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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 – Coordinating City Agencies to Address Serious Mental Illness.

September 17, 2021

The New York Civil Liberties Union (NYCLU) appreciates this opportunity to submit the following testimony regarding the coordination of New York City's agencies to address serious mental illness.

The NYCLU, the New York State affiliate of the American Civil Liberties Union, is a not-for-profit, nonpartisan organization with eight offices throughout 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, including the right of every New Yorker to enjoy life, liberty, due process, and equal protection under law. This includes our work in pursuit of community safety, and our work to advance the rights of New Yorkers who struggle with mental health issues. The NYCLU has long been a coalition partner of both Correct Crisis Intervention Today – NYC (CCIT-NYC) and Communities United for Police Reform (CPR).

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We hope that the Council will begin a period of more robust and frequent monitoring of the City's response as a whole to the plight of New Yorkers who live with mental health challenges. New York City's public mental health services are simply dysfunctional -- from policies to procedures to programs to facilities -- and the system's negative impact on Black and Brown communities is quite deeply entrenched.

The inordinate number of mental health crisis calls handled by the New York Police Department (roughly 200,000 annually) are a symptom of a system that provides care only after people experience a mental health issue, instead of providing services and supports that promote health and wellness, and avert crisis. A public health response to emotional distress and mental health emergencies cannot be limited solely to a perceived or actual emergency,

but must include a continuum of services encompassing preventive, emergency response, and longer-term support services.

In New York City, police are the first to respond to the scene of someone in a mental health crisis, and many transport individuals to an emergency room, jail, or psychiatric hospital. 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.[1] 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, resulting in unnecessary and unjust serious bodily injury and death to those who simply need the care and support of trained health professionals (e.g. social workers and psychologists).

Even if an individual is connected to mental health services, the mental health care that is currently delivered, especially for people reliant on the public mental health system, is routinely second-rate, dismissive of choice or convenience, difficult to obtain in many neighborhoods and rarely linguistically competent, culturally competent, gender competent, or, in any way, person-centered. Preventive care will keep people healthy and well through the provision of social supports, starting with economic security, safe affordable housing, available employment, meaningful social connections, and the ability to access beneficial services in one's own community.

The Mayor's Office of Community Mental Health (MOCMH) and the new interagency Mental Health Council established by Mayoral Executive Order 68, May 5, 2021, have an opportunity 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 the NYPD's involvement as responders and that uses a racial equity framework to inform its design and performance.

However, the new interagency Mental Health Council is composed entirely of city employees.[2] Policy and planning originates in a top down fashion conducted entirely by city employees who are not likely to have any meaningful connection to the impacted neighborhoods and the people most in need. The communities disproportionately impacted by mental health concerns are integral to the development of an action plan that focuses both

[1] 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.

[2] E.O. 68 provides that Council membership shall include City office or agency Commissioners or their designees from agencies including, but not limited to, the Department of Health and Mental Hygiene, the Human Resources Administration, the Administration for Children's Services, the Police Department, the Fire Department, the Mayor's Office of Criminal Justice, and the Department for the Aging. Representatives of the Department of Education and the New York City Health & Hospitals Corporation are invited, but not mandated, to participate in the Council. The New York City Department of Health and Mental Hygiene serves as a "technical advisor" to the Council.

on the systems at work, together with the underlying social determinants of health which undermine mental health care: lack of accessible services, limited housing options, virtually non-existent social supports, high unemployment and underemployment, racism, and police violence. Notably, those with the highest needs, including people who are homeless or incarcerated, have the least access to care.

This is completely unacceptable and a squandered opportunity to meaningfully include peers, community members, and subject experts in a policy-making role. The absence of these critical stakeholders as members of the Council is particularly troubling given that the mandate of the Mental Health Council is to "reduce the disparity between neighborhoods […] and reduce the total number of mental health emergencies by addressing mental health needs before they become crises."

The Council cannot operate 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.

New Yorkers seeking mental health services, from preventative, to crisis to post-crisis stabilization and wrap around services, 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.

MOCMH and the Council are charged, among other things, with identifying critical gaps in care that are preventing New Yorkers with mental health needs from accessing and staying connected to care, "incubating innovative strategies to close these gaps in care," maximizing the promotion of mental health within and across City agencies by developing citywide policies and practices, including coordinating agencies to effectively and equitably maximize mental health crisis prevention, intervention and stabilization practices; promoting mental health screening; increasing referrals to care; offering relevant training; implementing other strategies that promote mental health; and eliminating barriers to care through engagement with under-served populations.

How will the MOCMH's and the Council's accomplish compliance with the mandates identified in E.O. 68? Are MOCHMH and the Council charged with the use of a racial equity

framework to inform the design and performance of the mental health crisis response protocol.[3]

We also suggest that this Committee closely examine the following issues:

- the failures of transparency and public reporting by MOCMH's B-HEARD [Behavioral Health Emergency Assistance Response Division] pilot project that is currently deploying teams of health professionals - including EMTs/paramedics and mental health professionals - to 911 mental health calls, in East Harlem and parts of north and central Harlem;

- the NYPD's unilateral adoption in June 2021 of the ICAT-Integrating Communications, Assessment and Tactics training program developed by the Police Executive Research Forum, or PERF, as the latest crisis intervention and de-escalation training model for all NYPD service members; and

- the appropriate role for MOCMH and the Council, and its individual members, in homeless initiatives, particularly those that involve the involuntary removals of those individuals who are or are deemed to be homeless, that are carried out under N.Y. State Mental Hygiene Law § 9.58 with the assistance of nurses who may or may not operate under the auspices of New York City Health and Hospitals and the New York City Department of Homeless Services.

Failure of Transparency and Reporting by B-HEARD

MOCMH launched the B-HEARD pilot project in June 2021. In this model, both mental and physical health professionals are charged to respond to 911 mental health emergency calls. The goals of the B-HEARD pilot are to route 911 mental health calls to a health-centered B-HEARD response whenever it is appropriate to do so and increase connection to community-based care, reduce unnecessary transports to hospitals, and reduce unnecessary use of police resources.[4]

[3] MOCMH and the Council would appear to operate entirely outside of 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.

[4] *See* https://mentalhealth.cityofnewyork.us/b-heard. The B-HEARD pilot largely continues to embed an NYPD response in the pilot as calls that involve a weapon, an imminent risk of violence, or where NYPD or EMS call-takers know that an individual has an immediate need for a transport to a medical facility will continue to receive a traditional 911 response—an ambulance and police officers. The B-HEARD pilot is not a true non-police response model that is similar to the CAHOOTS Whitebird Clinic Model, nor is it at all similar to the non-police response model advanced by CCIT-NYC.

Almost four months into operation of the B-HEARD pilot, MOCMH has posted data on only the first month of operations.[5] But, the NYPD has taken public issue with the accuracy of the data reported by MOCMH.[6] The "latest news" on the B-HEARD website dates from June 9, 2021. B-HEARD has apparently established some sort of advisory board which has met only once. Most of the operations of B-HEARD are cloaked in secrecy.

What is B-HEARD actually doing and how well is B-HEARD actually performing? Members of CCIT-NYC have posited a number of questions to B-HEARD personnel that have not been answered. Perhaps the Committee can obtain answers to the questions that we have not been able to obtain. The CCIT-NYC questions are attached to this testimony at exhibit A.

NYPD's ICAT Training Program

Currently, NYPD officers and the New York City Fire Department's Emergency Medical Services Emergency Medical Technicians (EMTs) still 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 ("CIT") program intended to train NYPD officers in de-escalation techniques they should use while interacting with people experiencing a mental health crisis. Since this training program began, 16 New Yorkers in a mental health crisis were killed during confrontations with police and another three were shot and critically wounded — compared to seven people killed in the seven years prior to when the program began. That training program was terminated, without public notice, at some point during the pandemic.[7]

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[5] *See B-HEARD, Transforming NYC's Response to Mental Health Crises, FIRST MONTH OF OPERATIONS,* https://mentalhealth.cityofnewyork.us/wp-content/uploads/2021/07/B-HEARD-First-Month-Data.pdf.

[6] "First responders in a new city program aimed to keep cops from answering 911 mental health calls are repeatedly calling for police assistance," NYPD Commissioner Dermot Shea said. *See NYPD still called in to help with police-free emergency mental health response teams,* Thomas Tracy, New York Daily News, June 24, 2021, https://www.nydailynews.com/new-york/nyc-crime/ny-first-responders-pilot-program-call-police-20210624-w3n7z5v7tfhrno5t5vqfiwk4ty-story.html.

[7] 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.

In June, 2021, NYPD Chief Dermot Shea indicated that the NYPD will be training all 35,000 of its officers in new de-escalation tactics to avoid use of force. The new program is called ICAT-Integrating Communications, Assessment and Tactics. The ICAT training has apparently already been rolled out to the Emergency Services Unit. It is not clear whether the former CIT training has been terminated. Whatever the training module deployed by NYPD, the NYPD remains deeply entrenched in NYC's mental health crisis response model.

There is no forward-facing information on the NYPD website about the ICAT training. Indeed, most of the available information is set forth on the website of the Police Executive Research Forum (PERF) is an independent research organization that focuses exclusively on policing issues.[8] Whatever this ICAT training may be, it certainly was not developed in consultation with any impacted communities' members, much less the recently created Mayor's Office of Community Mental Health or the new interagency Mental Health Council – to which the NYPD belongs. We know this because PERF was already training the NYPD as of June 21, 2021 according to PERF.

NYPD Assistant Police Chief Kenneth Corey, the head of training for the NYPD, is quoted in a Washington Post article,[9] noting that it "would take about two years for the entire NYPD to go through ICAT training and that commanders would closely monitor the impact it had citywide."

Chuck Wexler, the head of PERF, is quoted in that same Washington Post article as follows:

> "If you want to get at the heart of police reform," Wexler said, "it's the use-of-force issue. It's not about the homeless, or the schools or qualified immunity. **It's about all these 'lawful but awful' shootings**, that 40 percent of people who don't have guns. Cops are doing what they're trained to do. And for New York, that's a department that wants to be at the forefront."

This quote demonstrates quite clearly that law enforcement officers' training is fundamentally incompatible with a public health response to people in crisis. This

[8] *See* June 26, 2021 *Dear Perf Members letter re Addressing the Defining Issue in Policing Today*, available at https://www.policeforum.org/trending26jun21. The Washington Post has covered the NYPD's embrace of PERF's ICAT training curriculum. *Amid rising police violence, New York City police to train entire force in de-escalation,* Tom Jackman, June 23, 2021, https://www.washingtonpost.com/nation/2021/06/23/new-york-police-deescalate/. That Washington Post article quotes NYPD as indicating that the ICAT training is intended to kick in "only in situations where subject doesn't have a gun."

[9] The Washington Post has covered the NYPD's embrace of PERF's ICAT training curriculum. *Amid rising police violence, New York City police to train entire force in de-escalation,* Tom Jackman, June 23, 2021, https://www.washingtonpost.com/nation/2021/06/23/new-york-police-deescalate/. That Washington Post article quotes NYPD as indicating that the ICAT training is intended to apply "only in situations where subject doesn't have a gun."

Committee should reject the concept of "lawful but awful shootings" of people in mental health crisis. The Committee should do all in its power to stop the NYPD's ICAT training.

The NYPD is moving forward, apparently entirely unchecked, to maintain, and embed, its outsize and unwarranted role in mental health crisis response. The entrenchment of the NYPD in mental health crisis response in New York City flies in the face of nationwide initiatives to fundamentally transform the role of policing in New York City and New York State – we must start by ending our over-reliance on police as first responders in every crisis. 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. "Daniel's Law" is an example of a statewide initiative that would provide the opportunity to meet this moment with a bold new vision for community safety that starts with removing police as the default solution to address mental health needs.[10]

New Yorkers 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.[11] 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.[12]

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[10] "Daniel's Law," A.4697 (Bronson) / S.4814 (Brouk).

[11] 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").

[12] *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-

This Committee should not permit the NYPD to dictate the contours of the New York City mental health crisis response system.

Street Homeless Initiatives

Finally, homeless New Yorkers, advocates and service providers have watched with great concern regarding several new and expanded Department of Homeless Services street homelessness initiatives. Details about these initiatives are not readily available but the observations and information learned so far suggest a troubling escalation of sweeps and criminalization of unsheltered New Yorkers.

We urge this Committee to exercise its oversight authority to understand what involvement by MOCMH and the Council, and its individual members, is occurring and what an appropriate role for MOCMH and the Council should be, with respect to the operation and oversight of these recent homeless initiatives including homeless outreach, clean-ups, and "sweeps"; healthcare provision; other targeted initiatives such as the Penn Station Initiative, Expanded Subway Initiative, Daily Priority Cleanings Initiative, and the 311 Service Request Operation.

It is of particular importance, we submit, that this Committee understand the scope and operation of homeless initiatives that involve the involuntary removals of those individuals who are or are deemed to be homeless to psychiatric facilities, pursuant to N.Y. State Mental Hygiene Law § 9.58. We understand that these involuntary removals are being carried out with the assistance of street health nurses who may or may not operate under the auspices of New York City Health and Hospitals and the New York City Department of Homeless Services.

Conclusion

The NYCLU thanks the Committee for the opportunity to provide testimony. We stand ready to working with the members of this Committee, and all appropriate partners, to advance meaningful policy changes that will improve the lives of New Yorkers confronting mental health challenges.

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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."

Exhibit A: Questions relating to the B-HEARD project.

Recruitment and Training of Staff and Officers

- Composition of team members – language, culture, ethnicity, community background, and lived experience.
- What has been the turnover rate? Reasons for turnover.
- Will there be an opportunity to observe training that the social workers and EMTs receive?
- How does the NYPD ICAT training incorporate the B-HEARD pilot?
- Will the NYPD's prior CIT training resume and who will be conducting the training?
- Will B-HEARD be incorporated into the ongoing training of officers?
- Is there any cross training between B-HEARD and NYPD first responders?
- Press reports suggest EMTs concerned about their safety and not many applied to B-HEARD. Is this true, and if so, has the experience of working with B-HEARD changed the attitude of EMT staff?

Operational Issues

- What is the NYPD's role(s) in the pilot? Is there an ongoing assessment and feedback process to analyze the BH/MH-related calls to better target resources?
- Have officers at the Housing Authority's Police Service Areas (#5 and #6 in Upper Manhattan) been included in the training or planning for the pilot?
- Can a flow chart / decision tree be developed to show how the system works: from calls to dispatch to follow up?
- List of community resources currently being used.
- If B-HEARD team requests an ambulance, do police also come?
- Can an ambulance transport to connection center or only to hospital?
- Uniform for EMT and social worker.
- Can callers request a B-HEARD team via 911, 311, or NYC-WELL?

Data and Outcomes

- It would be helpful to have a dashboard presentation on the website that tracks the outcomes of the pilot with key indicators. How do we measure success? One suggestion is that MH/BH-related calls to 911 drop to zero in the pilot area.
- During the first month, the total number of MH/BH calls = 560, of which 25% (138) routed to B-HEARD teams. The goal is to route at least 50%. Why was this metric selected, as opposed to 80%, 90%, or 100%?
- Average time from dispatch to arrival on scene.
- The types of locations to which teams are dispatched—are there any clear trends?
- How are calls resolved—any trends based on the type of calls, location, or other factors?
- Average amount of time a team spends on a call?
- Percent of people who are homeless? For those, the percent connected to permanent housing.

- Were any "hot spots" identified?
- Frequent users?

Dispatch Protocols

- The description of when police will continue to be sent is not precise: "…emergency situations involving a weapon or imminent risk of harm to themselves and/or others…" and "…violence and/or imminent suicide or harm…" and "…violence, weapons, imminent harm, criminality, or other circumstances requiring law enforcement assistance…"
- Overall, can there be more clarity on dispatch protocols to determine risk of violence?
- The FAQs distinguish between a "mental health emergency" and a "behavioral health crisis," with the former, but not the latter, requiring a call to 911. Is there a clear distinction between the two?
- Of the 138 calls routed to B-HEARD, 20% re-routed to NYPD because teams were not available at the time. The CAHOOTS protocol is to establish a queue and respond to each call when a team is available, which might be an hour or more.
- Press statement by NYPD Commissioner Shay said that the B-HEARD teams frequently call for police support (80% of the time), however the data indicates this only happened 7 times. What is the correct number and why don't the NYPD stats agree with the B-HEARD stats?

Services and Support

- "In 95% of cases, people received assistance from B-HEARD teams…"
- 25% counseled on-site
- 25% transported to support services
- 50% transported to a hospital
- "Everyone served by B-HEARD was offered follow-up care…"
- What type of assistance did people typically receive?
- How often have Health Engagement and Assessment Teams been used and what has been their effectiveness in engaging people in ongoing support? Who is tracking these outcomes? ("…HEAT services are generally in place for up to 90 days, depending on the person's level of engagement and need…")
- Is there any overlap with mobile crisis, intensive mobile treatment, and co-response teams that are assigned to same geographic area?
- What has been the role and effectiveness of the support and connection center?
- The agenda for the advisory committee meeting includes a request for social services and other supportive resources from the community. What are the main gaps in services and supports the B-HEARD teams are finding, for example, housing, re-entry supports, substance use treatment, etc.?
- Is it possible to develop a profile of the "typical" person the B-HEARD team is seeing: race, gender, disability, housing stability, substance use, education, and so on?
- Is there a healthcare database or EHR-type file for the individuals contacted by B-HEARD that documents treatment and health issues?