship, trauma, or incarceration. These programs must be equipped to meet the needs of people who are newly being introduced to mental health care, to create a familiar, nonthreatening therapeutic environment for those who may be hesitant to engage in treatment. Such programs must employ trained clinicians who are fluent in multiple languages. We must not place the burden on the patient to educate the clinician about the realities of incarceration, gun violence, or racism.

Expand access to supportive and affordable housing

People with serious mental health concerns are disproportionately homeless or housing insecure, which creates additional barriers to for people to access the treatment they need to manage their mental illness. People experiencing homelessness may have difficulties connecting to providers, affording treatment or medication, or accessing transportation to appointments.

In the midst of the COVD-19 pandemic, some of the people we serve have been released from City jails or hospitals and placed in emergency hotels. This setting has proven life changing for some of the people with serious mental illness we serve. In lieu of a loud, chaotic and often violent congregate shelters, people have private rooms in clean, comfortable buildings where they are treated with dignity and respect. One client—who has struggled to manage his mental illness while living on the streets—has been in a hotel for several months. In this time, he has been connected to voluntary mental health services, stabilized on his medications, and is able to remain in communication with our office and his treatment team to complete his court mandated programs. The stability and safety of a clean, safe environment where he has access to supportive services on site has changed his life. The City must work to expand access to supportive housing for people with serious mental illness or substance use disorders, as well as ensure access to affordable housing for all.

Conclusion

BDS is grateful to the Committee on Mental Health, Disabilities and Addiction for hosting this critical hearing and shining a spotlight this issue. Thank you for your time and consideration of our comments. We look forward to further discussing these and other issues that impact the people and communities we serve.

If you have any questions, please feel free to reach out to Kathleen McKenna, Senior Policy Social Worker at 718-254-0700 x210 or kmckenna@bds.org.

SAPNANYC

New York City Council
Committee on Mental Health, Disabilities, and Addiction
February 22, 2021

Testimony of Diya Basu-Sen
Executive Director, Sapna NYC

As Executive Director of Sapna NYC, I would like to testify on behalf of **Sapna NYC** and our South Asian community. Access to mental health services and the stigma surrounding it are a significant issue in the South Asian community. A lack of culturally competent linguistically accessible mental health services means that even for those community members who have managed to overcome the stigma surrounding seeking help, it is nearly impossible to find affordable, accessible, and appropriate care. Imagine being a survivor or domestic violence and having to speak through a language line to get counseling. Imagine having to explain the intricacies of the South Asian multi-generational joint family dynamic before being able to delve into the issues you are having at home. While NYC is working to expand mental health messaging and services, it simply does not have the cultural competence or the relationship of trust with the community to effectively provide these much-needed mental health services at this time. **Community-based organizations like Sapna NYC are perfectly situated to not only provide these services in a way that is effective and acceptable for immigrant communities, but also to combat the stigma that keeps our communities from accessing the mental help they need.**

A few weeks ago, our health worker told me that one of the mothers in her child health program shared that she was being abused by her husband. She had been in the program for six months, spending countless hours talking to our health worker about her baby, their eating habits, her fears of being a new mother, but she never mentioned any problems with her husband. It took her six months to share that she was in trouble and that she would like to speak to someone. It took her six months to trust us enough to tell her story and even consider that there could be a future for her that did not include the abuse she had been facing for years. It turned out that she was not yet ready to take the step of leaving, but she did want to start speaking to someone. She wanted to find ways to cope with her current abuse as well as build towards a future without it. She did not want to seek help anywhere else because she said she trusted the Sapna staff—that we felt like friends and that she was comfortable with us, that she could speak to us in Bengali and that we would understand her culture. These are the women who are in need, but unless they can get these services from a community-based organization they trust, will never access mental health services. Furthermore, when coming to a place like Sapna NYC, women like this mother can not only access mental health services, but also English classes, yoga/wellness classes, computer programs, and case management all in her mother tongue without any extra burden placed on her.

The COVID-19 pandemic has disproportionately impacted working class immigrant communities who suffered from high rates of infection and skyrocketing unemployment. It has placed a heavy mental burden on our community including loss and grief, isolation, extreme fear, economic instability, food insecurity, and prolonged life-threatening illness. Our immigrant communities were at the epicenter of the pandemic and every member of our community has experienced loss without the traditional means of coping, grieving, and gaining closure. Even as we begin to emerge from the pandemic, we understand that the mental toll of months of fear and uncertainty will last for months and even years to come. That

is in addition to issues like domestic violence, imposter syndrome, lack of autonomy or independence, isolation, depression, familial pressures, etc. that we always see in our community. In addition to insufficient linguistically accessible services for the South Asian community, most providers and agencies are not able to offer culturally competent programming that makes these services truly accessible. This is particularly true when it comes to mental health services for immigrant communities. These communities require in-language services from someone they trust from an organization that understands the cultural context of their experiences.

Sapna NYC, Inc. is a community-based organization that works with South Asian immigrant women at the intersection of health, empowerment, and advocacy. We are the only CBO in the Bronx that can offer culturally attuned programming and services to the pan-Asian community in Bengali, Sylheti, Hindi, and Urdu. We work to increase access for our women – access to services, access to knowledge and information, access to systems, and access to pathways for social mobility. We deliver culturally attuned and linguistically accessible programs with the belief that physical and mental health, economic empowerment, and women's empowerment are all linked and that to truly address one, we must address all. Our services are holistic and allow women to access multiple needs all at the same time in the same place. At Sapna we not only provide direct services and education, we also strive to lift up the voices of our community and fight to make their needs heard.

The Asian Pacific American (APA) community is by percentage the fastest growing group in New York City, nearly doubling every decade since 1970 and making up over 15% of the population. **NYC's Bangladeshi population is among the fastest growing ethnic groups and according to NYC MOIA, there has been an 83% increase from 2008 to 2018 with close to 100,000 Bangladeshi New Yorkers reported in their 2019 report.** While these communities are growing by leaps and bounds, particularly the Bangladeshi community in the Bronx, resources for our community are not growing at nearly the same pace. It is imperative that NYC invests in community-based organizations that can provide culturally competent and linguistically accessible mental health services to the communities with whom they have spent years developing a relationship of trust. These organizations can not only take a traditional clinical approach to mental health, but also to consider various cultural and alternative ways of approaching mental well-being. **These holistic mental health services will ensure that our most vulnerable New Yorkers are not left behind and that as a city we have a truly equitable recovery from the pandemic that does not just focus economic and physical health recovery, but on the deep and devastating mental impacts that unaddressed will keep our communities from healing and moving forward. Immigrants are the backbone of our city and it is our responsibility to make sure that we invest in the services and organizations that serve them. While we understand that resources are being stretched even more than usual, we have an obligation to pass a moral budget, one that does not balance the budget on the backs of the city's most vulnerable communities.**

The Arab American Association of New York

Testimony of the Arab American Association of New York on Mental Health Crisis Response

February 22, 2021

Chairperson Ayala, members of the Committee on Mental Health, Disabilities and Addiction, I want to thank you for the opportunity to testify before you here today. My name is Zaynab Tawil, and I'm the Domestic Violence Program Manager and Community Mental Health Organizer with the Arab American Association of New York.

Mohammad Bah was many things to many people - a son, a brother, an honor student, and a friend. When his mother called an ambulance to assist him during a mental health crisis on September 25, 2012, though, the NYPD officers who actually responded to her call saw him differently. Without the training or knowledge of how to properly respond to his mental health crisis, they did what they do far too often and ended his life. Almost a decade later, New York's Arab and Muslim live in the shadow of Mr. Bah's killing, but we know his case is far from unique. To say that there's a profound mental health crisis in New York's Arab American community would be an understatement. The lack of access to mental health care available to the Arab Americans and the stigma surrounding accessing it has done a great deal of harm in our community. For years, families and lives have been irreparably damaged as a result of lack of access to affordable and culturally sensitive mental healthcare accessible mental health care for Arab Americans. Since the beginning of the COVID-19 epidemic, these challenges have intensified severely. Families and individuals in our community are starting to crack under the pressures of loss of income, at-home schooling, domestic quarantine, and countless other mental health stressors caused by COVID-19. Lack of access to mental healthcare has created a crisis in our community, but the NYPD's response to this crisis has created a string of tragedies, both small and large, in our community for decades. It is time for this to end.

Other organizations have testified about the countless cases like that of Mohammad Bah, but I'd like to bring attention to a quieter but equally insidious effect of our city's current mental health response crisis - just how easy it is for victims of spousal and domestic abuse to slip

through the cracks. Arab Americans of all ages and from all backgrounds have been acutely affected by the mental health effects of this crisis. Of particular worry, though, is the alarming jump in incidents of domestic and partner violence, both reported and unreported, our community has seen. It is an unfortunate truth that in some traditional Arab households, it is all too common that women can find themselves victimized at the hands of abusive partners who wield absolute power over their lives. Before COVID, organizations like AAANY provided women at risk of falling into these situations with resources and information that could protect them from abuse, and we have fought to keep doing so through COVID-19. However at-home quarantines, loss of access to culturally acceptable spaces outside the home, and increasing household tensions surrounding at-home schooling and loss of partner income have put thousands of Arab women quite literally in situations where their lives may be on the line.

Almost always, the NYPD is the first and too often only lifeline women in these situations have. When an instance of domestic abuse is responded to by a law enforcement officer untrained to handle these situations, the risk to everyone in the household is dramatically increased be that the risk of the NYPD escalating violence towards someone in the house, or even worse waving off the patterns of abuse in the house and allowing them to continue. Every domestic abuse situation is unique, delicate, and volatile, and the level of care and response they require simply can't be provided by an average patrol officer. The creation of a citywide mental health emergency response protocol could provide victims of abuse with a lifeline to help and resources they otherwise wouldn’t have, and could provide a route to recovery and healing the system currently can’t provide.

It is imperative that the City create an office that directly responds to and manages mental health crises in New York City. However, we cannot support legislation that involves the police in this process. Our city’s response to mental health crises has already destroyed thousands of lives, and the police have played a major role in this destruction. We cannot continue to allow them to play any sort of role in the response to mental health crises, lest we find ourselves repeating the same mistakes in a new framework.

My name is Katrina Corbell, and I am a resident of New York. I am testifying in support of the establishment of an Office of Community Mental Health, and having such an Office establish a three-digit hotline, staffed by mental health call operators, for individuals experiencing a mental health emergency.

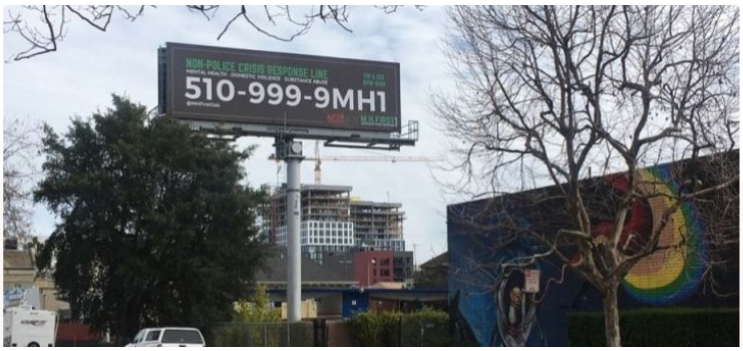
Intro

Yes, NYC needs an active alternative to 911 for mental health crises; ideally if 911 could yield a mental health response team, then fine, all's well. However, currently, 911 even for a mental health crisis does not yield a mental health response team. It yields police more to "protect" other responders and the community at large more than providing service to the person having a mental health episode, police likely not trained in mental health, not trained in the three thousand hours of practicum outside of the hundreds of hours of education and homework learning of the various psychological and psychiatric conditions, which drugs—prescription or/and others—may be enhancing underlying conditions, and skills in de-escalation (hint, not flashing a gun or pepper spray or flash bombs/flash grenades as all of those can excite or trigger someone already having a moment).

I will provide two examples from the West Coast friends of mine have happened to share with me this week on social media, as an example of what is already up and running. One, in Oakland, California was started last year, while another in Eugene, Oregon has lasted over 30 years! I will then also touch base on a few NYC programs that hopefully you have heard of, or may look into as you consider moving this program into future phases of development and implementation.

Oakland, CA

Mental Health First Billboards in Oakland



$13,000 raised of $12,200 goal

266 donors | 1.2K shares | 266 followers

Share

Donate now

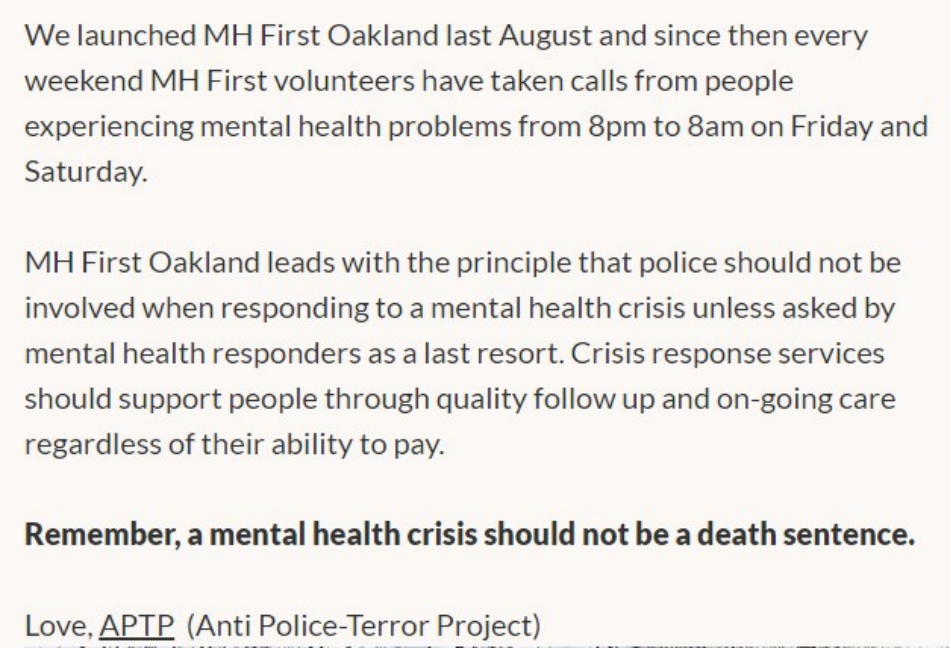
Anti Police-Terror Project is organizing this fundraiser.

Created February 17, 2021 | Volunteer & Service

Oakland,

We need your help to get the word out about Mental Health First Oakland . This is a free non-police response to a mental health crisis. We want to raise awareness of this resource for our community so that folks know it's available and we don't need to call the police anymore.

Please consider donating to fund the billboards. It will cost $12,200 to pay for three billboards to be put up in Oakland starting on February 15th. We will utilize the money raised to pay for these billboards



Above are screenshots for a fundraiser for billboards a friend shared on facebook earlier this week. In Jungian terms, synchronicity. Links are below for more information, it is in the San Francisco East Bay, or, Oakland, California area and was started in August 2020.

Fundraiser by Anti Police-Terror Project : Mental Health First Billboards in Oakland (gofundme.com)

Their website for further information is https://www.antipoliceterrorproject.org/mh-first-oakland.

Eugene, OR

Although other examples in my links and from a quick google search show police forces that are trained from 4, 8, and 40 hour mental health courses, and in some cases such officers would still respond with a clinician or clinician in training, though to the person or persons they are responding to, they are still a police officer, a cop.

One example that I hope others have brought to your attention already is in Eugene, Oregon; they're CAHOOTS, which serves as an alternative to the police, though yes, they also know when to utilize police in emergency situations. From brookings.edu:

> ***CAHOOTS—Eugene, Oregon***
> The Crisis Assistance Helping Out on the Streets (CAHOOTS) program is an initiative led by the White Bird Clinic, a Federally Qualified Health Center (FQHC) located in Eugene, Oregon. The program consists of two-person teams: one medic, nurse, paramedic, or EMT; and a crisis worker trained in social and behavioral health services. CAHOOTS calls come in through Eugene's 911 system through which local police dispatchers are trained to recognize non-violent, behavioral health focused situations and can route calls directly to the CAHOOTS team. The specialized team responds – without police officers – to first assess the situation. If necessary, the team can then call for immediate police backup; otherwise, the team stabilizes the individual within the community. When there is a case of urgent medical need or psychological crisis, the team can undertake an assessment, supply information and referrals, or provide transportation to the next step in treatment. In 2019, of the 24,000 CAHOOTS calls received, police backup was requested only 150 times. The budget for CAHOOTS is about $2.1 million annually.

Young Minds for Mental Health describes the need for CAHOOTS brilliantly in their article, drawing attention to the issue of people living with mental illnesses facing police (seems like this may also fall under Americans with Disability Act, as those living with Disabilities have the right to be protected, so shouldn't the city, counties, and state protect people with any and all disabilities from likely deaths, in this case from police brutalities? Including, but not limited to, persons with SMI but also the classic cases of persons having seizures or severe asthma flare ups being ignored resulting in their deaths? Hmm? Off topic, but still gets to me. RIP, Eric Garner et al) :

> Across the country, police officers are faced with the task of responding to mental health crises at unprecedented rates. Law enforcement agencies estimate that anywhere from 5 to 15% of their annual calls involve an individual with a mental illness. Despite the fact that police officers are likely the first responders, they often lack the appropriate training to respond to mental health crises, putting the 11.4 million Americans that endure severe mental illnesses at risk in these situations.

> While there has been huge progress in fighting for mandated mental health training for law enforcement officers, this leads to the question – should they be responsible for these calls? Does inserting an ill-prepared police officer into an already chaotic situation put people in crisis at greater risk? Doesn't it seem odd that people experiencing a crisis are more likely to encounter a policer officer than a medical professional? People living with mental illnesses are *16x more likely* to be killed in a police encounter compared to a typical civilian. Yes, *16x more likely*.
>
> Police officers have enough responsibilities to begin with, and mandating specialized social work training will not solve the issue at hand. There should be a team of responders equipped to help people in crisis. We have ambulances stocked with EMTs ready at any moment, so why not develop the same teams to focus on mental health emergencies? Embracing this exact mentality, the city of Eugene, Oregon has established a team called **CAHOOTS (Crisis Assistants Helping Out On The Streets).** (From www.youngmindsformentalhealth.com)

And, from wakeforestlawreview.com:

> In Eugene, Oregon, when police receive psychiatric crisis calls, they aren't usually the ones dispatched.[17] Cahoots, Oregon's 30-year old program diverts nonviolent, often mental health-related 911 calls to a medic, nurse, or EMT and a crisis worker with years of experience in mental health.[18] The teams drive up in white vans stocked with medical supplies, blankets, and water while wearing boots, jeans, and T-shirt and helps with issues such as counseling, suicide prevention, substance abuse, housing, and medical care.[19] Tim Black, the Eugene Cahoots' operations coordinator noted that "[the] difference in uniforms can assist folks with letting their guard down and being open to accepting the help that is being offered."[20] For people with a history of volatile arrests often while in mental health crisis, this approach could help make treatment more accessible, safer, and less traumatic.[21]
>
> Far from the police approach of name and up against the car, the Cahoots team respond to these heightened situations and present themselves in a non-threatening manner in order to prevent an escalation of the situation.[22] A team like Cahoots helps deescalate heightened tensions in a crisis situation while also attempting to resolve the problem without having to go through the channels of the criminal system.[23] Ensuring that those who need help are greeted by the people who have the ability and training to help them and point them to further resources within the community.[24]
>
> Additionally, the Eugene Police Department uses its Cahoots staff for other highlight-emotional circumstances too.[25] For example, Cahoots delivers death notices, hand out water bottles and socks to people living on the streets, and take after-hours community medical referrals.[26] Furthermore, the staff offers those services to the city for half the cost of a police officer.[27]

(More sources describing CAHOOTS and those presented are listed here for more information: https://www.cnn.com/2020/07/05/us/cahoots-replace-police-mental-health-trnd/index.html

http://wakeforestlawreview.com/2019/10/in-cahoots-with-the-police-how-eugene-oregon-teams-police-officers-with-mental-health-professionals-to-create-an-alternative-response-system/

https://youngmindsformentalhealth.com/2019/09/27/mental-health-responders-in-cahoots-with-eugene-oregon/

https://www.eugene-or.gov/926/Crisis-Intervention-Training

https://www.theatlantic.com/politics/archive/2020/12/cahoots-program-may-reduce-likelihood-of-police-violence/617477/

https://www.brookings.edu/research/innovative-solutions-to-address-the-mental-health-crisis-shifting-away-from-police-as-first-responders/)

There are many, numerous organizations currently responding in localized ways at the moment to help with surviving the various aspects of COVID-19 including, but not limited to, the 14, 21, 30 day periods of the SARS-CoV-2 itself; the long haul, post-covid, and/or what has how been named "PASC" as of Feb 2021 by Dr. Fauci; those who have lost a friend, family member, partner colleague, or other community member to COVID-19 or a complication from COVID-19; all of the millions of people who have missed work or are continuing to miss work due to the work and school closures or/and changes following the outbreak of SARS-CoV-2 and COVID-19.

I still recall in the middle of March, 2020 friends putting out a call for how to organize, set-up ways to help others. I suggested using models from the Occupy Sandy days, and all of us perhaps were hopeful or/and naïve in thinking it may be a quick response, as even the governor had initially only called for a 14 day shut-down following what some educational employees would have done with or without his and the mayor's support. And, tapping into some loosely knit from previous time's networks, a re-emergence of mutual aid networks popped up, primarily but not exclusively focused on geography. The, or a, common unifying cause was the mutuality and how

all were uniting to help one another, and how perhaps some people would need help before they were able to offer help. However, that was acceptable. No proof of identity. No proof of economic stability. No proof of citizenship. No proof of residency. Just a request for assistance, which, by today's U.S. standards, is unfortunately a risk, one that some of us are encouraging people to not be ashamed in admitting one needs nor taking, yet ensuring one can find a reputable agency to take such a risk with. Not, for instance, an agency known for its reputation of colors such as "black and blue" when seeking warmth and comfort.

Brooklyn's **The Base** is one such place that had proposed training people in Emergency Mental Health Rapid Response, similar to Eugene OR's CAHOOTs program over 4 years ago. It would be a form of Peer Advocacy, or Peer Outreach, an alternative to calling 911 and risking having someone's loved one or roommate becoming killed by police officers who first arrive and oft overreact rather than arrive and de-escalate the situation, despite what any law enforcement claims about *x* number of hours trained in mental health. Police instinct is still their instinct and they are still known for killing asthmatics, shooting people in one's own public housing apartment buildings, driving through intersections just to pull into Dunkin' Donuts parking lots (no, no robbery or other crime was occurring, they just did not want to miss a yellow light and display patience! And yes, not just Dunkin' Donuts, dinner tends to be more open.), having to be pressured to even try and care about investigating murders of transgender people.

Yet, how one may respond to peers is potentially more intimate than with cops; complete strangers or even perceived enemies versus someone more relatable. An ally trained in de-escalation versus pepper spray and LRAD? And, yes, as with CAHOOTS, trained to know when to call the police for truly emergent needs, yet trained to know how to de-escalate so many of those to prevent so many misfortunes from occurring.

New York City has far more than Eugene's 170,000 people, I understand! That is why we need the infrastructure and support to have a more unified network similar to that of our current **Crisis Respite centers**. I only know a glimpse of them so far, and hope that they have spoken already or will be invited in for information gathering and input in this process. It seems like they would be a great place to start, having developed rapport with local community hospitals and are across the five boroughs, likely have other community connections with local artists and non-profits, community centers, et cetera including alumni that may be able to give feedback that may not have heard about this meeting, this opportunity to present testimony.

I hope that it will not turn into like our current street homeless outreach scenario, where certain agencies seem to bid and win exclusive rights for exclusive areas, then miss those of us who are homeless on the subways although we pass by said "outreach workers,", often above ground sitting in their heated vans. Or like different contracted agencies that claim they cannot help until one is back on the streets, yet then say they are only homeless prevention and should have been contacted before one was on the streets. Or can only help under 26 year olds, or under 23 year olds, or over 50 year olds, or other ifs, ands, or buts, when people in crisis are people in crisis and need help, not police, not policies. Assistance.

I hope that this more egalitarian, where all who want to help are able to find a way to help, to be involved, acquire funding, and not overstep each other or overshadow each other. Working together instead of against one another is always more efficient. Although, one may sense why that does not apply to the NYPD? See below.

DV/IPV: Domestic violence and Intimate Partner violence are two essential times when this type of funding may be key. Currently, NYPD advertises there is a worker posted at each precinct that one can talk to, however each precinct's specialist has various hours and they are not posted, are not known to colleagues, and the cops on duty do not know how to respect a person coming in seeking guidance in filing a report thought to be necessary in obtaining a Temporary Restraining Order (TRO) (and, hint: in Family Court proceedings, it isn't: just file at the Civic Court and skip the city police; spread the word). Some of the aforementioned examples have talked about how domestic violence cases are part of what their community mental health projects involved, included, played a role in addressing, and as I can speak first hand in how the NYPD did not help me in my DV/IPV case, and reluctantly helped me after trying to back out of providing assistance when a stranger attacked me in Hell's Kitchen in 2018, not all of us trust the police, and such incidents lead to us not intending to ever confide in the police, want our tax dollars to fund the police programs that seem to not work, and would rather fund programs that are person-centered, train people who will invest time and energy in learning a specialty related directly to what they are doing for their work, and be able to implement that as their day to day work, not reaching for guns, or pepper sprays, or tasers, or reaching for handcuffs and accidentally grabbing and shooting a gun at a person's back, killing them instead.

DV, IPV cases are unfortunately present even among police communities. I have no current statistics on that right this second, but coming from a fundamentalist, working families background, I grew up where everyone presented themselves as though everything was fine and there was nothing wrong at all. Public image was everything, and never ask for help. That is the stigma that needs to be addressed, the barrier that needs to be broken, on all sides by people, again, who are specialty-trained in this arena. Even if, as in some cities, some police officers

were to become peer certified and focus on that as their main specialty, then they can choose to work among their peers, cops, to help address the internal strife's that need to be addressed, and that's another topic for another testimonial day. Stories have made the news recently however, across gender lines, about DV/IPV within NYPD and NYPD families. Hence why I am still including it.

Again, a person having, experiencing, enduring an emotional, spiritual, mental health crisis is bound to respond better to a friend, ally, peer, "average Joe" or "average Jane" trained in de-escalation and Peer Support and other techniques, dozens and often hundreds if not thousands of hours of specialized courses if not years of experience in person-based communication, psychology, sociology and other classes, to learn how to relate to people, how to bond with people, how to communicate with people, how to ensure the safety and wellness of the person, themselves, and those around them. And, all at a fraction of what the police department costs, and with little to zero criminal records for the people having a mental health crisis at that moment. De-escalation, de-criminalization. Humanization.

Thank you.

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Testimony of Beth Haroules
On Behalf of the New York Civil Liberties Union
Before the New York City Council Committee on Mental Health, Disabilities and Addiction Regarding Oversight – New York City's Mental Health Emergency Response and Ints. 2210-2021 and 2222-2021

February 22, 2021

The New York Civil Liberties Union (NYCLU) appreciates this opportunity to submit the following testimony regarding Oversight of New York City's Mental Health Emergency Response and Ints. 2210-2021 and 2222-2021.

The NYCLU, the New York State affiliate of the American Civil Liberties Union, is a not-for-profit, nonpartisan organization with eight offices across the state and over 180,000 members and supporters. The NYCLU defends and promotes the fundamental principles and values embodied in the Bill of Rights, the U.S. Constitution, and the New York Constitution through an integrated program of litigation, legislative advocacy, public education, and community organizing. In the forefront of those efforts has been our defense of the rights of those individuals with disabilities under the Federal Constitution and the New York State Constitution. Another key component of the NYCLU's work is to protect New Yorkers against abusive and discriminatory law enforcement practices. The NYCLU has also long been a coalition partner of both Correct Crisis Intervention Today – NYC (CCIT-NYC) and Communities United for Police Reform (CPR).

We urge the Council to withdraw Int. 2210 and to develop a truly comprehensive mental health system – one that is based on prevention, that includes an appropriate and comprehensive strategy for responding to people experiencing mental health crises, one that actually does not embed and perpetuate New York Police Department (NYPD) involvement as responders and that uses a racial equity framework to inform its design and performance.

We all know that NYPD officers have long been the first to respond to 911 calls about New Yorkers experiencing issues related to mental health, homelessness, and substance abuse.[1] But police are not mental health counselors or social workers; they lack the comprehensive training and skills needed to provide the safe and appropriate response to those in distress.[2] Moreover, the presence of armed police officers too frequently escalates crisis situations. In worst case scenarios, officers use force in response to a person in crisis, causing serious bodily injury and, as has been the case with too many New Yorkers, death.

Mental health crises are health issues not criminal ones, and New York City has a duty to respond to them as such. New Yorkers in crisis deserve the care and support of trained, community-based, culturally competent health professionals. New Yorkers deserve a well-funded system of respite care centers, mental health urgent care centers, drop-in centers for those with mental health concerns and safe havens for people with mental health concerns. These services must be easy to access, open to the public 24/7, and prioritize serving those neighborhoods that struggle most with crises. A service delivery system of this sort would provide people with mental health conditions resources and support that can stop crisis situations from emerging. Development, and investment, in community-based organizations that improve overall quality of life will subsequently improve Citywide mental health, and must be prioritized. Continuing to vest the response to mental health and addiction crises in the hands of the NYPD, as Int. 2210 does, is not the right response.

The City's Current Response to Mental Health Crises

Currently, NYPD officers and the New York City Fire Department's Emergency Medical Services 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.

For the past five years, the City adopted a crisis intervention training program intended to train NYPD officers in de-escalation techniques they should use while interacting with people experiencing a mental health crisis. Yet, since this training program began, 16 New Yorkers in a mental health crisis were killed during confrontations with police and another

[1] The NYPD estimates that it receives over 175,000 emergency calls for service involving a person in a mental health crisis a year. *See, e.g. Mayor de Blasio, First Lady McCray and City Council Members Announce $37 Million Annual Investment in New Strategies to Address Serious Mental Illness,* October 21, 2019 (noting mental health 911 calls numbered 179,569 in 2018), available at https://www1.nyc.gov/office-of-the-mayor/news/496-19/mayor-de-blasio-first-lady-mccray-City-council-members-37-million-annual-investment. *See also New York City announces new mental health teams to respond to mental health crises,* November 10, 2020 (noting the "overall number of mental health 911 calls fell by over 8,000 in 2019 [and t]his decline […] has continued into 2020"), available at https://thrivenyc.Cityofnewyork.us/news/announcements/new-york-City-announces-new-mental-health-teams-to-respond-to-mental-health-crises.

[2] Police have limited options, all grounded in traditional policing models of command, control and coercion principles, when responding to a person in crisis. They may arrest the individual; refer the person to mental health services or transport the person for an involuntary psychiatric evaluation; resolve the situation informally, for example, asking the individual to leave the scene; or if the individual is a crime victim, take a report and perhaps provide assistance.

three were shot and critically wounded — compared to seven people killed in the seven years prior to when the program began.[3] That training program was terminated, without public notice, at some point during the pandemic.[4]

The City has assembled a limited array of "non-police" teams for mental health outreach but has severely restricted the types of situations they may respond to and limited their availability.[5] None of the non-police teams are linked to the City's 911 system which might

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[3] The following individuals either died, or suffered grievous harm, at the hands of NYPD since the NYPD began its crisis intervention training in 2015: Mario Ocasio–June 2015; Rashaun Lloyd-June 2016; Deborah Danner-October 2016; Ariel Galarza-November 2016; Dwayne Jeune-July 2017; Andy Sookdeo-August 2017; Miguel Richards-September 2017; Cornell Lockhart–November 2017; Dwayne Pritchett–January 2018; James Owens-January 2018; Michael Hansford-January 2018; Saheed Vassell-April 2018; Susan Muller-September 2018; Michael Cordero-March 2019; Jarrell Davis-March 2019; Kawaski Trawick-May 2019; Kwesi Ashun-October 2019; Peyman Bahadoran-June 2020; George Zapantis-July 2020. *See, e.g.* CCIT-NYC: IN REMEMBRANCE, available at https://www.communityaccess.org/ccit-nyc-in-remembrance.

[4] In 2015, after years of pressure from advocates, the NYPD agreed to train its officers on how to interact with and de-escalate situations where people apparently experiencing a mental health crisis. According to the City and the Mayor's Management report, around 18,000 NYPD officers have received the training since then, at a cost of $5.3 million dollars a year. But, the City had fallen years behind its goal of training 23,000 NYPD patrol officers by 2018, and the efficacy of the program was questioned by some of the same advocates who initially pushed for it. This training program was abruptly terminated and all NYPD staff affiliated with the program reassigned to other duties at some point during the pandemic. Although NYPD has indicated that the program will be resumed, whether the program has been halted indefinitely or canceled outright is still unclear. *See NYPD Abruptly Halts Training Program Meant To Help Police De-Escalate Encounters With People In Mental Health Crisis*, Gwynne Hogan, WNYC, September 25, 2020, https://gothamist.com/news/nypd-abruptly-halts-training-program-meant-help-police-de-escalate-encounters-people-mental-health-crisis.

[5] NYC has a limited number of mobile crisis teams – and had previously proposed, but then withdrew from this year's budget, adding five mobile crisis teams to respond to crisis calls. The mobile crisis teams cannot respond to 911 emergency calls. Mobile crisis teams also do not have a means to transport people to drop-in centers, hospitals, or other appropriate healthcare resources. If transport is required, mobile crisis team members must call 911. In addition, mobile crisis teams at best respond to the immediate crisis at hand, and do little to ensure the mental health recipient is connected to longer-term community resources. Mobile crisis teams do not always have a peer – an individual with lived mental health experience – on staff and they utilize the no-longer acceptable "medical model," which often focuses narrowly on medication rather than a person's ability to recover and live well. Moreover, mobile crisis teams consist of five staff members and are relatively expensive. Mobile Crisis Teams, which are run by hospitals and staffed by social workers, are only dispatched through the NYC Well mental health hotline, generally to individuals with a pre-existing relationship to the hospital. Mobile Crisis Teams can take up to 48 hours to arrive on the scene. Crisis Services/Mental Health, available at https://www1.nyc.gov/site/doh/health/health-topics/crisis-emergency-services.page.

New York also has Health Engagement Assessment Teams (HEAT teams) which consist of one peer and one clinician. But HEAT teams are only used by police for areas of outreach that do not involve any possibility of any public safety risk; like mobile crisis teams, HEAT teams cannot be deployed to 911 mental health crisis calls and they cannot transport anyone. HEAT teams are called by police, or local agencies such as the Department of Homeless Services. NYC Thrive also operates various ACT teams, which provide mobile outpatient care to those with mental illness but are not designed to respond to crises. *See e.g., De Blasio's Promised 'Comprehensive Strategy' for City Response to People in Mental Health Crisis is Well Behind Schedule*, Truman Stephens, Gotham Gazette, August 23, 2019, available at https://www.gothamgazette.com/City/8754-de-blasio-s-promised-comprehensive-strategy-for-City-response-to-people-in-mental-health-crisis-is-well-behind-schedule.

Co-Response Teams (CRT) are a collaboration between the NYPD and DOHMH. Each CRT includes two police officers and one behavioral health professional. These teams work 16 hours per day, 7 days per week, to serve

permit them to serve as first responders to mental health crises. NYPD remains deeply entrenched in NYC's mental health crisis response model.

The NYPD can no longer be tasked with responding to calls of residents experiencing a mental health or substance use crisis. The City must, instead, immediately establish a civilian crisis system that deploys culturally competent and gender competent social/crisis workers, medics, and mental health peers; not law enforcement officers who specialize in addressing crime. Such crisis response professionals must have the training and expertise to safely stabilize individuals in crisis and connect them to services and/or treatment, if necessary, and to do so in a way that dramatically reduces the risk of serious injury and death to those individuals in crisis and, indeed, to members of the community. The design, implementation, and monitoring of such a crisis response system must be driven by the impacted communities.

New Yorkers, and people across this nation, want a true reimaging of what is considered public safety and the role of law enforcement – particularly with respect to responding to people in a health crisis. Programs replacing police with social workers, mental health counselors, and medical staff have been in operation for at least a year in Austin, Texas; Eugene, Oregon; Olympia, Washington; and Edmonton, Canada.[6] These programs are all focused on providing more appropriate services and reducing government spending. Other cities have recently begun or approved crisis response programs of their own.[7]

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community members presenting with mental health or substance use challenges who are at an elevated risk of harm to themselves or others. The teams offer only short-term engagement. NYC had also previously proposed, but then withdrew from this year's budget, expanding its use of co-response teams. *See, e.g.* Co-Response Teams, https://thrivenyc.Cityofnewyork.us/program/co-response-teams.

[6] Eugene's program has operated since 1989, and in 2019 responded to 20% (24,000) of all 911 calls, with a police backup request rate of 0.625% (160). *See Alternatives to Police as First Responders: Crisis Response Programs*, Matt DeLaus, Albany Law School, November 16, 2020, available at https://www.albanylaw.edu/centers/government-law-center/policing/explainers/Pages/Alternatives-to-Police-as-First-Responders-Crisis-Response-Programs.aspx#_bookmark3 ("Albany Government Law Center Explainer").

[7] *Id. noting* "Cities with non-police crisis response programs in operation less than a year include Portland, Oregon, and Denver, Colorado. *See* https://www.usatoday.com/story/news/nation/2020/06/22/defund-police-what-means-black-lives-matter/3218862001/. Oakland, California, decided to fund a crisis response program, but it is not yet in operation. See https://www.kron4.com/news/bay-area/mobile-response-unit-coming-to-oakland-to-help-with-non-violent-911-calls. Local governments that have decided to fund a crisis response program since George Floyd's killing include Los Angeles, California (https://www.cnn.com/2020/10/14/us/los-angeles-unarmed-crisis-response-teams-911-calls/index.html); Miami-Dade County, Florida (http://www.miamidade.gov/govaction/legistarfiles/Matters/Y2020/201239_Analysis.pdf; http://www.miamidade.gov/govaction/legistarfiles/Matters/Y2020/201239.pdf); Philadelphia, Pennsylvania (https://philadelphia.pa.networkofcare.org/mh/news-article-detail.aspx?id=116033); Rochester, New York (https://www.rochesterfirst.com/news/local-news/watch-live-mayor-warren-to-announce-crisis-intervention-program/); Salt Lake City, Utah; Albuquerque, New Mexico; Hartford, Connecticut; Durham, North Carolina (https://www.prainc.com/wp-content/uploads/2020/08/PoliceReformAcrossUS508.pdf at 2-4); and San Francisco, California (https://www.usatoday.com/story/news/nation/2020/06/22/defund-police-what-means-black-lives-matter/3218862001/). Many other locales are exploring the possibility. *See, e.g.*, https://www.prainc.com/wp-content/uploads/2020/08/PoliceReformAcrossUS508.pdf."

The Albany Government Law Center Explainer notes that, while the programs vary in design, there are certain critical takeaways for local governments attempting to reform and implement a crisis response program are to

(i) include stakeholders in the program design process,
(ii) aim to build trust within the police department and community,
(iii) have a designated place within the 911 and emergency-response processes,
(iv) have adequate funding with access to mid-year increases if necessary,
(v) have a capable host organization/agency and be appropriately administratively housed,
(vi) properly train employees, 911 call-takers, and other first responders,
(vii) use past and current call data to inform operations, and
(viii) have the ability to transfer or refer clients to other service providers.[8]

Int. 2210 does not appear to have been crafted with any of these "takeaways" at hand.

Objections to Int. 2210

Int. 2210 purports to limit the reach of law enforcement, leading to the elimination of NYPD from mental health crisis response to New Yorkers. Regrettably, Int. 2210 falls far too short in achieving that goal. As written, Int. 2210 maintains, and embeds, the outsize role of NYPD in mental health crisis response due to the astoundingly broad definition of public safety emergency.

Ints. 2210 and 2222 touch on a variety of elements that should be incorporated into a comprehensive public health system that is based on crisis prevention and that is grounded in health and recovery outcomes -- but those elements are ill-developed, if at all. Int. 2210 contains a selection of piecemeal actions that neither establishes an appropriate crisis response model nor effects the breadth of systemic change necessary to address the 180,000 crisis calls the NYPD receives annually. Int. 2222 establishes a 3-digit emergency hotline that is not even integrated into the crisis response protocol that Int. 2210 purports to establish. A crisis system must not operate in isolation but must instead strive to fully incorporate within the broader system of care so seamless transitions evolve to connect people in crisis to care based on the assessed need of the individual.

At bottom, Ints. 2210 and 2222 are most pernicious because they divert public attention from genuinely transformative changes to a larger system of care to address the needs of community members.

[8] *Id.*

The City should take this opportunity to immediately establish a civilian crisis system that deploys culturally and gender competent social/crisis workers, medics, and peers and that does not continue to be built on law enforcement officers whose training is fundamentally incompatible with a public health response to people in crisis.

Our principal concerns are foundational:

- Int. 2210 operates to embed police in the equation of crisis response. This is a result of the definition of the term "public safety emergency" in proposed § 17-2001 being written as broadly and vaguely as it is. As written, almost any mental health crisis could be defined as a "public safety emergency" to which NYPD will be dispatched pursuant to proposed § 14-191.[9] Proposed § 17-2003 appears to rest entirely on the premise that there are few, if any, circumstance when NYPD will not, in fact, be first responder or responding without the mental health emergency response unit on scene.

- Int. 2210 appears to have been drafted without any consultation with subject experts, community-based providers, and, most critically, New Yorkers who have had firsthand experience with the mental health system and encounters with crisis responders. An initiative of this nature must be evidence-based, person-centered, and community-driven.[10] Given that the Public Advocate is a co-sponsor of this proposed legislation, Int. 2210 is a remarkably uninformed effort to impose systemic change on merely one part of a mental health system that itself is entirely broken without any consultation with community stakeholders. [11]

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[9] Proposed § 14-192 also vests training with respect to current members of the NYPD, all 911 call operators, and all new academy recruits and all new 911 call operators, regarding the mental health emergency response protocol largely within NYPD. As noted above, a model that permits NYPD to train itself has repeatedly been tried and failed.

[10] See Taleed El-Sabawi and Jennifer J. Carroll, *A Model Act for a Behavioral Health Crisis Response Team* (advocating for an evidence-based, person-centered, and community-driven behavioral health response team model), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3683432.

[11] Certainly, Int. 2210 does not reflect the understanding of New York City's mental health crisis response system reflected by the Public Advocate in his comprehensive September 2019 plan to improve the mental health crisis response system. That plan acknowledged the critical need to include stakeholders in all stages of the program design process, implementation process and ongoing assessment process. Improving New York City Responses to Individuals in Mental Health Crisis. Public Advocate for the City of New York, Jumaane D. Williams, September 2019, available at https://www.pubadvocate.nyc.gov/reports/improving-new-york-Citys-responses-to-individuals-in-mental-health-crisis/.

The Public Advocate developed this comprehensive plan, nowhere reflected in Int. 2210, in consultation with CCIT-NYC, CPR and the White Bird Clinic [operating the CAHOOTS program in Eugene Oregon]. *See, e.g. White Bird Clinic, Crisis Assistance Helping Out On The Streets, Media Guide* 2020 (2020) (reviewing the history of CAHOOTS, the services provided, and the financial savings), https://whitebirdclinic.org/wp-content/uploads/2020/07/CAHOOTS-Media.pdf and CAHOOTS brochure, https://whitebirdclinic.org/wp-content/uploads/2020/06/11x8.5_trifold_brochure_CAHOOTS.pdf.

CCIT-NYC's recommendations to reform the mental health crisis response system, including the deployment of trained peers and health workers instead of the police, the use of an alternative health emergency number to replace

- Int. 2210 also appears not even to complete that community input will be solicited in the design of the emergency response protocol and that the community will be involved in monitoring the effectiveness of the services. Int. 2210 does not mandate the establishment of a community advisory board or council. Individuals living with behavioral health challenges and their families, certified peer specialists who have shared that lived experience, community-based organization and culturally competent behavioral health care professionals all must drive the creation, implementation, oversight and evaluation of any new services to ensure that they meet the needs of the City's residents. [12]

- Int. 2210 does not appear to contemplate the use of a racial equity framework to inform the design and performance of the mental health crisis response protocol.[13]

Our other concerns with Int. 2210 are more structural, relating to the proposed design and operation of the new office of community mental health and the related mental health crisis response protocols. Proposed line edits are insufficient to address the poorly conceived ideas and program assumptions related to the project's function and operation that are too many to list here.

We offer a few examples to demonstrate the nature and type of the structural issues:

- Proposed § 17-2002 situates the new Office of Community Mental Health within the New York City Department of Health and Mental Health ("DOHMH"). DOHMH should not be the entity to actually provide crisis response services. Rather, as the CCIT-NYC proposal suggests, and as is the case with CAHOOTS, DOHMH should contract with peer-driven, community-based organizations that offer quality care to individuals experiencing mental health crisis, are well connected with these

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911, and the requirement that peers be included in future planning initiatives, is published in a follow up report that was shared widely with elected officials and City planners. *Responding to a Psychiatric Emergency: A Vision for Public Health Reform in New York City. A Discussion Paper by Community Access*, February 2019, available at https://www.communityaccess.org/storage/images/Miscellaneous/Responding_to_a_Psychiatric_Emergency_-_Discussion_Paper.pdf.

CCIT-NYC has also recently issued a detailed description of a pilot crisis response program modeled after the CAHOOTS program in Eugene, Oregon which has also been shared widely with elected officials, including the Public Advocate and many members of this Council, as well as other City agency planners. *Piloting a Peer-Driven Mental Health Crisis Response Program, CCIT-NYC*, available at http://www.ccitnyc.org/who-we-are/our-proposal/.

[12] Not only must these individuals be included in the discussions, they must participate in key decisions, including the hiring and training of certified peer specialists, dispatch personnel and other personnel.

[13] Int. 2210 appears to operate entirely outside of the New York City Department of Health and Mental Hygiene (DOHMH)'s Race to Justice initiative. This initiative is intended to reform internal policies, practices, and operations to advance racial equity and social justice across DOHMH operations; to address systemic racism, to implement policies to lessen the impact of structural oppression, and to strengthen collaborations with communities across the City. *See* https://www1.nyc.gov/assets/doh/downloads/pdf/che/community-engagement-framework.pdf.

individuals, are culturally and gender competent, and have the trust of people living with disabilities.

- Proposed § 17-2004(a) appears to mandate that a "mental health clinician" will respond to mental health crises. That term is undefined. Mental health clinicians are often largely representative of the medical model of mental health care service delivery and there should be consideration given to other types of mental health practitioners who are skilled to deliver more than a medicalized model of crisis intervention. Many mental health crisis response models call for the inclusion of emergency medical technicians who understand that physical health problems such as elevated insulin levels or urinary tract infections may present as a mental health crisis.

- There is no reason that proposed § 17-2004(b) should contemplate a response time of 30 minutes instead of a response time that is comparable with non-mental health health emergencies handled by NYPD and/or EMT. The New York City 911 End-to-End Response Time tracker indicates that the response time for life-threatening medical emergencies is some eight minutes, with non-life-threatening medical emergencies responded to in some ten minutes.[14]

- Proposed § 17-2004(d) contemplates that best practices concerning "titles" and "uniforms" shall be identified by the new Office of Community Mental Health. Titles and uniforms perpetuate a policing-response model. The CAHOOTS responders, for example specifically wear street clothing that do not suggest affiliation with law enforcement.

- The public education and outreach set forth in proposed § 17-2006 does not contemplate the inclusion of sites operated by other City agencies, such as the Department of Education, as locales for public education and outreach. Peers from relevant communities should be included in all public education and outreach and outreach should target New York City students and young people – without regard to the neighborhood in which they may live.

- The reporting requirements set forth in proposed § 17-2007 are virtually meaningless as they do not address genuine population health or individual health and recovery outcomes. And, to the extent proposed § 17-2007(b)(1) contemplates an "audit" of mental health service needs and gaps in care, such an audit should be conducted first to inform the creation of the emergency response system contemplated by Int. 2210 and then to identify ongoing service needs and gaps in care.

[14] *See NYC Analytic: End-to-End Detail, NYC 911 Reporting*, available at https://www1.nyc.gov/site/911reporting/reports/end-to-end-detail.page.

- Int. 2210 also fails to acknowledge how, much less whether, any protection will be afforded to protected health information, including prohibition of access to such protected health information by law enforcement and immigration enforcement.

Comments concerning Int. 2222

Any 911 alternative need to be fully integrated into a non-NYPD controlled dispatch and response system. Int. 2210 does not do that.

Int. 2222 calls for the creation of a 3-digit mental health emergency hotline. It is not clear how, or if Int. 2222 relates to Int. 2210. Int. 2210 does not reference this mental health emergency hotline which appears to be part of the new chapter 20 added to Title 17 of the New York City Administrative Code by Int. 2210. Int. 2222 stands completely alone but cross-references Int. 2210 by adding a proposed § 17-2008 to Title 17. Int. 2222 however does not integrate the 3-digit hotline into Ins. 2210, requiring only that there be establishment of "guidelines for call operators of the 3-digit hotline […] to identify calls as potential health emergencies" as part of the mental health emergency protocol established in Int. 2210 (proposed § 17-2003).

Int. 2210 does not reference this new emergency hotline and Int. 2222 does not require any coordination and/or clarity on who has jurisdiction amongst responders when the new 3-digit system has dispatched responders but the other "emergency first responders" addressed in Int. 2210 (proposed § 17-2003(3)).

Conclusion

The NYCLU thanks the Committees for the opportunity to provide testimony and for their consideration of this critically important issues and we stand ready to working with the members of this committee, the Public Advocate, and all appropriate partners to advance meaningful policy changes that will save lives.

SHELTERING ARMS 18 23

Children and Family Services

Embracing Hope *and* Building Futures *for* Generations

Testimony delivered by Leonor Walcott, Director of Youth Services
Prepared for the NY City Council
Committee on Mental Health, Disabilities and Addiction
February 22, 2021

Good afternoon. My name is Leonor Walcott and I am a licensed Social Worker and the Director of Youth Services at Sheltering Arms. Thank you, Chair Louis and members of the Committee for the opportunity to testify before you today.

Sheltering Arms is one of the City's largest providers of education, youth development, and community and family well-being programs for the Bronx, Manhattan, Brooklyn, and Queens. We serve nearly 15,000 children, youth, and families each year, and employ more than 1,200 staff from across New York City.

Sheltering Arms Experience with Mental Health Emergencies

Sheltering Arms has served youth in the Foster care and Runaway and Homeless Youth (RHY) systems for more than two decades. Our staff provide social emotional support and safe and stable living environments where young people can reside free of harm. When youth are in crisis, staff are trained and equipped to meet the immediate and individual needs of youth. However, our frontline staff are not mental health professionals. If a youth is experiencing a mental health emergency that is beyond the scope of our direct support staff. It's the difference between treating a paper cut versus a wound that requires stitches.

In cases when a youth is experiencing a psychiatric crisis, the youth may be incoherent, having difficulties determining what is real from what is not, delusional and disorganized thinking, experiencing hallucinations both visual, and or auditory. May be Suicidal, could be experiencing mood instability with aggression and making live threats to cause harm to self and others. As such safety of the youth and staff is paramount, such instances require immediate psychiatric intervention.

Youth in the RHY system are transient and often do not have adequate mental health supports, proper medications, or preexisting community supports. Given the age of onset of mental illness many of the youth in our RHY and Foster Care programs are also experiencing their first mental health emergency.

Problems with the Current System

We are glad that the Council recognizes that the current resources for emergency mental health calls are not sufficient, as our team has experienced long response times of over 2 hours, outsized responses and insufficient assistance when NYPD arrived on site. A recent call example shows how necessary Intro 2210 is. A young person in our Crisis Shelter, locked himself in the bathroom, refused to come out, and refused to provide verbal responses. Based on his history of behavior, staff made the correct decision to call 911 for an EDP (emotionally disturbed person). This call was responded to by 14 police officers. As the director of youth services I provided the staff with over the phone coaching on how to work best with the officers on site. This outsized response not only created additional trauma for the youth experiencing the mental health emergency, but also created a traumatic and triggering experience for other youth in our homes -- some of whom have had negative experiences with NYPD.

Additionally, in our experience we have found that when some police officers arrive at the facility they are looking for a young person to "act out," and if youth is not behaving that way, rather than using trauma-informed techniques to coach the youth to accept services, officers have often made it extremely difficult to have a young person escorted to a psychiatric ER for needed care. Responding officers have made comments like "they're just having a temper tantrum," disregarding staff's clinical recommendation. The need for trauma-informed, culturally-competent, and trained response is great.

Intro 2210

Intro 2210 is long overdue, important, and necessary to support an effective system for emergency mental health response. Sheltering Arms strongly supports this bill, but makes the following recommendations to strengthen it:

1. **The protocols must be developed with meaningful involvement of community-based organizations, mental health providers, and the NYPD** in order to ensure that the protocol meets the needs of individuals in the community.
2. **We support setting a 30-minute response time**, and urge the Council to ensure that the Office of Community Mental Health receives the resources it needs to make this a reality. Thirty minutes is an ambitious response time, given that the Mobile Crisis Unit has a response time of two hours, but we agree that this time frame is necessary in order to ensure effective support for individuals in crisis.
3. **We also support and emphasize the training requirements for NYPD, 911 operators and dispatchers.**

Intro 2222

Finally, we support Intro 2222. A separate three-digit hotline for mental health emergency response will help ensure that these situations receive appropriate and timely response.

Thank you for this opportunity to testify and for your commitment to ensuring an effective and appropriate response to mental health emergencies. I'm happy to answer any questions you may have.

Sincerely,

Leonor Walcott
lwalcott@shelteringarmsny.org

City Council Committee on Mental Health, Disabilities, and Addiction
Feb 22nd, 2021
Zoom name: Sarah Sitzler she/her
Subject: Remove NYPD from all mental health emergencies and make quality healthcare services accessible to everyone.

My name is Sarah Sitzler and I am a resident of District 40. I would urge that the language of Intros 2210 and 2222 be re-written to explicitly exclude NYPD involvement.

Police should not be called for mental health emergencies. Deploying Police implies a criminal element is present, and that is detrimental to the person in crisis getting the help they need. A person in a mental health crisis requires help from an individual who possesses delicate, skilled, de-escalation training and experience. Police, no matter what training they receive,just don't possess the same skills to be proactive in cases of crises, because they are not healthcare providers. Other cities have adapted community based crisis response programs that work with little to no police involvement. As mentioned, the CAHOOTS program in Eugene, OR has been operating since 1989. "Responders don't carry weapons, and among the roughly 24,000 calls CAHOOTS received last year, teams requested police backup only 150 times, according to the program." New York should build our new crisis response team off of this CAHOOTS model.

Some of the language of this bill that I would like to highlight is that the new Office of Mental Health would "identify gaps in care and coordinate needs between city agencies, community based organizations, and mental health care providers." This is vital to reshaping the ways in which we think about and treat mental illness. Specifically, we must start taking actions to provide preventative care to New Yorkers struggling with mental illness, so that they are not ignored, so that they can access quality and culturally sensitive care that they require no matter what their status in regards to housing, income, or immigration. Follow up care is just as vital: without it, the first point of contact is almost worthless.

I can testify that as a low income New Yorker, who has been on Medicaid for years in the past, who deals with acute depression and anxiety, that access to quality mental healthcare providers for low income New Yorkers is greatly limited. When I had previously lived in Bushwick I could not find a psychiatrist anywhere near my neighborhood. Once a month I was taking time off work to travel at least 90 minutes by 2 different trains to see a psychiatrist in Coney Island. Oftentimes I would wait another 90 minutes just to be seen for less than 5 minutes to give them a urine sample and get my prescription refilled. (I still don't know why they needed a urine sample every time, because other psychiatrists have not done that.) Several times, my doctor was not there, even though I had an appointment, and the receptionist didn't know where she was so I had to reschedule. This would have been frustrating under regular circumstances, but I was having suicidal ideations and trying to get my depression under control, so when my doctor was absent and I had to wait to get my medication it felt like a devastating blow. All this to say, that had I had several hundreds of dollars to spend on an out of network psychiatrist each month, I am confident I would have had much better experiences. In addition to lack of financial resources, not everyone has the same access to searching for help online. Sometimes there are technical, cultural, and language barriers. I urge the Council to listen to the individuals from various organizations who work directly with our neighbors who

suffer from various forms of mental illness with varying abilities, age, languages, and cultural backgrounds. The input of these professionals must be adhered to and regarded, because they have the years of experience and the insight necessary to building truly impactful programs.

Again, I would like to stress the importance of listening to advocates and removing NYPD involvement in crisis responses. According to the Treatment Advocacy Center, “people with untreated mental illness are 16 times more likely to be killed during a police encounter than other civilians approached by law enforcement.” We cannot allow any more senseless deaths at the hands of police. As we’ve seen time and again, police response to individuals in mental health crisis, especially Black men, has tragically resulted in their deaths. These men deserved not only humanity, which they were denied at the hands of police, but they deserved real compassion and care. I want to stress the importance of preventative care here, because they deserved care not only in the moments that they were in crisis, but they deserved quality care in the days, weeks, and months, leading up to their crises. An emphasis must be placed on developing effective modes of care in our predominantly Black and Brown communities who have been slighted for too long.

It is not only adults, but Black children, and children of color, who are often grossly mistreated by police when they are in crisis. We cannot allow any more children to be traumatized, like the little girl in Rochester, who was pepper sprayed in the face by Rochester PD, because they did not know what to do for her while she was in extreme distress. That little girl now has to carry that trauma for the rest of her life. It isn’t solely senseless deaths that destroy families, but the trauma experienced by mentally ill people during their most vulnerable moments, in times of crises, when they are dehumanized and brutalized by police, that leave emotional scars that are often lifelong afflictions compounded on top of mental illness. I ask that you, Councilmembers, do all that you can through legislation to protect BIPOC children from this preventable traumatization by the police. Remove NYPD from the equation. It is an immeasurable disservice to both the public and the NYPD to keep officers involved in mental health emergency responses. It is time we start treating mental health as the medical issue that it is, not the criminal issue it is not.

HEARING OF THE NEW YORK CITY COUNCIL'S
COMMITTEE ON MENTAL HEALTH, DISABILITIES, AND ADDICTION

STATEMENT OF JEFF STRABONE

Monday, February 22, 2021

Good afternoon, Chair Louis and members of the Committee on Mental Health, Disabilities, and Addiction. My name is Jeff Strabone. I am a lifelong resident New Yorker and former vice-chair of Community Board Six in Brooklyn. I live in the 39th District. I thank the Committee for its time and for listening.

The subject of my testimony today is Intro 2210-2021, which would create an office of community mental health and a citywide mental health emergency response protocol.

To put it simply, people with mental health emergencies don't need police with guns. They need a different kind of help. And around the country, many police forces know this, too.

This statement includes, as an attachment, testimony of October 1, 2020 to Connecticut's Police Transparency and Accountability Task Force by Stephen Wanczyk-Karp on behalf of the Connecticut chapter of the National Association of Social Workers listing cities around the country that have created or piloted similar 911 alternatives using social workers: Denton, Texas; Dallas, Texas; Alexandria, Kentucky; Greensboro, North Carolina; Eugene, Oregon; Olympia, Washington; Denver, Colorado; Albuquerque, New Mexico; Los Angeles, California; Buffalo, New York; Willimantic, Connecticut; and New Haven, Connecticut. I hope New York City will add itself to this list of innovators. New York should not be outdone by Willimantic, Connecticut.

Police are not social workers or psychologists—and we should not task them with roles and responsibilities far beyond their expertise.

Police know this. After a mass shooting of police officers in Dallas in July 2016, Dallas Police Chief David Brown said the following:

> "We're asking cops to do too much in this country. We are. We're just asking us to do too much. Every societal failure, we put it off on the cops to solve. Not enough mental health funding, let the cops handle it. Not enough drug addiction funding, let's give it to the cops. Here in Dallas we got a loose dog problem; let's have the cops chase loose dogs. Schools fail, give it to the cops. […] That's too much to ask. Policing was never meant to solve all those problems. And I just ask for other parts of our democracy along with the free press to help us, to help us and not put that burden all on law enforcement to resolve."[1]

Chief Brown was right. And New York should listen.

[1] https://www.washingtonpost.com/news/post-nation/wp/2016/07/11/grief-and-anger-continue-after-dallas-attacks-and-police-shootings-as-debate-rages-over-policing/.

Since the election of Ronald Reagan in 1980, our federal, state, and local governments have cut and cut and cut all but two types of funding: war and police. If you cut mental health spending and increase police spending year after year, you're going to be sending police to mental health crises that they're not equipped to deal with.

You all know the saying, Don't bring a knife to a gun fight. I say, Don't send a cop with a gun to someone's dark night of the soul. Send a social worker.

Let cops be cops and social workers be social workers. They're not the same. We need both. Fund both.

Thank you.

Testimony on Utilization of Social Workers by Police Departments

October 1, 2020

Police Transparency & Accountability Task Force

October 1, 2020

On behalf of the National Association of Social Workers, CT Chapter representing over 2,300 members, we offer t
the utilization of social workers by police departments. This testimony is in keeping with An Act Concerning Police
that mandates police departments to study the utilization of social workers in calls for assistance, with such evalua
within six months of enactment of the Act. The National Association of Social Workers, CT Chapter (NASW/CT) su
opportunity to rethink the best manner to respond to certain 911 calls. We offer the following examples and recomr
means of addressing community needs in a manner that encourages safe resolution of issues that need not requir

To start with, let us give you a quick example of where dispatching of a social worker would have best dealt with a
Police Department had a call regarding a woman who was acting confused. The woman had driven from her home
clearly unsure of where she was. An officer was called to the scene and spent the next 90 minutes tracking down f
perfect example of where a social work response would have been most appropriate, freeing up the officer for othe

There are two main models of utilization of social workers or other clinicians for 911 calls. One model is direct emp
within a police department. This includes police officers and social workers teamed together to respond to calls, th
brought in after a call to work with and follow up on cases and the social worker independently responding to calls.
contract with a community-based organization that employs social workers and other clinicians, with certain 911 ca

service for response. Both models have been successfully operationalized throughout the nation and are growing i models, social workers are the professionals most often utilized to respond to calls related to mental health, homel and other matters not requiring a law enforcement officer.

Here are examples from communities that have instituted or in the process of creating alternative 911 call

- In Denton, Texas 4 licensed clinical social workers are employed for direct service, overseen by a social work created a unified special mental health unit within the police department.
- Dallas, Texas has instituted the Right Care program where police officers respond to assure the scene is secu immediately follow. The Right Care clinical team handles 200-250 calls per month. In those city districts where there has been a 10% reduction in citations for disorderly conduct, intoxication and trespassing.
- Alexandria, Kentucky hired a social worker to handle mental health calls and are planning to hire a second so found a cost savings in doing so, vs hiring an officer.
- The City of Greensboro, NC, contracts with a private practice group of 8 clinicians who respond 24/7 to behav They intervene on the scene, refer the person(s) in need to community resources and follow up in 24 hours ar
- In Eugene, Oregon a long-standing program, CAHOOTS has been in existence that in 2017 responded to 17% 24,000 calls handled and only 150 needing police back-up.
- Olympia, Washington has a Crisis Response Unit staffed by two social workers.
- In Denver, Colorado the Support Team Assisted Response (STAR) is run through the police department but h rather a single van that deploys a paramedic and a social worker on calls for substance abuse and mental hea
- Albuquerque, New Mexico has formed a separate department on community safety staffed by mental health a professionals.
- The University of Southern California, Suzanne Dworak-Peck School of Social Work places social work intern Police Department.
- The Mayor of Buffalo, NY recently announced the hiring of social workers to pair up with police officers for me calls, following a police officer shooting a homeless person who had mental illness.
- In Willimantic, CT 2 social work interns are now placed with the local police department. The students are sup professor at Eastern CT State University.
- New Haven, CT is launching a pilot program that will have clinicians respond to mental health and substance contracted community agency. They expect to have the program up and running in Spring 2021.

Similar programs are in existence or being launched in communities across the country.

Social workers have extensive training in working with diverse populations, are problem solvers, experts in de-esca "person-in-environment" approach assist individuals and families to resolve societal problems. Social workers are a resources and know how to access them. Social workers are advocates for clients in a way that creates trust and s These are the types of skills that make for successful engagement within the community. Just as police officers are issues of law enforcement, social workers are experts in resolving social problems that bring individuals into encou Formal and informal connections between police and social workers is a recipe for improved outcomes for certain S

NASW/CT recommends that police departments engage local officials and the larger community in discussion of u Police departments, with the support of their municipality, can respond to police accountability in a proactive mann of social workers, either within the department or as a separate coordinated system of response. This will demonst improved outcomes that we know police departments seek and will indicate a willingness to change with the times community needs in a way that encourages safe resolution of issues that need not be police matters. It may also a that are having difficulty recruiting officers by reducing the need for police officers to be available for all 911 calls.

We urge the Police Transparency and Accountability Task Force to include in its recommendations the adoption by social workers as either internal employees or contracted service providers to handle 911 calls that are deemed ap response. Such a recommendation by the Task Force will further encourage municipalities to develop improved res related to mental health and human service needs.

NASW/CT is available to further engage with the Task Force on the recommendations put forth in this testimony. W opportunities to dialogue on how best to utilize social workers with police. Please contact Stephen Wanczyk-Karp, skarp.naswct@socialworkers.org or 860-212-4054 for further information and discussion.

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HEARING OF THE NEW YORK CITY COUNCIL'S COMMITTEE ON MENTAL HEALTH, DISABILITIES AND ADDITION

Statement of Johanna Robinson

Wednesday, February 24, 2021

To Chair Louis and the members of the Committee on Mental Health, Disabilities and Addition:

My name is Johanna Robinson and I am currently a resident of Bushwick, Brooklyn. The subject of my testimony today is Intro 2210-2021, which would create an office of community mental health and a citywide mental health emergency response protocol.

This is an issue which has great personal significance to me. I am strongly in support of this bill. In 2012, my mother suffered from an episode of psychosis while battling cancer, likely brought on from strong anesthetics used during a surgery. At this point we were home from the hospital and when the need arose for me to dial 911, I knew that I had to emphasize that she had cancer on the call over the fact that she was having a mental health crisis. My fear was that her precarious health situation would not be taken into account if emergency personal showed up and were presented with a confused, violent person rather than knowing this was a very ill person. This should not be the case. No one should have to be scared by what kind of response they are met with when getting care for a loved one, and physical health and mental health should be taken with an equal amount of respect and seriousness.

Five years later, in 2017, one of my best friends suffered a mental health crisis but was not so lucky to have a preexisting physical health condition that her husband could emphasize on the phone when making the 911 call. Officers showed up at her house and proceeded to put her in jail for 5 days where she received no mental health treatment and her condition of psychosis only worsened. I honestly feel like it's a miracle that she is still alive today, although this handling of her situation has resulted in severe PTSD and I can only speculate that her recovery

time has been lengthened by years over what it could have been if she had immediately received treatment.

I'm sure many of you are aware that on the day of the hearing, on February 22, Angelo Quinto was killed in Antioch, CA after police showed up at his house responding to a 911 call for a mental health crisis. This is deplorable and all to common. We cannot allow families to continue being scared to get help for their loved ones in NYC.

Sincerely,
Johanna Robinson

HEARING OF THE NEW YORK CITY COUNCIL'S
COMMITTEE ON MENTAL HEALTH, DISABILITIES, AND ADDICTION

STATEMENT OF JUSTIN VALDES

Monday, February 22, 2021

Good afternoon, Chair Louis and members of the Committee on Mental Health, Disabilities, and Addiction. My name is Justin Valdes. I was born in Flushing, Queens and currently reside in Ridgewood, Queens.

The subject of my testimony today is Intro 2210-2021, which would create an office of community mental health and a citywide mental health emergency response protocol.

Police officers do not have the training to handle a mental health crisis. This fact is made abundantly clear by two recent incidents in Rochester NY.

In one incident, a nine year old girl was cuffed and pepper sprayed. She was distressed and calling for her father. The police were called because her mother was suicidal. In what world is it acceptable for them to have pepper sprayed her and held her down? It would clearly traumatize her further and shows a complete lack of understanding for what would have been required to handle this situation. A social worker would have responded far differently because of the training they've been given.

In the other incident, Daniel Prude died from asphyxiation due to the hood placed over his head. This man had a mental health crisis and the lack of training and understanding on the part of the police lead directly to his death. A social worker, an actual medical response team would not have killed him.

Was it Einstein who said that the definition of insanity is trying the same thing over and over again expecting the same results? That is exactly what we do when we cut funding for sensible programs and funnel it into the police force. We have a one size solution to fit all situations, and it has negatively impacted families and communities and will only continue to do so.

Let's please move in a direction that will match the right solution to the specific situation. It's proven to save lives.

Thank you.

Testimony
New York City Council Committee on Mental Health, Disabilities and Addiction
January 22, 2021

Eric Vassell
Father of Saheed Vassell
Justice Committee Member

My name is Eric Vassell. I am the father of Saheed Vassell, who was killed by the Strategic Response Group officers NYPD on April 4, 2018.

I'm here today to oppose bill #2210. The topic of this bill is very close to my heart because Saheed was someone who struggled with mental health issues, like so many other New Yorkers.

I want to make clear that this bill would not have saved Saheed's life. I appreciate that the City Council is thinking about this issue but I want to make clear that this bill would not have saved Saheed's life. Saheed would still have been killed.

First, you cannot build a mental health response system without also creating and funding better mental healthcare for Black communities. The mental health issues we are facing in Black and Brown communities is another pandemic because of racism.

We need a different model – not the psychiatric model that Intro 2210 relies on. Just like with the coronavirus pandemic, Black and Brown communities suffer more because the City does not prioritize us. Eliminating this pandemic has to be our goal. We can only do this if we have a healthcare system that treats people who are suffering with humanity.

Saheed first started to struggle with mental health issues after his close friend was killed by the police. He needed help to process this trauma, but he was just given a whole lot of tablets. It didn't help his sickness.

For Saheed being in the hospital was like being in prison. It traumatized him. He told me that he did not want to go back into that prison situation. Many times when Saheed needed help, we tried to find mental health options, but we could not find programs that would really help him. He was treated like a number, not a human. They just wanted to lock him down somewhere and give him tablets. There was no real assistance, no job training or help getting a job. The City's healthcare system failed Saheed, his mother and me long before he was killed.

Intro 2210 only connects people with systems that dehumanize and criminalize them.
The City has to make it priority to develop the services we really need in Black and Brown communities.

Second - Intro 2210 makes it so that the NYPD will still arrive in many of the situations when people just need a health approach.

This will not work. People who are suffering like my son need to be treated with care. They need someone who understands what they are going through. Seeing officers with guns will only make things worse.

If you are Black or Brown, when the NYPD sees the color of our skin – ego and bias kicks in. Maybe they will step back if the person is white, but even if this bill is passed, they will still treat Black and Brown people like criminals.

This is especially true since they are never held accountable. Officers gunned Saheed down in the middle of the street in broad daylight, but nothing ever happened to them. **The bill does nothing to ensure officers will be held accountable in the future.**

3 -- It's not enough to just retrain 911 operators when one main problem is that the NYPD controls 911. Racism means that our Black children are always seen as dangerous.

We need the 911 system to be taken out of the hands of the police. We have seen time and time again the NYPD does not treat all communities equally. This bill will not change that. If the NYPD continues to control 911 and is part of training 911 operators, we will keep seeing the same thing when it comes to Black and Brown communities: police will be sent and people who should be receiving care will be hurt and killed, like what happened with my son, Saheed.

I appreciate that you are trying to address this problem – but please – let's do it right. We need to have a plan that addresses all of the problems together. We cannot have the police continue to show up. We need to take 911 out of the NYPD. And we need services that treat our loved ones with dignity. Intro 2210 should not move forward, or else there will be more Saheeds, more Mohamed Bahs and more Kawaski Trawicks.