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**September 17, 2021**

**Testimony of**

**Mackenzie Arnold, Legal Fellow**

**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**

**Oversight - Coordinating City Agencies to Address Serious Mental Illness**

My name is Mackenzie Arnold, and I am a Legal Fellow in the Disability and Health Justice Programs at New York Lawyers for the Public Interest. Thank you for the opportunity to present testimony on the critical issue of mental-health crisis response in New York City.

Today, I am here to discuss the City's recent actions regarding mental health crisis response and, in particular, the B-HEARD program. New York Lawyers for the Public Interest (NYLPI) is encouraged and thankful that the City has allocated $112 million to establishing a mental health crisis response system. But that investment is only as valuable as the programs it is invested in. My comments today (1) outline why the B-HEARD program fails to provide a pathway to meaningful crisis response and (2) provide a set of actionable steps the City can take to create a more robust, transformative crisis response system. **Our hope is that once you and the Mayor's Office of Community Mental Health have reviewed our comments, you will partner with peers and community organizations like NYLPI and Correct Crisis Intervention Today – NYC (CCIT-NYC) to make community-led crisis response a reality.**

Each year, the City of New York receives upwards of 170,000 calls seeking aid for community members experiencing mental-health crises[1]—an increase of nearly 80% since 2009.[2] In most of these instances, police are the first to respond.[3] Despite the overwhelming volume of calls, almost none of these responses result in the sustainable, long-term care people need to live and thrive in their communities. Instead, police use the blunt tools they know best, resulting in arrest or forced hospitalization in 64% of cases.[4] Far too often, these encounters end tragically: in violence, incarceration, involuntary hospitalization, and—most heartbreakingly—death.[5]

But even these most egregious outcomes understate the true extent of harm created by existing response. In essence, **New York City has developed a system of identifying *hundreds of thousands* of its most vulnerable citizens in moments of intense need.** It then spends enormous amounts of time and resources to send police officers to situations they have no expertise handling. And these officers arrive unable to evaluate or offer any of the long-term social, physical, or mental-health resources necessary to provide stability to those in need.

In doing this, existing police-driven crisis response squanders a crucial opportunity to provide long-term care at the exact moment it is needed most. **We urge the City to recognize the enormity of this loss:**

> **Every time a crisis call is referred to police, the City diverts essential resources to an intervention fundamentally incapable of helping, and one more person loses the opportunity to receive necessary support.**

This is why NYLPI is here to testify today. Because, despite efforts by the City to recognize the severity of this crisis, its current plan—specifically the **B-HEARD program**—continues to treat police as the default response in far too many cases. This approach is **(1) inconsistent with comparable, successful programs adopted in other cities; (2) contrary to best practices and evidence accepted by governments, community members, advocates, and police alike; and (3) antithetical to the safety needs of both citizens and crisis responders.**

According to the only data released thus far, the B-HEARD pilot program has operated for only 16 hours a day, received only ***25%*** of crisis calls during those hours, and has—even in the most limited of pilots—rejected 1 in 5 of all referrals. In other words, ***>80%*** **of crisis calls receive no**

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[1] PUBLIC ADVOCATE FOR THE CITY OF NEW YORK, IMPROVING NEW YORK CITY'S RESPONSE TO INDIVIDUAL IN MENTAL HEALTH CRISIS 5 (2019), https://www.pubadvocate.nyc.gov/reports/improving-new-york-citys-responses-to-individuals-in-mental-health-crisis/ (reporting 179,569 calls in 2018); Ben Chapman, *New York City to Dispatch Mental-Health Teams to Some 911 Calls*, WASH. POST (Nov. 20, 2020), https://www.wsj.com/articles/new-york-city-to-dispatch-mental-health-teams-to-some-911-calls-11605047892 (reporting 171,490 calls in 2019).

[2] *Id.* at 5.

[3] *Id.* at 4.

[4] Theresa C. Tobin, *Policing and Special Populations: Strategies to Overcome Policing Challenges Encountered with Mentally Ill Individuals*, POLICING & MINORITY COMMUNITIES 79 (2019), https://link.springer.com/chapter/10.1007/978-3-030-19182-5_5.

[5] *See* Greg Smith, *The NYPD's Mental Illness Response Breakdown*, N.Y. MAGAZINE (Mar. 21, 2019), https://nymag.com/intelligencer/2019/03/special-report-nypds-mental-illness-response-breakdown.html.

**aid from B-HEARD, and for 8 hours a day, 0% of calls receive crisis response.** This is a far cry from the City's stated goal of *serving* 70% of all crisis calls,[6] an already limited goal for a program serving mental health needs.

Of additional concern, B-HEARD

- Has response times as long as 30 minutes,[7] more than 3 times that of standard emergency response[8]
- Continues to treat police as the default response to the vast majority of mental health crises
- Creates no role for peers (individuals with lived mental health experience)
- Fails to connect community members with the long-term, comprehensive social, physical, and mental health supports needed to provide lasting stability to those in crisis
- Was developed without any input from community partners or peers
- Operates exclusively through the existing 911 system, distrusted by many in the community and oriented toward police response
- Fails to provide staff with trauma-informed and experiential training led by skilled peer instructors
- Has failed to develop outcome metrics to meaningfully measure effectiveness
- Has already failed to disclose basic data for purposes of accountability (as of September 2021, the program had released only one month of data from June 2021)
- Provides no role for community oversight or input.

By serving such a narrow portion of all crisis calls, excluding peers, and failing to engage with essential community partners, **the B-HEARD program creates a system much closer to traditional policing than the City Council undoubtedly set out to create** when it allocated $112M to mental health crisis response.

To address these concerns, CCIT-NYC, a coalition of more than 80 community mental health advocacy and other organizations, including NYLPI, has developed a proposal[9] to make non-police response available to individuals experiencing mental health crises. This proposal has been developed in consultation with affected communities through two 100+ person focus groups and a recently completed community survey. The proposal was developed in line with the practices of the highly successful CAHOOTS model that has operated in Eugene, Oregon for more than three decades.

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[6] This figure is based on communications between Susan Herman and CCIT-NYC on January 25, 2021. To date, the Mayor's Office of Community Mental Health has not released data on actual response times, despite having promised this data to the City Council in its February 22, 2021 testimony.
[7] *Id.*
[8] *See* NYC Analytic: End-to-End Detail, NYC 911 Reporting, NYC.Gov, https://www1.nyc.gov/site/911reporting/reports/end-to-end-detail.page.
[9] *Our Proposal*, CCIT-NYC, https://www.ccitnyc.org/ourproposal. Note that the proposal, which currently calls for a pilot program, is being revised to reflect the City's Council's allocation of sufficient funding for a city-wide crisis response system.

**NYLPI makes the following recommendations:**

1. **Vastly expand the category of crisis calls offered non-police crisis response.**

Responding to less than 20 percent of *crisis* calls is barely an improvement on the status quo. The longest standing crisis response program—Eugene, Oregon's CAHOOTS program—handles **17% of *all* 911 calls in Eugene.**[10] Crisis calls are mental health emergencies and require a mental health response. Police should, at most, be an exception, not the default.

**Importantly, this can be done safely**: In CAHOOTS' three decades of service, handling as many as 24,000 calls a year, **not a single person—community member or staff—has ever been seriously injured.**[11] Other programs have had similarly impeccable safety records, with a recent review of existing programs finding that **of the thirty-three crisis teams surveyed, none had experienced a serious injury to a staff member.**[12]

**Even minor injuries** (such as being rear-ended in traffic on the way to a call or being spat on by a client) **are exceptionally rare: occurring in 1 in every 25,958 calls**.[13]

2. **Create roles for peers and a long-term plan to hire and train necessary staff from affected communities.**

Community crisis response derives its value from the unique skills of those responding to calls. Today, it is widely accepted that 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**.[14]

The longest standing crisis response program, **CAHOOTS, has stated that at any given time, upwards of 75% of its staff are peers.**[15]

**Community surveys have shown that community members have a strong preference for peer involvement.** This appeared in NYLPI's recent community survey in New York (soon to be published) and an earlier, expansive survey conducted in Toronto, which found that **"[n]early all**

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[10] URBAN STRATEGIES COUNCIL, REPORT ON THE FEASIBILITY AND IMPLEMENTATION OF A PILOT OF MOBILE ASSISTANCE COMMUNITY RESPONDERS OF OAKLAND (MACRO) 8–9 (JUNE 10, 2020), https://urbanstrategies.org/wp-content/uploads/2020/06/USC-MACRO-REPORT-6_10_20.pdf.

[11] Ari Shapiro, *'CAHOOTS': How Social Workers and Police Share Responsibilities in Eugene, Oregon*, NPR (June 20, 2020), https://www.npr.org/2020/06/10/874339977/cahoots-how-social-workers-and-police-share-responsibilities-in-eugene-oregon.

[12] REACH OUT RESPONSE NETWORK, FINAL REPORT ON ALTERNATIVE CRISIS RESPONSE MODELS FOR TORONTO 86 (2020), https://static1.squarespace.com/static/5f29dc87171bd201ef5cf275/t/5fdbdc1c15119267ed92945a/1608244256195/Final+Report+on+Alternative+Crisis+Response+Models+for+Toronto.pdf.

[13] *Id.*

[14] 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).

[15] Based on conversations between CAHOOTS Director of Consulting, Tim Black and CCIT-NYC.

**participants identified peer workers as being essential to the success of the team"**[16] with many noting uniquely positive experiences with peer support.[17]

**Affected communities' preferences for peers have been embodied in longstanding demands from community advocates.** In September 2019, the Public Advocate published a plan to improve the mental health crisis response system that incorporated nearly all of CCIT-NYC and NYLPI's 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.[18]

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.

3. **Create an oversight board, the majority of whose members would be peers from low-income backgrounds and communities of color.**

Communities need a say in how crisis response develops, and community input ensures accountability and better-informed decision making. True accountability requires continuous oversight, advanced notice and consultation regarding key decisions, data transparency, and opportunities for direct involvement in decision making.

The development of the B-HEARD program itself is clear evidence of the need for these safeguards. **The irony is not lost on NYLPI, its community partners, or peers that a program named "B-*HEARD*" sought no input from affected communities in developing its program**, provided no notice of its plans, and has *to this day* refused to include peers and community organizations in its planning or implementation.

The Public Advocate's report, included specific provisions for the **creation of an oversight body, the majority of whose members would be peers from low-income backgrounds and communities of color.**[19]

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 protecting the identity of individuals receiving mental health services, the work of the oversight body would be open for public review via livestreamed meetings and posted reports, public feedback, and other critical data on a user-friendly web portal.

[16] REACH OUT RESPONSE NETWORK, *supra* note 12, at 39–41.
[17] *Id.* at 24.
[18] PUBLIC ADVOCATE, *supra* note 1, at 15 (emphasis added).
[19] *Id. at* 20.

4. **Provide consistent, immediate coverage 24/7.**

Mental health crises require immediate aid wherever and whenever they occur. And the community needs to be able to trust that they will receive a mental health response when one is needed.

In our recent community survey, numerous people raised concerns about calling 911 to provide aid during a crisis for fear that police would escalate the situation. A situation where citizens cannot be sure whether they are calling the police or a trained mental-health crisis worker produces uncertainty and mistrust in a system that requires the opposite.

When responses do come, they must be swift. EMS response times to life-threatening emergencies are only 8:32 minutes[20]; and even non-life-threatening medical emergencies receive response in only 10:04 minutes.[21] Mental health crises are among the most serious of emergencies and merit the same treatment received by traditional 911 response. Delays of even minutes will have concrete negative effects on the wellbeing of those in crisis.

5. **Provide holistic, accessible, long-term services that are integrated into the broader public health, housing, and social-support systems.**

Mental health crises do not emerge in isolation, and stabilization alone is only a small portion of the response needed. **Programs like CAHOOTS provide comprehensive access to health, housing, substance use, food, and other forms of supports necessary for people to live full and supported lives in their communities**.[22] Stopping short of providing these services misses the vast majority of the value of a crisis response system and leaves New Yorkers in a position not that different from the one they face today.

6. **Allow direct access to services through a separate non-911 number like 988.**

As noted above, numerous community members and peers have expressed concerns about calling 911 for fear that police may escalate crisis situations. For this reason, a separate 3-digit number must be established for all calls related to mental health concerns. As New York City's Public Advocate recognized, having an alternative to 911 "allows for people experiencing mental health crises or those around them to feel comfortable calling for response to get needed services, while knowing that it won't initiate a full-blown police response that could escalate the situation or criminalize the person in crisis."[23]

**Many other cities—including Houston, Chattanooga, Portland, and Sacramento[24]—allow community members to access crisis response through alternate numbers without any contact with 911 dispatch.** These alternatives are feasible and acknowledge the fact that mental health can be fully separated from police-based response.

[20] NYC Analytic: End-to-End Detail, *supra* note 8.
[21] *Id.*
[22] URBAN STRATEGIES COUNCIL, *supra* note 10, at 8–9.
[23] PUBLIC ADVOCATE, *supra* note 1, at 11.
[24] REACH OUT RESPONSE NETWORK, *supra* note 12, at 73.

7. **Release data to enable meaningful community oversight.**

The Mayor's Office of Community Mental Health has promised transparency. It must follow through on that promise. To date, the City has released just one month of data (from June 2021) with no timetable for the release of additional information.

**What information has been released provides little insight into the quality of the program or the services received.** Data transparency requires the release of meaningful and thorough information by which B-HEARD can be evaluated. What few data points the City provides do not allow for that analysis or even basic comparisons.[25] **As just one example, pie charts contrasting the percentage of people who refuse care from B-HEARD with the percentage who refuse care from traditional response provide almost no explanatory value** because the compared sample populations (callers screened for B-HEARD eligibility vs. all crisis callers) differ in many of the characteristics we would expect to explain this gap. **Imprecise data is little better than no data at all.**

**Even where the City has promised data, it has failed to follow through**. In testimony this February, Director Susan Herman promised data regarding (1) "the time from dispatch to arrival on scene [of B-HEARD teams]," (2) "the kinds of locations to which [B-HEARD] teams are dispatched," and (3) information on "how calls are resolved."[26] The first two data points have not been released, and the third is discussed in only cursory detail. The New York City Recovery Plan similarly promised information on "key outputs" like "the kinds of help the B-HEARD teams provide" and the "percentage of B-HEARD clients offered follow-up care."[27] Simply stating that "everyone served . . . was offered follow-up care" with no further elaboration on the types, length, and quality of that care provides no insight or accountability.

To make our concerns clear, NYLPI asks the Office of Community Mental Health to **immediately release existing data from the months of July and August and begin collecting and releasing the following data:**

- Rules and information used to determine eligibility for a B-HEARD response, with clear factual details about why a call was diverted to traditional police response
- Clear, disaggregated information on each of the services received during and after crisis response, including details on each non-hospital response
- Complete data on response times—including not only the average, but the distribution of all response times and explanations for any significant delays in response

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[25] *See generally* BE HEARD: TRANSFORMING NYC'S RESPONSE TO MENTAL HEALTH CRISES, FIRST MONTH OPERATIONS, MAYOR'S OFFICE OF COMMUNITY MENTAL HEALTH (July 2021), https://mentalhealth.cityofnewyork.us/wp-content/uploads/2021/07/B-HEARD-First-Month-Data.pdf.

[26] Testimony of Susan Herman on the City's Progress on and Plans to Continue Strengthening Mental Health Crisis Prevention and Response, Committee on Mental Health, Disabilities, and Addictions (Feb 22, 2021), https://mentalhealth.cityofnewyork.us/news/testimony/testimony-of-susan-herman-on-plans-to-continue-strengthening-crisis-prevention.

[27] New York City Recovery Plan: State and Local Fiscal Recovery Funds, 2021 Report, CITY OF NEW YORK (2021), https://www1.nyc.gov/assets/covid19fundingtracker/downloads/slfrf-annual-recovery-plan-report.pdf.

- Data sufficient to draw meaningful comparisons between case outcomes for those who receive services and those who do not
- Data on any injuries sustained by those receiving aid, and those providing aid, from B-HEARD
- Follow-up data on long-term case outcomes, referral success, and recurrence of crises

8. **Partner with existing peer-driven and other mental health advocacy groups to manage program implementation.**

In order to implement the recommendations above, **we call on the City Council and the Mayor's Office of Community Mental Health to partner directly with NYLPI and CCIT-NYC in developing and implementing a mental health crisis response system.**

**Partnering with community-led organizations and peers is a common practice embraced by other cities.** CAHOOTS is based in a Federally Qualified Health Center.[28] Olympia, Washington's Crisis Response Unit is staffed by a third-party organization specializing in peer-delivered care.[29] New Haven, Connecticut partnered with a longstanding community clinic based at Yale.[30] **And both Oakland, California and Toronto, Canada have partnered with advocacy organizations to conduct community outreach, research best practices, develop community partnerships, and make recommendations for staffing, managing, and training their crisis response teams.**[31] New York City should do the same.

**Without developing these community partnerships, it is unlikely that the City will be able to adequately staff and train crisis response teams at the scale of other cities.** Nor will it be able to incorporate best practices from other regions.

NYLPI and our partners are ready and able to provide our support to the City. That's why we worked with CCIT-NYC to draft and submit a proposal back in 2020 and why we have been attending hearings like these ever since. It's also why NYLPI hired me as a legal fellow to work full-time, exclusively on crisis response for the next year. We are ready to help and hope the City Council and the Mayor's Office of Community Mental Health will work with us.

We look forward to discussing these critical issues with you and thank you for your consideration. Please reach out with any questions or interest to MArnold@NYLPI.org or (212) 244-4664.

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[28] *What We Do*, White Bird Clinic, https://whitebirdclinic.org/about/ .
[29] Abby Spegman, *Olympia's Crisis Response Team Had Nearly 700 Calls in its First Two Months*, OLYMPIAN (June 4, 2019), https://www.theolympian.com/news/local/article230718039.html.
[30] Mary E. O'Leary, *Official: New Haven Crisis Response Team Could Take 10% of 911 Calls for Police*, NEW HAVEN REGISTER (May 11, 2021), https://www.nhregister.com/news/article/Officials-New-Haven-Crisis-Response-Team-could-16168634.php.
[31] *See generally* URBAN STRATEGIES COUNCIL, *supra* note 10 and REACH OUT RESPONSE NETWORK, *supra* note 12, at 4.

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.