NYLPI
JUSTICE THROUGH COMMUNITY POWER

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Testimony of

Courtney Hauck, Pro Bono Scholar

on behalf of

New York Lawyers for the Public Interest

before the

Council of the City of New York

Committee on Health

and

Committee on Mental Health, Disabilities, and Addiction

regarding

New York City's Response to

Individuals Experiencing Mental Health Crises

My name is Courtney Hauck and I am a Pro Bono Scholar in the Disability Justice Program at New York Lawyers for the Public Interest (NYLPI) (Juris Doctor Candidate June 2021). Thank you for the opportunity to present testimony on the critical issue of budget allocations for a non-police response to individuals experiencing mental health crises.

> *When the police showed up, they disregarded me, they would not take my complaint, they didn't investigate . . . I wasn't treated as a person. And*

that day I realized that people living with mental health concerns did not have any human or civil rights.[1]

When an individual experiences a mental health crisis, a well-trained crisis care team will de-escalate the event with respect and empathy. Yet in communities like New York City that lack an adequate mental health crisis response system, law enforcement become the de-facto first responders. We would not ask police officers to perform surgery; why, then, do we ask them routinely to respond to mental health crises? As federal mental health authorities recognize, ***only people with extensive training in de-escalation practices should respond to a mental health crisis, and the most appropriate individuals to respond are peers*** (people with lived mental health experience) and health care providers.[2]

Since 2015, ***police in New York City have killed at least 23 individuals*** who were experiencing mental health crises or had a history of mental illness, most of whom were Black or other people of color.[3] The scores of people experiencing mental health crises who have been killed and seriously injured by police, and the broader criminalization of mental illness, are microcosms of the police brutality and mass incarceration that are being protested around the world today. Moreover, ***individuals experiencing mental health crises account for approximately a quarter of all people killed by police nationwide***.[4] Even if encounters do not end in death or injury at the hands of police, individuals with mental illness often find themselves forcibly committed or incarcerated, beginning a cycle of readmissions, reincarceration, and homelessness.[5] This reality falls even more heavily on communities of color, which experience both disability and police violence at disproportionate rates.[6] The longer it takes to reform

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[1] Christina Sparrock, CPA, peer mental health advocate, and CCIT-NYC partner. NYLPI, *Establishing a Non-Police Response to Mental Health Crises*, Facebook Live (Nov. 12, 2020), https://fb.watch/47LjZMIyVB (hereinafter *Establishing a Non-Police Response*).

[2] SAMHSA, *National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit* 8 (2020), https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf ("In too many communities, the 'crisis system' has been unofficially handed over to law enforcement; sometimes with devastating outcomes."); *id.* at 18 (recommending that mobile crisis response teams incorporate peers and respond *without* law enforcement unless special circumstances require otherwise).

[3] Data compiled from *Washington Post* police shooting data as of March 10, 2021, Julie Tate, Jennifer Jenkins, Steven Rich & John Muyskens, *Fatal Force Database*, GitHub, https://github.com/washingtonpost/data-police-shootings, and other public news sources. *See* Appendix A.

[4] Wesley Lowery, Kimberly Kindy, Keith L. Alexander, Julie Tate, Jennifer Jenkins & Steven Rich, *Distraught People, Deadly Results*, Wash. Post (June 30, 2015), https://www.washingtonpost.com/sf/investigative/2015/06/30/distraught-people-deadly-results.

[5] *See* SAMHSA, *supra* note 2, at 8, 27; *Jailing People with Mental Illness*, NAMI, https://www.nami.org/Advocacy/Policy-Priorities/Divert-from-Justice-Involvement/Jailing-People-with-Mental-Illness.

[6] *See* Mayor's Off. for People with Disabilities, *AccessibleNYC* 138 (2020), https://www1.nyc.gov/assets/mopd/downloads/pdf/AccessibleNYC2020.pdf (noting that 73% of New York City residents with disabilities are people of color); Elle Lett, Emmanuella Ngozi Asabor, Theodore Corbin & Dowin

this City's response to individuals experiencing mental health crises, the more lives will be at risk.

In contrast to law enforcement responses to mental health crises, ***peer-driven de-escalation models*** have been shown to be highly effective and safe for all individuals involved. In over 30 years since CAHOOTS (Crisis Assistance Helping Out On The Streets), a peer-driven program in Eugene, Oregon, was founded, ***not a single crisis responder, nor a single person experiencing a crisis, has ever been seriously injured*** during a CAHOOTS crisis response.[7]

Building on this model, Correct Crisis Intervention Today – NYC (CCIT-NYC), a coalition of more than ***80 community mental health advocacy and other organizations***, including NYLPI, has developed a proposal (attached as Appendix B) to make non-police responses available to individuals experiencing mental health crises. This proposal has been developed in consultation with affected communities through ***two 100+ peer focus groups*** and an ***ongoing community survey***. Critical components of CCIT-NYC's proposal are:

- teams of trained peers and emergency medical technicians (EMTs);
- teams run by peer-driven, culturally-competent community organizations;
- response times comparable to those of other emergency services;
- 24/7 operating hours;
- calls routed to a number other than 911; and
- oversight by an advisory board of 51% or more peers from low-income Black, Latinx, and other communities of color.

Adopting CCIT-NYC's proposed reforms will ***save lives, facilitate more effective de-escalation, and break cycles of recurring hospital readmissions, incarceration, homelessness, and suicide***.[8]

Further, investing in this proposal will also *save City resources*:

First, by reallocating funds from the New York Police Department (NYPD) budget (since police will have at most a minimal role in mental health crisis response), the Council can ensure that individuals experiencing mental health crises will receive appropriate services to de-escalate the crises and obtain access to mental health care—at ***no additional cost to taxpayers and vast savings to the public***.

Boatright, *Racial Inequity in Fatal US Police Shootings, 2015–2020*, 75 J. Epidemiology & Cmty. Health 394 (2021) (finding that Black, Indigenous, and other people of color experience significantly higher rates of death by police shootings).

[7] *Establishing a Non-Police Response*, *supra* note 1 (statements by Tim Black, CAHOOTS).

[8] *See* SAMHSA, *supra* note 2, at 8.

As a reference, the CAHOOTS program budget is about $2.1 million per year, compared to about $90 million for police serving the same jurisdiction.[9] Scaling this figure to New York City's 77 police precincts, the Council should anticipate a budget of roughly $100 million per year to implement CCIT-NYC's proposal citywide.[10] This is equivalent to ***less than 1% of total annual spending on the NYPD*** (roughly $11 billion in FY 2020[11]), or approximately 1.8% of City allocations for NYPD's operating budget ($5.6 billion in FY 2020[12]).

Second, this proposal will conserve City resources both by lessening the burden on inpatient psychiatric facilities, police, and other de-facto first responders, and by reducing City spending on claims stemming from NYPD encounters with people experiencing mental health crises.[13] Although City Comptroller records do not track this data with precision, such encounters likely account for a significant portion of the City's over $95 million per year in payments for personal injuries due to excessive force, false arrest, and other NYPD misconduct.[14] For instance, in 2019, ***roughly 21% of all NYPD uses of force and 30% of all Taser discharges involved people experiencing mental health crises***.[15] By diverting responses to mental health crises away from law enforcement, the City can avoid the monetary costs associated with NYPD misconduct claims attributable to encounters with people experiencing mental health crises, and protect the ***priceless resources of human life and dignity*** for all New Yorkers.

In short, by reallocating less than 1% of the NYPD's budget, City Council can save invaluable human lives, conserve significant City and public resources, and ensure safe

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[9] *What Is CAHOOTS?*, White Bird Clinic (Oct. 29, 2020), https://whitebirdclinic.org/what-is-cahoots.

[10] 2019 Census data indicates that New York City's population is about 8.419 million people, which is about 48.8 times the population of the CAHOOTS service area in Eugene-Springfield, Oregon (172,622 per 2019 Census data). Scaling CCIT-NYC's proposal to all 77 precincts, therefore, will require roughly $102.4 million: 8.419 million divided by 172,622 and then multiplied by $2.1 million.

[11] *See Seven Facts About the NYPD Budget*, Citizens Budget Comm'n (June 12, 2020), https://cbcny.org/research/seven-facts-about-nypd-budget.

[12] *See* Council of the City of N.Y., *Report to the Committee on Finance and the Committee on Public Safety on the Fiscal 2021 Executive Budget for the New York Police Department* 1 (2020), https://council.nyc.gov/budget/wp-content/uploads/sites/54/2020/05/FY21-NYPD-Executive-Report-1.pdf.

[13] *See* SAMHSA, *supra* note 2, at 8 ("With non-existent or inadequate crisis care, costs escalate due to an overdependence on restrictive, longer-term hospital stays, hospital readmissions, overuse of law enforcement and human tragedies that result from a lack of access to care."); Greg B. Smith, *The NYPD's Mental Illness Response Breakdown*, City (Mar. 21, 2019), https://www.thecity.nyc/special-report/2019/3/21/21211184/the-nypd-s-mental-illness-response-breakdown (indicating that most 911 calls involving people with mental illness result in emergency room visits).

[14] *See* Off. of the N.Y.C. Comptroller, *Claims Report: Fiscal Year 2019*, at 10, 13 (2020), https://comptroller.nyc.gov/wp-content/uploads/documents/Claims-Report-FY-2019.pdf.

[15] *See* NYPD, *Use of Force Report 2019*, at 46, 55 (2020), https://www1.nyc.gov/assets/nypd/downloads/pdf/use-of-force/use-of-force-2019-2020-11-03.pdf.

and effective crisis care for all New Yorkers experiencing mental health crises. For these reasons, NYLPI urges this Council to take immediate action to fund non-police responses to mental health crises, and in doing so, protect the ***1.7 million City residents living with mental illness***.[16]

Critically, for the reasons set forth in NYLPI's February 22, 2021 testimony before the Committee on Mental Health, Disabilities, and Addiction, annexed hereto as Appendix C, ***NYLPI urges this Council not to pass Int. No. 2210-2021 as written, because it will authorize far greater police involvement in mental health crises than it intends***.

Thank you for your consideration. I can be reached at (212) 244-4664 or CHauck@NYLPI.org. I look forward to the opportunity to discuss how best to support live-saving mental health crisis interventions.

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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.

[16] *See* Off. of the Mayor, *Report: Understanding New York City's Mental Health Challenge* 1 (2015), https://www1.nyc.gov/assets/home/downloads/pdf/press-releases/2015/thriveNYC_white_paper.pdf ("At least one in five adult New Yorkers is likely to experience a mental health disorder in any given year.").

Appendix A: People killed as a result of police encounters in NYC who had a history of mental illness, expressed suicidal intentions, or were experiencing mental distress at the time of their encounter with police, *January 1, 2015 through March 10, 2021**

Name	*Date*	*Manner of Death*	*Age*	*Gender*	*Race*	*Borough*
Jonathan Efraim	4/22/15	shot	30	M	White	Queens
David Felix	4/25/15	shot	24	M	Black	Manhattan
Mario Ocasio	6/8/15	beaten and Tasered	51	M	Hispanic/Latinx	Bronx
Anthony Paul II	7/1/15	cuts by saw (defending entry), Tasered	29	M	Black	Bronx
Garry Conrad	5/18/16	shot	46	M	White	Manhattan
Rashaun Lloyd	6/19/16	shot	25	M	Black	Bronx
Deborah Danner	10/18/16	shot	66	F	Black	Bronx
Ariel Galarza	11/2/16	Tasered/dry stun	49	M	Hispanic/Latinx	Bronx
Manuel Rosales	11/4/16	shot	35	M	Hispanic/Latinx	Manhattan
Erickson Brito	11/19/16	shot	21	M	Black	Brooklyn
James Owens	1/3/17	shot and Tasered	63	M	Black	Brooklyn
Dwayne Jeune	7/31/17	shot	32	M	Black	Brooklyn
Miguel Richards	9/6/17	shot	31	M	Black	Manhattan
Cornell Lockhart	11/13/17	shot	67	M	Black	Bronx
Dwayne Pritchett	1/28/18	multiple causes	48	M	Black	Bronx
Michael Hansford	1/29/18	shot	52	M	Black	Bronx
Saheed Vassell	4/4/18	shot	34	M	Black	Manhattan
Susan Muller	9/17/18	shot	54	F	White	Queens
Robert Myers	1/3/19	shot	63	M	White	Brooklyn
Kawaski Trawick	4/14/19	shot	32	M	Black	Manhattan
Kwesi Ashun	10/25/19	shot	33	M	Black	Manhattan
Luis Manuel Vasquez	12/13/20	shot	52	M	Hispanic/Latinx	Manhattan
George Zapantis	6/21/20	Tasered	29	M	White	Queens

*Data compiled from *Washington Post* police shooting data as of March 10, 2021, Julie Tate, Jennifer Jenkins, Steven Rich & John Muyskens, *Fatal Force Database*, GitHub, https://github.com/washingtonpost/data-police-shootings, and other public news sources.

CCIT-NYC

CORRECT CRISIS INTERVENTION TODAY

FIGHTING TO TRANSFORM RESPONSES TO MENTAL HEALTH CRISES

Piloting a Peer-Driven Mental Health Crisis Response Program

The need:

The New York Police Department (NYPD) began providing Crisis Intervention Team (CIT) training in June 2015. In the four and a half ensuing years, sixteen mental health recipients were fatally shot by the police, and four others were shot and arrested.

Not surprisingly, many mental health recipients, family members, and health providers fear calling 911 because of these and other similar tragedies. This causes many people to delay reaching out for help until circumstances have escalated to a critical stage.

Mental healthcare responses to mental health crises are universally considered the best practice. For example, the leaders of CIT international – a group consisting primarily of police, which created crisis intervention team (CIT) training 35 years ago – now argue that only a mental healthcare response is appropriate for a mental health crisis. In the CIT International's recent best practice guide, they note that even a co-response model (police and mental health workers) is an inappropriate response because it still involves the police. Other police leaders also say mental health workers should be used in lieu of police.

Although New York City created a taskforce to determine an appropriate mechanism for responding to mental health crises, the initiatives put forth by the taskforce do not systematically address how to best respond to the *180,000 crisis calls per year* received by the NYPD. The taskforce failed to recognize that responding to mental health crises is a public health issue, and it continued to view the NYPD as the first responder for the vast majority of crisis calls.

In response to the taskforce's suggestions, the City proposed adding only five mobile crisis teams to respond to crisis calls. However, the minimal increase in mobile crisis teams does not even come close to serving a city of 9,000,000 people and countless visitors. And critically, 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.

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 active risk, and, like mobile crisis teams, they cannot be deployed to 911 mental health crisis calls and they cannot transport anyone.

The Solution:

We propose forming a mental health crisis response team that would embody existing best practices in non-police alternative mental health crisis response. The team would consist of one peer trained as a crisis counselor and one emergency medical technician (EMT).

What is the role of the peers?

During all stages of the pilot (planning, design, implementation, maintenance, evaluation), peers from low-income Black, Latinx and other communities of color within the areas in which the pilot is taking place, who do not have a governmental interest, will be included in the discussions and given the ability to weigh in on key decisions, including the hiring and training of peers, dispatch personnel and other personnel. During the planning for the pilot, multiple forums will be held in the pilot communities, at times that allow working people to attend, in order provide input into the pilot.

Where would the pilot be located?

In order to provide complete coverage to a given geographical area, the pilot will be located in two police precincts with the highest number of "emotional health crisis" calls (formerly derisively referred to as "Emotionally Disturbed Person" or "EDP" calls): Midtown South's 14th Precinct with 4,356 mental health crisis calls in 2018 and Brooklyn's 75th Precinct with 5,428 mental health crisis calls in 2018. The selected precincts are among those with the highest number of mental health calls per capita.

What would the peer-driven mental health crisis response teams look like?

The new mental health crisis response team would embody existing best practices in non-police alternative mental health crisis response, and consist of one peer trained as a crisis counselor and one emergency medical technician (EMT). 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.

The Office of Consumer Affairs in the New York City Department of Health and Mental Hygiene (DOHMH) will contract with non-governmental agencies which will deploy the mental health crisis response teams.

The mental health crisis response teams will consist of peers who have worked with people in crisis, such as those who have worked in crisis respite centers, and also have experience in de-

escalating crises. It would be desirable for the peers to either have lived or worked in the areas in which they are hired to serve.

The teams must operate 24/7, 365 days a year, in three consecutive shifts per precinct (8 a.m. to 4 p.m., 4 p.m. to 12 a.m., and 12 a.m. to 8 a.m.), with two teams in place for the day and evening shifts, and one team for the overnight shift. Since each team consists of two people, the staffing need for the pilot requires 38 total FTE's for the two precincts for all shifts.

In addition, the pilot requires one Project Director, two Supervisors and one Administrator.

The pilot also requires two vans per precinct so that the team can transport individuals to drop-in centers, safe havens, the new support and connection centers, urgent care centers, or hospitals.

What type of training will the pilot provide?

The agency with which DOHMH contracts, operating with consensus from peer-driven organizations and peers from low-income Black, Latinx and other communities of color, who do not have a governmental conflict of interest, will be responsible for training all mental health crisis response teams, NYC Well staff involved in the project, as well as all 911 operators who will likely still be responsible for directing some of these calls .

How would people call for the mental health crisis response team?

The pilot will establish a new number dedicated to mental health crisis calls such as "WEL" or 988, which anyone can call. The calls would go to NYC Well's hotline and will be staffed by NYC Well staff who would automatically send the calls to the mental health crisis response teams. Since NYC Well operators will be dispatching mobile crisis teams in the next few months it will be cost-effective to have NYC Well also dispatch the mental health crisis response teams.

What would the average response time be for the mental health crisis response teams?

The average response time for the mental health crisis response teams will be the same as the current average response of police to non-mental health crises – or less time.

How long will the pilot last?

The pilot will last five years, thereby allowing sufficient time for start-up and evaluation.

If after 18 months the data reveal the pilot is having a positive impact based on established metrics, two additional pilots will be funded at that time.

How much will the pilot cost?

The pilot will cost roughly $3.5 million to $4.0 million annually for the two proposed precincts. Costs are estimated.

Notably, Eugene, Oregon, which is the size of one New York City police precinct, uses a similar mental health crisis response model which includes two workers and has an annual budget of $1.9 million.

The pilot requires training and data collection/evaluation (see below), which is not part of the Eugene budget, but is pivotal to determine how the pilot is working and what changes need to be made to it. Additional costs above those in Eugene will also be incurred by the pilot in order to keep salaries commensurate with the cost of living in New York City.

A draft budget is attached.

Which entity will run the pilot?
DOHMH will contract out with a non-governmental agency which will run the pilot.

Who will monitor the pilot?
The pilot will be monitored by an oversight board whose membership will be decided upon after soliciting recommendations from peers from low-income Black, Latinx and other communities of color.

Such a board must include independent peers from low-income Black, Latinx and other communities of color who do not have a governmental conflict of interest. These peers will constitute 51% of the board. Additional board members might include staff of NYC Well, the support and connection centers, the crisis respite centers, DOHMH, the New York State Department of Health (DOH), the New York State Office of Mental Health (OMH), the New York City Department of Homeless Services (DHS), the New York City Human Resources Administration (HRA), the New York City Fire Department (FDNY) and other Emergency Medical Service (EMS) providers, the Office of the Comptroller, the Community Board for the relevant precinct, the Public Advocate, the relevant Borough President, and members of the City Council and the New York State Legislature from the relevant precincts.

The oversight board will be empowered to request and obtain data from law enforcement agencies necessary to carry out this pilot. Law enforcement agencies will not at any point have access to identifying data related to participants in the pilot.

How will the pilot be monitored?
The oversight board will:

- hire an independent evaluation entity which will evaluate the pilot
- review data from the pilot project
- suggest changes to the pilot
- meet at least quarterly
- issue meeting agendas
- publicly list all agendas
- issue minutes of meetings
- publicly list all minutes
- ensure all meetings are open to the public
- pay stipends to those members who are not receiving a salary for participating in oversight board activities

There will be one oversight board for all pilot precincts.

How will data be collected?

Data will be collected and analyzed by an independent evaluation entity every three months once the pilot is operational. The data will be provided to the oversight board which will also have the right to request additional data, as needed.

The data evaluation entity must protect the privacy and autonomy of those receiving services from the mental health crisis teams. Data from this project will not be admissible in criminal cases. Summaries of the data collected, as well as the management and privacy plans, will be made transparent and accessible to the public.

How will the pilot be funded?

Primary funding will come from New York City's budget. New York City should also reach out to New York State for funding, possibly from money allocated statewide for CIT but never used for New York City.

How will the pilot be publicized?

NYC Well and all other City and State agencies which comprise the oversight board will work closely with CCITNYC and other advocates to develop an extensive list of agencies, community organizations, and individuals who will receive direct notice of the pilot. In addition, NYC Well will utilize its best efforts to obtain extensive media coverage of the pilot, and will prominently promote the pilot via social media and other campaigns to raise awareness amongst the public in the identified precincts.

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February 22, 2021

Testimony of

Ruth Lowenkron, Disability Justice Director

on behalf of

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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[17]. 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[18].

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[19], and individuals who are shot and killed by the police when experiencing mental health crises are disproportionately Black and other people of color[20]. 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;
- 24/7 operating hours;
- calls routed to a number other than 911; and

[17] 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.

[18] 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.

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

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

- 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[21]. **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;"
- 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

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

- 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.