Testimony by OCMH

Committee on Mental Health, Disabilities, and Addictions
Committee on Hospitals
Committee on Public Safety
Committee on Fire and Emergency Management

Testimony of Eva Wong, Executive Director of the Mayor's Office of Community Mental Health

Good morning, Chair Lee and members of the Committee on Mental Health, Disabilities, and Addictions; Chair Narcisse and members of the Committee on Hospitals; Chair Salaam and members of the Committee on Public Safety; and Chair Ariola and members of the Committee of Fire and Emergency Management.

My name is Eva Wong, Executive Director of the Mayor's Office of Community Mental Health. I am joined by several colleagues:

- Jason Hansman, Senior Advisor of Behavioral Health Communications and Policy in the Office of Behavioral Health at NYC Health + Hospitals
- Chief Cesar Escobar, with the NYC Fire Department Emergency Management System Operations
- From NYPD, we have Captain Michael Butler (Interagency Operations), Chief Olufunmilola Obe (Training), Deputy Chief Ebony Washington (Communications), and Joshua Levin (Director of Legislative Affairs)
- Jaime Neckles, Assistant Commissioner of Mental Health at the NYC Department of Health and Mental Hygiene; and
- Laquisha Grant, Deputy Executive Director of Mental Health Access from my office.

Thank you for the opportunity to testify.

In Spring 2021, during the COVID-19 pandemic, New York City launched the Behavioral Health Emergency Assistance Response Division (known as B-HEARD) as a health-centered response to 911 mental health calls. B-HEARD has since become an integral part of the City's crisis response and mental healthcare system, transforming emergency mental health responses. Previously, 911 mental health calls were handled solely by NYPD and FDNY EMS, often resulting in hospital transports, which were the only treatment option available. B-HEARD reimagines this process, enabling rapid, on-site support for individuals in crisis—an essential improvement in our mental health care system

I will now turn to specifics on B-HEARD.

When B-HEARD was announced in November 2020, many across the country were grappling with how to prioritize mental health in emergency responses instead of relying solely on law enforcement. New York City's solution was to unite FDNY EMS and NYC Health + Hospitals, combining FDNY's emergency response expertise with NYC Health + Hospitals' extensive mental health services, which account for over 60% of the city's behavioral health care. The result was the creation of a new option for people in crisis: interdisciplinary teams – where two EMTs are paired with a mental health professional – to respond as a single unit to 911 mental health calls that do not have violence or weapons as the primary concerns. B-HEARD teams have both the experience and expertise to de-escalate crisis situations and respond to a full range of medical and mental health problems. The teams assist individuals in crisis by providing

immediate health-centered assessments from trained medical and mental health professionals. The goals of the program reflect the city's commitment to ensuring the highest patient outcome through:

- Routing 911 mental health calls to a health-centered B-HEARD response whenever it is appropriate to do so;
- Increasing connection to community-based care;
- Reducing unnecessary voluntary transports to hospitals; and
- Reducing unnecessary use of police resources.

A core principle of B-HEARD is to provide community-based care for individuals experiencing mental health emergencies. This approach allows people to receive appropriate help at home or in their community, ensuring that only those who truly need further evaluation are transported to hospitals. Since the pilot's start, 44% of individuals assessed were connected to community services instead of being taken to a hospital.

In New York City, 911 remains the primary way to request help during emergencies, including mental health crises. Most calls come from bystanders, making it challenging to gather accurate information. The complexity of these calls directly affects B-HEARD's response capacity. To ensure appropriate deployment, EMS 911 call-takers assess calls for violence, weapons, and immediate hospital transport needs. Fully triaged calls are more likely to result in meaningful support.

B-HEARD teams respond to mental health calls independently from NYPD dispatch decisions, although NYPD is informed of B-HEARD deployments. NYPD will respond to high-risk situations, and once a B-HEARD team arrives, they can request police backup if necessary.

Since launching B-HEARD in 2021, we have continuously optimized our health-centered crisis response model based on insights gained. For instance, FDNY EMS developed an automated algorithm to help call-takers determine if an individual has previously been assessed by a mental health clinician. Additionally, FDNY has hired more EMS 911 call-takers in FY24, and a recent patient satisfaction survey showed overwhelmingly positive feedback for B-HEARD.

As the program has expanded to more communities, we have continually examined innovative ways to improve the B-HEARD teams' ability to get to more calls as well as strengthen New York City's responses to mental health emergency calls. Last week the city announced two new strategies that have been implemented to strengthen B-HEARD's ability to provide as many New Yorkers as possible with a health-centered emergency crisis response.

The first strategy is prioritizing sending teams to 911 mental health calls that have been fully triaged by EMS call-takers as appropriate for a B-HEARD response. For almost a year, B-HEARD teams were dispatched to a broader range of mental health calls, namely ones assigned to NYPD and/or EMS where eligibility for a B-HEARD response may not have been established yet during the call triaging process. This did result in B-HEARD teams responding to more calls and a higher percentage of mental health 911 calls, however, after monitoring this new approach closely, the city learned that the teams were experiencing a higher number of instances where the patients were no longer on the scene or in need of their assistance when they responded to the calls that had not been fully triaged. Therefore, the city will prioritize deploying B-HEARD teams to calls that have been fully triaged by EMS 911 call-takers to maximize the time B-HEARD teams spend serving patients.

Coupled with this approach, the city will be switching from using police precincts as geographic boundaries within the existing pilot area to flexible ones that are more aligned with how EMS units are dispatched. This program modification will allow existing teams to be

nimble in their ability to respond to nearby calls outside a precinct boundary once they have completed a call. Rather than being confined to only responding to calls within certain precincts, the teams will be given flexibility to go to calls that are more convenient from an operational standpoint, which will increase their ability to respond to the most appropriate calls.

B-HEARD has consistently been responding to the majority of eligible calls in the pilot area since launch. The number of people who received a B-HEARD response increased significantly from about 2,000 in FY22 to over 7,000 in FY23 to about 15,000 in FY24. This means more and more people in crisis received support from a mental health professional when they needed it most during the first three years of operations.

Each B-HEARD response reflects the City's historic commitment to providing people experiencing a mental health crisis with the most appropriate care by pairing mental health clinicians with EMTs. Each encounter with a B-HEARD team means the City is providing a more appropriate response and better care to an individual experiencing a mental health crisis.

I thank your Committees for your ongoing partnership and commitment to serving New Yorkers who experience a mental health crisis. We are happy to answer any questions you have.

I would like to pass it along to Jamie Neckles, Assistant Commissioner for the Bureau of Mental Health at DOHMH.

NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE
Ashwin Vasan, MD, PhD
Commissioner

Testimony

of

Jamie Neckles
Assistant Commissioner, Bureau of Mental Health
New York City Department of Health and Mental Hygiene

before the

New York City Council

Committee on Mental Health, Disabilities and Addiction
Committee on Fire and Emergency Management
Committee on Public Safety
Committee on Hospitals

On

Oversight: Behavioral Health Emergency Assistance Response Division (B-HEARD) and Responses to Mental Health Crises.

And

Int. 532-2024
Int. 1019-2024

September 23, 2024
City Council Chambers
New York, NY

Good afternoon, Chairs Lee, Salaam, Ariola, Narcisse and members of the Committees. I am Jamie Neckles, Assistant Commissioner for the Bureau of Mental Health at the New York City Department of Health and Mental Hygiene (the Health Department). Thank you for the opportunity to testify today. I am pleased to be here with my colleagues to explain the Health Department's vital role in addressing the mental health needs of New Yorkers.

The Health Department's mandate is to protect and promote the health and wellbeing of all New Yorkers. Promoting mental health is a critical part of this responsibility. We employ a public health approach to this work with the primary goal of preventing mental health crises before they happen. However, when they do occur, we seek to ensure all New Yorkers have access to responsive care that includes health and social supports that are affordable, accessible, effective, and free of stigma.

Providing support in moments of mental health crisis is a tremendous duty that we share with our city partners. My colleagues at the Mayor's Office of Community Mental Health (OCMH) spoke to one critical piece of this ecosystem – the BHEARD program. This is a health-centered response to 911 mental health emergencies administered by the NYC Fire Department and NYC Health + Hospitals (H+H) with oversight from OCMH.

I will speak to the mental health crisis response and treatment infrastructure that the Health Department administers. This is to give context for the broader system in which FDNY and H+H's BHEARD program operates and promote awareness of valuable services and supports available to New Yorkers from the Health Department. First, I want to provide some context for the Health Department's work in this space.

What constitutes a "Mental Health Crisis" can look very different from person to person. You do not need a diagnosable mental illness, a serious mental illness, or be experiencing homelessness. A crisis may be triggered by a myriad of different internal emotional or cognitive experiences, interpersonal conflicts, including abuse or violence, or environmental stressors such neighborhood safety. It is essential to recognize the complexity and nuances of these experiences in this discussion.

Additionally, anyone can experience a mental health crisis. A diagnosis or specific experience is not required to experience this kind of distress. We are here today to discuss the mental health care system that aims to support all New Yorkers. It is important to note that the housing crisis, for example, exerts tremendous pressure on this system. Housing is a well-established determinant of health - lack of it negatively impacts health in many ways. As a city, we must support both mental health care infrastructure and affordable housing for all New Yorkers.

I will now speak to our programs. The Health Department offers three kinds of mental health crisis services, simply categorized as *Somone to Call, Someone to Respond, and Somewhere to Go.*

I'll start with *Someone to Call*. When someone experiences a mental health crisis, it can be helpful to talk to someone we trust: a friend or family member, a religious advisor, a mental health or health care provider. Anyone can reach out to 988 at any time of day or night, any day

of the year, to speak with a trained crisis counselor or peer support specialist. NYC 988 is the Health Department's largest mental health crisis service. 988 provided crisis counseling over 311,000 times via call, text, or chat during Fiscal Year 24. 988 counselors and peers will listen to a caller's situation and help them through a moment of crisis with emotional support and coping skills. They will also help connect them to ongoing mental health services that meet their needs.

Sometimes, a person may be unable or unwilling to seek mental health services to get through their crisis. This brings me to the *Someone to Respond category.* In these situations, NYC 988 will dispatch a Mobile Crisis Team (MCT) to visit the person wherever they live within a few hours, 8 am – 8 pm, 7 days a week, citywide. Mobile Crisis Teams are our cornerstone short-term intervention for non-life-threatening mental health crises. Mobile Crisis Teams represent a significant portion of the mental health crisis response infrastructure in the city. There are 24 teams serving all five boroughs: 19 teams serving adults and 5 teams serving children. In Fiscal Year 24, we received 16,500 referrals for adult mobile crisis teams.

Mobile Crisis Teams include both master's-level mental health clinicians and peer specialists. They meet face-to-face with the identified individual in crisis, as well as their family or other support systems, to engage, assess, de-escalate and connect individuals to the most appropriate services. Meetings typically occur wherever the person resides, such as a private apartment, a supportive housing setting or emergency shelter. After a crisis is de-escalated, people can be connected to out- or in-patient care if appropriate. We consider Mobile Crisis Teams a short-term intervention, typically ranging from 1-3 contacts in a two-week period.

Some people need more support than they can access in their home. These folks might need *Somewhere to Go*, our third and final category of mental health crisis services. For these situations, the Health Department also supports Crisis Residences, which provide an alternative to hospitalization for people experiencing mental health crises. They are warm, safe and supportive home-like places that offer 24-hour peer support, group activities, and connection to clinical services as needed. Guests typically can stay for up to one week. These open-door settings enable people to remain connected to their lives—school, work, family—while getting additional supports through a crisis. People may be referred to a crisis residence by 988, a mobile crisis team, their mental health provider, or self-refer.

Now that I've described our short-term crisis services that offer someone to call (988) someone to respond (Mobile Crisis Teams) and somewhere to go (Crisis Residences) - I'll move on to describe our long-term treatment and recovery programs. These programs are designed to serve people with the most complex behavioral health needs. We use the term Serious Mental Illness to refer to this combination of behavioral health and functional needs.

The Health Department manages New York City's Single Point of Access (SPOA) system to these specialty treatment and recovery services. People are connected to these programs by providers who make referrals through the Health Department's website. Referral sources include the crisis services providers I just described, as well as community based mental health, shelter, and housing providers who recognize that their client could benefit from a higher level of care.

Hospitals, jails and prisons also make referrals to our Single Point of Access, as a part of their discharge planning process. SPOA system received 4,107 referrals in FY24.

SPOA accessible treatment and recovery programs include Assertive Community Treatment (ACT) and Intensive Mobile Treatment (IMT) Teams, which have a combined capacity to serve about 6,500 people at a time. These programs provide long term engagement and treatment for people with serious mental illness who have not found the support they need in traditional settings. One of the many benefits of these programs is reduced risk of future mental health crises. Clinicians at the Health Department's SPOA review eligibility and make referrals to the appropriate level and location of care.

In addition to managing the referral process, the Health Department also contracts with community-based organizations and hospitals to operate Assertive Community Treatment (ACT) Teams. ACT Teams provide longer term mobile mental health and substance use treatment to people with documented serious mental illness. These teams are staffed by behavioral health clinicians and peers. There are 77 total ACT teams in the city. The Health Department contracts for 47 teams, the State Office of Mental Health contracts for the remaining 30 teams. Some of these teams specialize in certain populations. Our 6 Forensic ACT teams work exclusively with eligible individuals with current or past criminal legal involvement. Our 10 Shelter Partnered ACT teams work exclusively with eligible individuals residing in mental health shelters.

We also contract with community-based organization to operate Intensive Mobile Treatment (IMT) Teams. These are interdisciplinary teams, including peers, that provide mobile mental health and substance use treatment for people with serious behavioral health concerns, very complex life situations, transient living situations and/or involvement with the criminal legal system. We support 36 teams serving all 5 boroughs. These teams are designed to engage the hardest to reach New Yorkers.

The Health Department works tirelessly to administer short-term interventions to deescalate moments of mental health crises and provide long-term treatment and recovery supports in the community for people with complex and high needs. This is in addition to administering a continuum of other essential mental health services, such as youth and school-based programs, supportive housing, and much more.

The Health Department is deeply committed to this work and has been for decades. I am pleased with the progress we have made, but we still have so much more work to do. Thank you for the opportunity to testify today. I look forward to answering your questions.

Louis A. Molina
Commissioner

DCAS Testimony on Intro 532-2024 (CM Brannan)
Monday, September 23, 2024

About DCAS

The NYC Department of Citywide Administrative Services (DCAS) makes city government work for all New Yorkers. Our commitment to equity, effectiveness, and sustainability guides our work providing City agencies with the resources and support needed to succeed, including:

- Recruiting, hiring, and training City employees
- Managing 55 public buildings
- Acquiring, selling, and leasing City property
- Purchasing over $1 billion in goods and services for City agencies
- Overseeing the greenest municipal vehicle fleet in the country
- Leading the City's efforts to reduce carbon emissions from government operations

Background on the Non-Public School Security Guard Reimbursement Program

The enabling law for the Non-Public School Security Guard Reimbursement (NPS) Program, Local Law 2 of 2016 (LL 2), was enacted on January 5, 2016. In March of that year, DCAS was designated by then Mayor Bill de Blasio to oversee the implementation of this law. In July 2016, after conducting several meetings with educational constituency groups as well as a public hearing, DCAS finalized rules for the NPS program and posted them in The City Record. The program application launched on June 1, 2016.

LL 2 authorizes reimbursement to non-public schools for expenses related to hiring unarmed security guards. This law applies to “Qualifying Nonpublic Schools,” which means any non-profit elementary or secondary school in the city—other than a public school—providing instruction in accordance with the state education law, that has been assigned a Basic Educational Data System (BEDS) code by the New York State Department of Education (NYSED), or a similar successor identifier, and is serving students in any combination of grades, prekindergarten through twelve. Charter schools are not eligible for the program.

The program provides reimbursement for allowable costs for security guard services based on the number of students enrolled at a Qualified Nonpublic School. Non-public schools that enroll between 300 and 499 students would be reimbursed the cost of one security guard. Non-public schools with at least 500 to 999 students would be reimbursed the cost of two security guards, and the cost of any additional security guard would be reimbursed per every additional 500 students. Non-public schools would only receive reimbursements of allowable costs for State licensed security guard vendors from the qualified provider list to be established by DCAS.

How to Participate in NPS

Beginning each February, DCAS conducts outreach to prospective New York City schools using NYSED's school student enrollment list. They are advised of both the application requirements and filing period, which runs from March 1 to May 15 every year. To participate in the NPS program, interested schools apply via PASSPort for each school site with an individual BEDS code. Applications are reviewed for compliance with the following program eligibility requirements:

- Be a non-public school
- Be a non-profit school
- Have 300 or more students in any combination of grades, Pre-K through twelfth grades only
- Have an assigned NYSED BEDS code number for each instructional location

Schools deemed eligible for the NPS program are sent award letters detailing they have conditional approval for participation. The letter provides additional instructions to the school, which are to be completed before the Memorandum of Understanding (MOU) can be executed.

Once an MOU is executed, schools are then required to contract with a security vendor from the Qualified Provider List of vetted security vendors on DCAS' website. DCAS does not have a contract with the security guard vendors. The schools pay for security guard services, and then submit quarterly invoices with supporting documentation received from their security vendors to DCAS for reimbursement.

For the current school year (SY 2024-25), there are 232 schools preliminarily approved to participate in the program. The total budget is $19.8 million, which was allocated equally across all schools based on the number of guards.

Intro 532

Intro 532 would amend LL 2 to allow for reimbursement for school security guards in non-public schools with fewer than 300 students and increase the total annual funding for reimbursements under NPS from $19.8 million to $39.3 million.

Under this Administration, the safety and security of all New Yorkers, especially our city's students, is a top priority. Every child, regardless of the type of school they attend, deserves a safe learning environment, and through programs like the Non-Public School Security Guard Reimbursement Program, DCAS helps to provide vital resources to bring added security to non-public schools.

Since the inception of NPS, some schools with less than 300 students have raised concern about being excluded from the program. We recognize the City Council's desire to expand this program and its beneficiaries but have concerns about the bill's potential operational and fiscal impacts to DCAS, as drafted, and would like to engage in a dialogue with the Council on how best to enable more non-public schools to provide security for their students.

PUBLIC ADVOCATE FOR THE CITY OF NEW YORK

Jumaane D. Williams

STATEMENT OF PUBLIC ADVOCATE JUMAANE D. WILLIAMS TO THE NEW YORK CITY COUNCIL HEALTH COMMITTEE JOINT WITH COMMITTEE ON MENTAL HEALTH, DISABILITIES AND ADDICTION, PUBLIC SAFETY, HOSPITALS, AND FIRE AND EMERGENCY MANAGEMENT
SEPTEMBER 23, 2024

Good morning,

My name is Jumaane D. Williams, and I am the Public Advocate for the City of New York. Thank you to Chairs Lee, Salaam, Narcisse, and Ariola and the members of the Committees on Mental Health, Disabilities and Addiction; Public Safety; Hospitals; and Fire and Emergency Management for holding this hearing today.

Each year, the NYPD responds to approximately 200,000 calls related to people experiencing a mental health crisis.[1] Despite most often being the first responders, the police are not the best equipped to safely and effectively handle these calls. Additionally, officers have also themselves expressed that they do not want to be responding to these calls. When police respond to people in mental health crises, those who need help are often subject to use of force, arrest, incarceration, and even death. The fatal consequences of what happens when police respond to a person in a mental health crisis was exemplified in March, when 19-year-old Win Rozario called 911 while in emotional distress. As revealed in police body camera footage, the responding officers Tasered and then shot Rozario five times within three minutes of their arrival, after offering no help or attempting de-escalation—killing him.[2]

In light of tragedies where people in mental health crisis are killed by police, municipalities across the country have implemented various alternative response models. In 2021, New York City launched the Behavioral Health Emergency Assistance Response Division, or B-HEARD. B-HEARD teams are FDNY EMTs or paramedics teamed with a mental health professional from Health + Hospitals. These teams operate 16 hours a day, seven days a week, in 31 precincts (out of 77 total precincts). It has been heartening to hear that the number of 911 calls that B-HEARD responds to is increasing, responding to 73 percent of all eligible mental health calls in FY24,[3] but our goal should be for these teams to respond to every eligible call that comes in.

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[1] https://www.nylpi.org/campaign/transforming-mental-health-crisis-response/

[2] https://gothamist.com/news/video-shows-nypd-officers-killed-a-queens-teenager-minutes-after-he-called-911

[3] https://www.nychealthandhospitals.org/pressrelease/mayor-adams-announces-key-milestones-and-strategies-to-improve-crucial-911-mental-health-crisis-response-initiative/

Much of the reason that B-HEARD responds to so few calls lies in inadequate staffing. There is a shortage of 911 operators who can appropriately triage the calls, leading to a default police response. It can be difficult to discern over the phone what is happening at the scene, and whether there is a risk of harm to the caller or to the responders. The city is hiring more 911 staff and allowing B-HEARD teams to join or take over the response to some calls that were initially routed to the NYPD or EMS, but we do not have data on how often the NYPD or EMS calls in B-HEARD to assist on a call.

It is also imperative to ensure that 911 dispatchers are properly trained in how to effectively determine which calls can be sent to B-HEARD. Dispatch training must be improved to incorporate dispatching for mental health crises through ways such as a mental health solution tree that will branch off into separate dispatching categories for various responses. Mental health training must be conducted regularly to ensure calls are being appropriately dispatched to the right teams. We can also learn from models in other cities: in Chicago, dispatchers are regularly updated on the outcomes of calls directed to their Crisis Assistance Response and Engagement teams, and other cities have invited dispatchers on ride-alongs to see teams in action, increasing dispatchers' confidence in these teams.[4]

Staffing of the B-HEARD teams themselves is also an issue. Currently, the teams only operate 16 hours per day, and calls that are determined to be eligible for a B-HEARD response may go to police or traditional EMS anyway, because a B-HEARD team isn't available. It is understandable that B-HEARD responses may take much longer than a typical police response, as de-escalation and determining what an individual in crisis needs takes time. These calls can also be more challenging than a non-mental health call to EMS; we should be incentivizing EMS workers and paramedics to join B-HEARD teams and compensating them fairly for the work that they are doing. The city should also be allocating funding directly to H+H to hire social workers and mental health professionals for B-HEARD teams. While the city has not detailed what a citywide B-HEARD program would look like, if the program scaled up staffing at the same proportion it had to serve 25 precincts, that would mean just 280 people for all of the city's 77 precincts, compared to 35,000 NYPD officers.[5] If we want an effective alternative to police responses to people in mental health crises, we must be meaningfully prioritizing resources for that response; otherwise, we are endangering not only those who need help but those who respond.

Thank you.

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[4] https://tradeoffs.org/2024/07/18/the-fifth-branch-convincing-the-cops/
[5] https://www.politico.com/news/2023/04/17/mental-health-crisis-response-pilot-new-york-00091858

Office of the Richmond County District Attorney

THE COUNCIL OF THE CITY OF NEW YORK

COMMITTEE ON PUBLIC SAFETY
COMMITTEE ON MENTAL HEALTH, DISABILITIES AND ADDICTION
COMMITTEE ON FIRE AND EMERGENCY MANAGEMENT

OVERSIGHT: BEHAVIORAL HEALTH EMERGENCY RESPONSE DIVISION (B-HEARD) AND RESPONSES TO MENTAL HEALTH CRISES

September 23, 2024

MICHAEL E. MCMAHON

DISTRICT ATTORNEY

I. INTRODUCTION

Good morning, Chair Salaam and members of the Public Safety Committee; Chair Lee and members of the Mental Health, Disabilities and Addiction Committee; and Chair Ariola and members of the Fire and Emergency Management Committee. I hope your staffers and families are well and safe. I look forward to continuing our work to improve public safety.

On behalf of the Richmond County District Attorney's Office ("RCDA"), we thank you for the opportunity to submit testimony regarding our desire and the need for an expansion of the Behavioral Health Emergency Assistance Response Division or B-HEARD program to the borough of Staten Island, which is the only borough in this City currently without a B-HEARD presence.

II. B-HEARD HAS EXPANDED BUT NOT TO STATEN ISLAND

A meaningful development in New York City's approach to mental health emergencies has been the B-HEARD program. Piloted in Spring 2021, B-HEARD represents a long-overdue shift. This groundbreaking initiative dispatches teams comprised of FDNY EMTs/paramedics alongside mental health professionals from NYC Health + Hospitals (HHC) to directly address 911 calls involving mental health crises.

Initially implemented in East Harlem, B-HEARD has undergone substantial expansion. By October 2023, the program's reach encompassed all five boroughs except Staten Island, despite the lack of an HHC hospital there. The presence of HHC's Gotham Health Clinic with shuttle services to the Coney Island hospital in Brooklyn suggests that logistical solutions can be implemented to address this gap.

Data released in January 2024 underscores the promise of B-HEARD's effectiveness. The program not only responded to a record number of over 5,000 calls during the first half of 2023, but it also handled roughly a quarter of all mental health-related 911 calls within its operational hours. Notably, this represents a significant increase in response rates compared to earlier periods. More importantly, B-HEARD demonstrably connected over 40% of individuals who received a behavioral health assessment with ongoing support services within their communities, highlighting the program's ability to provide essential long-term care.

III. WHY STATEN ISLAND NEEDS A B-HEARD PRESENSE

Staten Island faces a mental health crisis marked by high rates of serious mental illness and a surging opioid epidemic. A 2023 NYC Department of Health report revealed a troubling disparity*: Staten Island has the highest adult serious mental illness ("SMI") rate of 7.3% compared to the city average of 5.8%.* Opioid-related deaths in Staten Island are also significantly higher than the national average. This crisis demands a multifaceted response, and the proven success of the B-HEARD program makes its borough-wide expansion with integrated support systems a compelling necessity.

Staten Island experiences roughly 7,000 "EDP" (emotionally disturbed person) calls annually. While police deliver these individuals for evaluation to the local psychiatric emergency room, many are released back to the public even if in mental health crisis, lacking access to crisis stabilization and long-term care.

It is vital to consider that the unique disproportionate ratio confronting Staten Island may be attributed, at least in part, to the isolated geographical location, gaps in immediate and convenient public transit, and lack of resources allocated to our borough, making access to a wider variety of services significantly more challenging.

B-HEARD dispatches specially trained teams – FDNY EMTs and paramedics partnered with mental health professionals from NYC Health & Hospitals – to respond to low-level, non-violent mental health calls. Studies show that B-HEARD reduces recidivism by addressing the root causes of criminal behavior. Consequently, expanding B-HEARD to Staten Island can yield significant benefits. It can reduce recidivism and crime rates, thereby freeing law enforcement resources for more serious offenses. Additionally, the program empowers individuals to reclaim control of their lives by offering them the tools and resources needed to overcome addiction and address mental illness, ultimately improving their well-being. Thus, B-HEARD will ultimately promote public safety for all Staten Islanders.

Integrating B-HEARD's effectiveness with Staten Island's existing behavioral health program and service network can further enhance its effectiveness. This could involve establishing a robust referral network connecting B-HEARD participants with long-term mental health and addiction treatment programs. Collaboration with Mobile Crisis Teams would ensure a seamless transition from emergency intervention to ongoing care. Finally, expanding community outreach programs

would educate Staten Islanders about B-HEARD and reduce the stigma surrounding mental health issues.

IV. OTHER MENTAL HEALTH SERVICES AND PROGRAMS NEEDED ON STATEN ISLAND

Mental Health Screenings At Arrest

While physical health assessments are standard protocol upon arrest, lack of immediate mental health assessments for arrestees often delays access and referral to crucial support services and diversion programs and contributes to recidivism. We believe it is critical that all arrestees be screened by a licensed social worker or similarly trained professional for mental health disorders as close to arrest as possible at the precinct at the time of arrest or at arraignments. We have urged the City for the last several years to consider funding and piloting a program to integrate mental health screenings at the precincts on Staten Island. We urge the City to once again consider supporting this potentially life-saving pilot.

Mental Health Support and Connection Center or Crisis Stabilization Center

An alternative to already overcrowded emergency rooms and the criminal justice system, a Staten Island Mental Health Support and Connection Center, similar to successful models in Manhattan, Houston, and Atlanta, could address the enormous and dangerous gap that currently exists in our community for those who are in mental health crisis or in need of stabilization services. Support and Connection Centers, otherwise known as Crisis Stabilization Centers, offer evaluation, treatment plans including mental health services and detox programs, and crucial connections to community support for clients – a needed resource and support to help reduce recidivism, and also an important partnership with any B-HEARD program. We urge the Council to site and fund a Support and Connection Center on Staten Island.

Staten Island Not Supported by City Funding for Mobile Crisis or ACT

Additionally, Staten Island has not been allocated the Mobile Crisis and ACT team funding as provided to other boroughs. The Mobile Crisis team serving Staten Island is, in fact, based out-of-borough at South Brooklyn (Coney Island) Hospital, which consequently, poses greater risk of missing individuals in need of services. Furthermore, the disproportionate funding provided to Staten Island for mental

health services leaves those under the care of an ACT, FACT or AOT team exposed to gaps in services.

V. CONCLUSION

Staten Island deserves the same access to successful mental health programs as the other four boroughs in New York City. The further expansion of B-HEARD with integrated support is crucial because the ever-growing demand for these services is evident: B-HEARD responded to over 5,000 calls from January to June 2023. The program is constantly evolving to meet this need as shown by the increased response rate and broader range of mental health calls it now handles. B-HEARD prioritizes connecting individuals with community-based care, thereby reducing unnecessary hospital visits. B-HEARD should first be expanded into the neighborhoods in Staten Island with the highest number of 911 mental health calls.

The City Council and Mayor must act now. By allocating resources to expand B-HEARD with integrated support systems in Staten Island, they can enhance public safety and foster a healthier, more resilient Staten Island for future generations. Let's prevent the silent storm from becoming a roar by bringing this comprehensive program to Staten Island.

Thank you for your time and consideration. I look forward to working with these committees and its members to achieve these goals and further our shared mission of a safer and more just New York for all.

Thank you.

CATHOLIC COMMUNITY RELATIONS COUNCIL

191 Joralemon Street, 2nd Floor, Brooklyn, NY 11201

Testimony of Joseph Rosenberg
Executive Director, Catholic Community Relations Council
Before the New York City Council Committee on Public Safety
Intro. 532
September 23, 2024

Good morning, Chair Salaam, and members of the New York City Council Committee on Public Safety. I am Joseph Rosenberg, Director of the Catholic Community Relations Council ("CCRC"), representing the Archdiocese of New York and Diocese of Brooklyn and Queens. We strongly support Int. 532, a bill that would help increase the safety of children, faculty, and staff at nonpublic schools throughout our City by expanding an important school security guard program passed by the Council in 2015.

Ensuring the health and safety of school children and especially protecting them from violence is a priority for all of us. New York City's public schools, for example, have had a security guard system in place for many years. The tens of thousands of children in our City's nonpublic schools, however, did not have a comparable security guard protection program until 2015.

That was when the New York City Council recognized this inequity and by a vote of 43-4 passed Local Law 2. The law allowed nonpublic schools to hire uniformed school security agents and be reimbursed for this cost by the City of New York. More than 200 nonpublic schools, including Catholic, Jewish, and Islamic schools currently participate in this successful program.

But Local Law 2 is deficient in that only schools with 300 or more students can be part of this public safety initiative. As a result, nonpublic schools with enrollments as large as 299 students are not eligible.

Int. 532 would rectify this problem. It allows all nonpublic schools to be eligible for this program regardless of the size of their student enrollment. This change significantly increases the number of nonpublic schools citywide that will be entitled to hire safety guards to help protect their students, their faculty, and their staff.

The schools of the Archdiocese of New York and the Diocese of Brooklyn and Queens have over 80 schools with 300 or more students that participate in the security guard program. Passing Int. 532 would enable an additional 78 catholic schools to hire security guards and be reimbursed by the City of New York.

The Catholic schools of New York City have a long-standing history of excellence with high school graduation rates of over 98%. These young people reflect the demographics of their local communities, with over 60% being students of color. Many are the children of immigrants and refugees. They and their counterparts in Jewish and Islamic schools and all other nonpublic schools deserve to be safe.

With the number of religious hate crimes increasing in our City and episodes of horrific violence against school children in our country becoming tragically commonplace, security measures to protect these young people should be expanded. On behalf of the parents, children, and faculty at nonpublic schools, we urge the passage of Int. 532.

THE CITY OF NEW YORK
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Testimony of Logan Clark, Assistant Director of Budget Review
New York City Independent Budget Office

To the New York City Council Committee on Public Safety
On Intro 0532-2024 to Expand the School Security Guard Program for Nonpublic Schools
Monday, September 23, 2024

Good morning Chair Salaam, Ranking Member Ariola, and other esteemed members of the Public Safety Committee. My name is Logan Clark, and I am the Assistant Director of Budget Review at the New York City Independent Budget Office (IBO). My portfolio at IBO covers analysis of the Department of Citywide Administrative Services (DCAS), in addition to other citywide operational costs. Thank you for the opportunity to testify.

I am here today to provide analysis on Intro 0532-2024, which concerns the reimbursement of nonpublic schools for the cost of security guard services, paid for through DCAS's budget. The Intro would expand eligibility of the program to smaller schools, which IBO estimates would double the total potential cost of the program. IBO estimates that the total potential cost of this legislation to the City could be an additional $19.8 million if all eligible nonpublic schools opted in, bringing the total possible program cost up to $39.6 million annually. However, even with the current program, spending remains below the capped levels.

Current Program

Under Local Law 2 of 2016, the City allows for nonpublic schools with more than 300 students to apply for reimbursement for costs of security guards. It is a multi-tiered program, allowing for schools with greater numbers of students to apply for more security guards. Schools are required to hire security guards according to the prevailing wage schedule set by the City Comptroller and DCAS maintains a prequalified vendor list. Assuming 180 days of school as required by state law, the cost of a security guard for a full school year would be at minimum $36,114 depending on the guard's years of experience. The program is currently capped at $19.8 million annually; however, as the table below shows, the City has not ever reached this limit. As of the 2023-2024 school year using data from the New York State Education Department, the total number of eligible schools is 277, and under the tiered system, equates to a total possible reimbursement for approximately 460 security guards across all schools. This would amount to a total of $16.6 million, if the guards are hired at the lowest possible prevailing wage. For context from the most recent closed fiscal (and

school) year, in 2023 the payments to schools totaled $16 million. However, in the four prior fiscal years, actual spending fell farther below the cap of $19.8 million.

Actual Spending for the Security Guard Program for Nonpublic Schools Has Remained Below the Cap for the Last Five Fiscal Years

Dollars in millions

Fiscal Year	School Year	Total Cash Expense
2019	2018 - 2019	$10.3
2020	2019 - 2020	$6.9
2021	2020 - 2021	$9.4
2022	2021 - 2022	$12.2
2023	2022 - 2023	$16.2
Five Year Average		**$11.0**

SOURCE: New York City Financial Management System

Potential Expansion

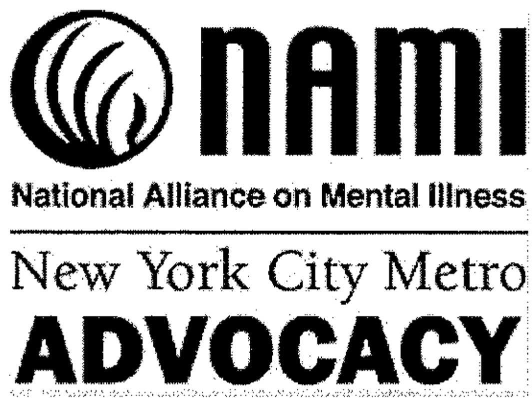
The proposed legislation would allow for nonpublic schools with fewer than 300 students to apply, under the same level of reimbursement as the current lowest tier which allows for one security guard. As of the 2023-2024 school year, there are 548 schools that would newly be allowed to seek reimbursement under this change. Additionally, the cap on total reimbursements would be increased to $39.3 million. At the lowest possible prevailing wage of $36,114 per eligible school security guard, IBO estimates that the potential cost to the city could be an additional $19.8 million annually for a total of $39.6 million, or slightly over the proposed cap. It is important to note that some schools have quite low enrollments—for example, 41 schools have 20 or fewer students.

As previously stated, that would require full program participation by every eligible school, for every single day of the school year. It is important to note that the current cap has not been met in any of the previous years since its implementation in 2016, and that the estimated costs are the ceiling, assuming the lowest labor costs. There is potential for additional expense to the City, should DCAS fully reimburse schools paying well above the prevailing wage, or more schools become eligible.

Number of Nonpublic Schools in NYC by Enrollment Size and Potential Number of Security Guards				
Enrollment Ranges	School Years		Potential Number of Security Guards	
	2022-2023	2023-2024	Eligible Guards Per School	Total 2023-2024 Guards
1 TO 299	564	548	1	548
300 to 499	140	148	1	148
500 to 999	99	94	2	188
1,000 to 1,499	24	24	3	72
1,500 to 1,999	5	5	4	20
2,000 to 2,500	5	5	5	25
2,500 to 3,000	0	1	6	6
Total	837	825		1,007
SOURCE: IBO Analysis of New York State Education Department (NYSED) Information and Reporting Services (IRS) Nonpublic School Enrollment data (https://www.p12.nysed.gov/irs/statistics/nonpublic/)				
New York City Independent Budget Office				

Finally, greater transparency in the total number of schools receiving reimbursement would be helpful in tracking payments in the City's financial data. For example, some payments are processed several years later, and there appear to be some charges out of miscellaneous codes which do not fully have all available recipient data. For the total number of participating schools, Council should require DCAS to publish data regarding the number of schools that have applied, and the number of schools accepted into the program.

Thank you for the opportunity to testify and IBO is happy to answer any questions.



New York City Council Oversight Hearing on the Behavioral Health Emergency Assistance Response Division (B-HEARD) and Responses to Mental Health Crises

before the

Committee on Mental Health, Disabilities and Addiction, jointly with the Committees on Public Safety, on Hospitals, and on Fire and Emergency Management

on

Monday, September 23rd at 10:00am

Testimony By: Jonathan Chung, MPA
Director of Public Policy & Advocacy
National Alliance on Mental Illness of New York City (NAMI-NYC)

INTRODUCTION

Good morning, Chairs Lee, Salaam, Narcisse, Ariola, and members of the joint committees. My name is Jonathan Chung, and I am testifying on behalf of the National Alliance on Mental Illness of New York City (NAMI-NYC), which is the *only* nonprofit providing free, direct, and extensive peer support *and* family support to New Yorkers who care for someone living with serious mental illness, and as a Steering Committee member of the Correct Crisis Intervention Today of NYC (CCIT-NYC). Thank you for holding today's important oversight hearing.

OUR WORK

NAMI-NYC is one of the largest affiliates of the National Alliance on Mental Illness, a grassroots mental health advocacy organization. For over 40 years, NAMI-NYC has served as a leading voice for the mental health community throughout the city, providing groundbreaking advocacy, education, and support services for individuals affected by mental illness, their families, and the greater public, all completely free-of-charge. Our renowned peer- and evidence-based services are unique in that they are led both for and by individuals and families affected by mental illness and are reflective of the diversity of New York City.

THE NEED TO INVEST IN THE DECRIMINALIZATION OF MENTAL ILLNESS

While NAMI-NYC appreciates the goals of the Behavioral Health Emergency Assistance Response Division (B-HEARD) pilot program and the City's attempt to shift crisis response to social workers and Emergency Medical Technicians (EMT), we have great concern with how the program is being implemented and with the current composition of the crisis response teams. **We have made clear to the City Council and the Adams Administration that it is extremely important to fully fund a mental health crisis response program that is city-wide, operates**

24 hours a day, 7 days a week, includes peer responders, has no police involvement, and uses independent emergency response personnel. What we advocate for is not embodied in the B-HEARD crisis response program coordinated out of the Mayor's Office of Community Mental Health (OCMH). These changes must be made as soon as possible to drastically improve the program.

In OCMH's *2023 Annual Report on Critical Gaps in the Mental Healthcare System in New York City*, the office agreed that using 911 as the main entry-point to access care during a mental health crisis typically leads "people in crisis through a predetermined set of responses that are not always health-centered for nonviolent situations, nor get them to the most appropriate type of care."[1] OCMH also used dispatching police and EMS as an example of such a response that "almost exclusively routes someone experiencing a mental health crisis to the hospital when the individual may be better served by being connected to care in the community."[2] They also give the example of how 911 dispatchers are sometimes unable to "deescalate or re-reroute calls to a NYC 988 mental health counselor or peer who would be the most effective and appropriate response for that situation."[3] All these examples show how 911 is the wrong venue for mental health crisis calls.

Two key goals of the B-HEARD program are to increase connection to community-based care and decrease hospitalizations. Yet just 6% of people who receive a B-HEARD response to a mental health crisis are transported to a community-based health care or social service location, and nearly 60% are still transported to the hospital. The program is failing to meet its goals and in turn, failing vulnerable New Yorkers in need of help. There must be more transparency around the

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[1] Wong, E. (2023). (rep.). 2023 Annual Report on Critical Gaps in the Mental Healthcare System in New York City. NYC Mayors Office of Community Mental Health . Retrieved March 23, 2023, from https://mentalhealth.cityofnewyork.us/wp-content/uploads/2023/02/2023-OCMH-Annual-Report.pdf.

[2] *Id.*

[3] *Id.*

B-HEARD program to inform best practices and investments in crisis response. The City must commit to working more closely with community-based service providers and to greater transparency. There has been no new data reported this fiscal year.

Since 2015, at least 20 individuals have been killed by police officers while experiencing a mental health crisis in New York City. Police officers are not social workers. They are trained to respond to and neutralize threats to public safety, not treat a person who is going through a mental health crisis. As a result of the City's poor allocation of resources, 20 people who should be alive are dead, and their families and loved ones are left grieving and searching for answers. We can and we must do better than this. These tragic encounters highlight the need to completely remove police officers from response teams, and instead, center peers- those with lived experience- and mental health professionals as first responders in situations where someone is experiencing a mental health crisis.

CONCLUSION

We strongly urge the Adams Administration to properly expand the B-HEARD pilot city-wide, **with the specific proposals outlined in this testimony** and relayed to this Council by our organization and other members of the CCIT-NYC coalition. Any new funds proposed to address the mental health crisis should go towards the inclusion of peer crisis workers–not the police or co-response teams–as part of *all* mental health crisis response teams. Peer crisis workers are highly capable and equipped to conduct the psychoeducation and outreach necessary to engage people facing mental health conditions, especially on the subway and the streets of NYC. Peers have the necessary skills and expertise to advocate for connection to community-based care and avoid unwanted and unnecessary transports to hospitals.

We thank the Committees for their consideration of our testimony. We look forward to working with the Council and Adams Administration to create a transparent program and true peer-led, nonpolice response to mental health crisis situations, coupled with a strong preventive community mental health model.

Respectfully,

Jonathan Chung, MPA (he/him/his)
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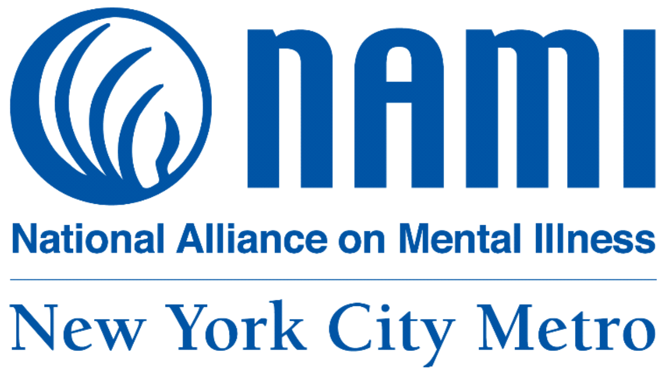

Behavioral Health Emergency Assistance Response Division (B-HEARD) and Responses to Mental Health Crises Oversight Hearing Testimony

Before the New York City Council

Committee on Mental Health, Disabilities and Addiction

Jointly with the Committee on Public Safety, Committee on Hospitals, and the Committee on Fire and Emergency Management

September 23, 2024

Presented by: Nicole Jakaj

Thank you Chairs Lee, Salaam, Narcisse, and Ariola, and to the other members of these committees for convening this critical oversight hearing.

My name is Nicole Jakaj and I am a NAMI NYC Ambassador from Queens and I am also a Medical Assistant with lived experience in supporting people facing mental health crises. I am here today to testify in support of the testimony provided by Correct Crisis Intervention Today - NYC (CCIT-NYC), a coalition of advocacy groups and other community organizations that consist of hundreds of community stakeholders, working to transform how New York City responds to mental health crises.

I was diagnosed with Anxiety and Panic Disorder a few years ago. I have gone to the Emergency Room several times while in the midst of crisis and these experiences in the ER truly did not help the situation get better. Overall, we need to have a more comprehensive health care system. Moreover, as a healthcare employee I have witnessed others facing a mental health crisis being surrounded by armed police officers which is not what someone in this kind of mindset needs and often only further escalates these already tense and difficult moments in someone's life.

Since 2015, 20 individuals have been killed by police officers while experiencing a mental health crisis in New York City. After decades of advocacy by CCIT-NYC and others, we appreciate New York City's attempts to shift crisis response through its Behavioral Health Emergency Assistance Response Division (B-HEARD) pilot.

Responding to mental health calls with health professionals instead of law enforcement is essential—about a quarter of all fatal police shootings in the U.S. involve someone experiencing a mental health crisis. However, we have significant concerns with the program's current structure and outcomes to date.

The current B-HEARD structure is fundamentally flawed and still very much relies on NYPD. B-HEARD teams are only dispatched through 911 rather than 988, the new federal three-digit number for mental health crisis calls. 911 does not accept requests for a B-HEARD team response. Other issues pertaining to scope of service include that the program is not citywide or 24/7, leaving far too many citizens with police as first responders to their mental health crises. We have seen time and time again, most recently with the death of Win Rozario, that it is entirely inappropriate to send police in response to mental health crisis calls and their presence only creates deadly escalation

CCIT-NYC calls for police to be completely removed as first responders to nonviolent mental health crisis calls, and for peers – people with lived mental health experience – to be a mandatory element of B-HEARD teams. Response teams that include people with lived experience will help to achieve the B-HEARD pilot goals by shifting the model to a person-centered approach rooted in genuine connection and communal well-being.

Two key goals of B-HEARD are to increase connection to community-based care and decrease hospitalizations. Yet just six percent of people who receive a B-HEARD response to a mental health crisis are transported to a community-based health care or social service location, and nearly 60% are still transported to the hospital. Peers have the skills and expertise to advocate for connection to community-based care and avoid unwanted and unnecessary transports to hospitals.

I believe in some cases when having a mental health crisis going to the ER does not help, and as

someone with lived experience those who are suffering need to be heard and this is why peer led support is crucial this program can actively help get the people the support they need and to feel safe while doing so.

Although B-HEARD's geographic bounds have expanded some since its inception, and it is responding to a higher volume of overall calls, the number of calls directed to B-HEARD are not keeping up with the rate of the program's expansion. The most recently-available data shows that only about one in four people who place mental health crisis calls in a qualifying area get a B-HEARD response. In an interview with New York One, the program openly stated that teams only respond to a mere three to five calls per day.

Finally, we need more transparency around the B-HEARD program to inform best practices and investments in crisis response. There has been no new data reported this fiscal year. The City must commit to regular reporting.

Of course, in order to continue to make progress towards its goals, the B-HEARD pilot will require sustained investment in the budget, starting with fully restoring the B-HEARD Program to Eliminate the Gap (PEG) cuts in the adopted budget. We look forward to working with the Chairs and members of these committees to improve B-HEARD and ensure that New Yorkers experiencing a mental health crisis receive the response they deserve.

Thank you for taking the time to consider my testimony.

Testimony of

Katherine LeGeros Bajuk
Mental Health Specialist Attorney
New York County Defender Services

Before the

New York City Council

Committees on Public Safety; Fire and Emergency Management; Hospitals; and Mental Health, Disabilities and Addiction

Oversight Hearing on Behavioral Health Emergency Assistance Response Division (B-HEARD) and Responses to Mental Health Crises

September 23, 2024

I. INTRODUCTION

My name is Katherine LeGeros Bajuk. I have been a public defender in New York since 1994, and am the Mental Health Attorney Specialist at New York County Defender Services (NYCDS) since 2015. NYCDS is a public defense office that has represented more than half a million people in Manhattan's Criminal and Supreme Courts. I represent NYCDS' clients in forensic psychiatric competency exams and in Manhattan Mental Health Court, serve as a resource for colleagues working with clients at the intersection of criminal law and mental health, attend meetings with the Mayor's Office of Criminal Justice and other policy workgroups, and train legal practitioners and community members on best practices in representing individuals with mental health issues.

Thank you for holding this hearing and allowing us to provide City Council with feedback on the B-HEARD program and the City's response to mental health crises, particularly as they affect our justice-involved clients. I am here today to testify in support of the testimony provided by Correct Crisis Intervention Today - NYC (CCIT-NYC), a coalition of advocacy groups and other community organizations that consist of hundreds of community stakeholders, working to transform how New York City responds to mental health crises.

Mental health crises are medical issues requiring proven health responses, but the majority of New York City's responses involve law enforcement. The current iteration of B-HEARD is ineffective, and perpetuates the historic weaponization of psychiatry to reinforce racist oppression.[1] Under the model in use now, people of color who need emergency medical care too often are diverted to the criminal legal system, unnecessarily involuntarily committed, or incarcerated. In many cases, these individuals suffer police violence and trauma.[2] New York City must instead adopt the recommendations of CCIT-NY: 1) expand B-HEARD into an alternative response that operates 24 hours a day, seven days a week, in every precinct throughout the city; 2) adopt the proven best practice of using peer-driven crisis response teams exclusive of any police involvement or coercion; 3) ensure data reporting and transparency for community oversight; 4) partner with community health treatment providers for local care, and 5) offer follow-up services to address what brought the individual to the point of crisis in the first place.

II. POLICE RESPONSE TO MENTAL HEALTH CRISES IN NYC

Historically, police have served as first responders to emergency calls involving mental health crises or alcohol or drug dependence.[3] But there is growing recognition that these cases would be better served by non-law enforcement entities.[4]

Police officers receive little to no training in how to handle mental health crises or emergencies. They are not formally equipped to recognize, assess, and treat mental health conditions, relying instead on experiences learned on-the-job.[5] Even where they do receive training, police are far more likely than mental health clinicians to involve individuals experiencing a mental health episode with the criminal legal system, rather than ensuring they receive needed healthcare.[6]

Yet the volume of these calls is enormous. Every day, New York City receives approximately 500 mental health-related 911-calls, totaling around 182,000 calls annually.[7]

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[1] *See, e.g.,* Ruth S. Shim, "Dismantling Structural Racism in Psychiatry: A Path to Mental Health Equity," 178 *Am. J. Psychiatry 7* (July 16, 2021), available at https://ajp.psychiatryonline.org/doi/10.1176/appi.ajp.2021.21060558.

[2] Eman Mubarak et al, "Promoting Antiracist Mental Health Crisis Responses," *AMA Journal of Ethics* (Aug 2022), available at https://journalofethics.ama-assn.org/article/promoting-antiracist-mental-health-crisis-responses/2022-08.

[3] Thomas S. Dee and Jaymes Pyne, "A Community Response Approach to Mental Health and Substance Abuse Crises Reduced Crime," Science Advances 8, no. 23 (June 10, 2022), https://www.science.org/doi/epdf/10.1126/sciadv.abm2106

[4] See, e.g., Meg O'Connor, "Non-police crisis response programs have been working. Here's how," The Appeal, Jan. 24, 2024, available at https://theappeal.org/non-police-crisis-response-programs-have-been-working-heres-how/.

[5] Nathan James et al., "Issues in Law Enforcement Reform: Responding to Mental Health Crises," Congressional Research Service, October 17, 2022, https://crsreports.congress.gov/product/pdf/R/R47285

[6] Thomas S. Dee and Jaymes Pyne, "A Community Response Approach to Mental Health and Substance Abuse Crises Reduced Crime," Science Advances 8, no. 23 (June 10, 2022), https://www.science.org/doi/epdf/10.1126/sciadv.abm2106

[7] Josephine Stratman, "NYC handling 500 calls per day to 911 for problems related to emotionally disturbed people," *Daily News*, Nov. 22, 2022, available at https://www.nydailynews.com/2022/11/22/nyc-handling-500-calls-per-day-to-911-for-problems-related-to-emotionally-disturbed-people/.

Police response to these emergencies also needlessly complicates an already-fraught situation, exacerbating the stress of and danger to the person in crisis, and in many instances, traumatizing their loved ones too. Law enforcement response increases the risk that the person in need will experience violence in their interaction with police. Horrendously, police involvement too-frequently results in the death of the person in need of medical care. A 2016 study published in the *American Journal of Preventive Medicine* estimated that almost fifty percent (50%) of fatal encounters with law enforcement involve someone with a mental health concern.[8] And nearly 1 in 4 people fatally shot by police since 2015 had a mental illness diagnosis - including a disproportionate number of people of color, according to a Washington Post database of fatal shootings by on-duty officers.[9]

The list of New Yorkers killed by NYPD during a mental health 911-call is long and disturbing, with 14 people dying at the hands of police in the two year period from 2017-2019 alone.[10] As a response to those shootings, then-Mayor Bill De Blasio convened a task force which ultimately led to the creation of the 2021 B-HEARD (Behavioral Health Emergency Assistance Response Division) pilot program in Manhattan for non-police responders to mental health crises.

The B-HEARD program is modeled somewhat[11] after the successful CAHOOTS (Crisis Assistance Helping Out On The Streets) program in Eugene, Oregon and the STAR (Support Team Assistance Response) program in Denver, Colorado. Both are proven, innovative and successful approaches to crisis response, focusing on mental health and social support rather than putting the person into custody, as used by traditional law enforcement intervention. However, almost three years into the pilot program, city data indicates that B-HEARD has fallen short of its promised impact. Worse, it appears to be trending in the wrong direction with response times getting slower and stepped-up police involvement in cases. It is useful to review other alternate response methods to understand that our current approach is not working, and that New Yorkers deserve a better system in place.

III. CAHOOTS & STAR

CAHOOTS is a non-police, peer-driven response team which provides immediate assistance to people experiencing mental health crises, substance use issues, and other non-emergency

[8] Sarah DeGue, Katherine A. Fowler & Cynthia Calkins, "Deaths Due to Use of Lethal Force by Law Enforcement," 51 *Am J. Prev Med* 2016, available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6080222/.

[9] https://www.washingtonpost.com/graphics/investigations/police-shootings-database/

[10] Since 2015, 20 people have been killed by police in New York while experiencing a mental health crisis. Doris A. Fuller, H. Richard Lamb, Michael Biasotti & John Snook, *Report: Overlooked in the Undercounted: The Role of Mental Illness in Fatal Law Enforcement Encounters* (Dec. 2015), available at https://www.tac.org/reports_publications/overlooked-in-the-undercounted-the-role-of-mental-illness-in-fatal-law-enforcement-encounters/

[11] Where CAHOOTS uses non-law enforcement and is peer-driven, B-HEARD suffers from an over-reliance on NYPD and FDNY. CAHOOTS highlights that in three decades of peer response, there are no incidences of serious injury to the person in crisis or to emergency response team member. Decarcerating Care: The Pathologizing of Resistance Series, *Taking Police Out of Mental Health Response*, 4/25/24 webinar

situations. The program was created in 1989 as a collaboration between a local healthcare clinic serving the homeless population and the City of Eugene, Oregon.[12] Instead of sending armed police officers to handle such calls, CAHOOTS dispatches trained mental health professionals and EMTs.[13] It currently includes six behavioral health specialists, who work in teams of two, in mobile units and on foot to serve community members all over the city.[14] It has grown into a 24-hour service in 2 cities, Eugene and Springfield.[15] Calls for CAHOOTS come in one of two ways: through the emergency 911 system, or via a non-emergency services system set up to handle the subset of calls that would not normally merit law enforcement response. CAHOOTS operates independently of law enforcement, using peers who can quickly build trust with the individual due to shared lived experiences. This model reduces confrontational interactions and increases the likelihood that people in crisis are diverted from arrest and jail while being connected to local mental health services.[16] This system has achieved remarkable success in its three decades of operation, serving as a national model for alternative crisis response.[17] Of the estimated 18,106 calls in which CAHOOTS was dispatched in 2021, only 301 required police backup.[18]

In Colorado, the STAR program deploys health professionals and paramedics who have substantial mental health training and experience to handle non-violent emergencies related to mental health, poverty, homelessness and substance use.[19] Since its inception in 2020, the STAR program has responded to over 12,000 calls that might otherwise have required a police response. The program expanded from one van in 2020 to eight vans currently in service.[20] A Stanford University study found this alternative response model effective in reducing police-reported criminal offenses; it also proved to be a cost-effective way to reduce police engagement with nonviolent individuals in crisis, responding instead with the necessary and appropriate health care.[21]

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[12] Ben Adam Climer & Ben Adam Climer, CAHOOTS: A Model for Prehospital Mental Health Crisis Intervention, 38 PSYCHIATRIC TIMES (2021), https://cdn.sanity.io/files/0vv8moc6/psychtimes/f86902c4b18eab135e8833494d49344ef8c084bd.pdf/PSY0121_ezine.pdf

[13] Zellie Thomas, "Why We Need to Rethink Policing in Mental Health Crises," New Jersey Monitor, March 15, 2023, https://newjerseymonitor.com/2023/03/15/why-we-need-to-rethink-policing-in-mental-health-crises/

[14] Vera Institute of Justice. "CASE STUDY: CRU and Familiar Faces," November 12, 2020. https://www.vera.org/behavioral-health-crisis-alternatives/cru-and-familiar-faces.

[15] Nathan James et al., "Issues in Law Enforcement Reform: Responding to Mental Health Crises," Congressional Research Service, October 17, 2022, https://crsreports.congress.gov/product/pdf/R/R47285

[16] Beck, Jackson, Melissa Reuland, and Leah Pope. "Olympia's Crisis Response Initiatives: A Case Study," November 2020.https://csgjusticecenter.org/wp-content/uploads/2021/12/CASE-STUDY-CRU-and-Familiar-Faces-Olympia-WA.pdf

[17] Eugene Police Department Crime Analysis Unit, CAHOOTS Program Analysis, https://www.eugene-or.gov/DocumentCenter/View/56717/CAHOOTS-Program-Analysis

[18] Id.

[19] Sarah Gillespie et al., "Understanding Denver's STAR Program," Understanding Denver's STAR Program, 2023, https://www.urban.org/sites/default/files/2023-08/Understanding%20Denver%E2%80%99s%20STAR%20Program.pdf.

[20] Shannon Cheng, "Denver'S STAR Program: Promising Alternative Crisis Response," Hacks & Wonks, April 16, 2024, https://www.officialhacksandwonks.com/denvers-star-program-offers-promising-alternative-response-to-mental-health-and-substance-use-crises/

[21] Thomas S. Dee and Jaymes Pyne, "A Community Response Approach to Mental Health and Substance Abuse Crises Reduced Crime," Science Advances 8, no. 23 (June 10, 2022), https://www.science.org/doi/epdf/10.1126/sciadv.abm2106

IV. B-HEARD

The B-HEARD program was launched on June 6, 2021 as a pilot project to route mental health emergencies reported to 911 to non-police, health-driven first responders.[22] The program functions by training 911 operators to screen for mental health emergencies that are better suited for a public health intervention instead of law enforcement response.[23] Those selected are referred to mental health response teams, composed of "emergency medical technicians/paramedics from the Fire Department's Emergency Medical Services and social workers from NYC Health + Hospitals."[24] In its original rollout, the program operated 16 hours a day, seven days a week in the 25th, 28th, and 32nd police precincts in East Harlem.[25] In November 2021, the program was expanded to the 26th and 30th precincts in Harlem and the Upper West Side, and at the end of March 2023, B-HEARD expanded to parts of Queens and additional neighborhoods in Brooklyn.[26] In October 2023, B-HEARD expanded to cover the entire borough of the Bronx.[27]

The B-HEARD pilot has had success in demonstrating that a mental health response is more appropriate, safe, and effective than traditional police responses. However, data shows the program remains vastly underutilized, underfunded and is still far from becoming the "primary" responder to mental health-related 911 calls. B-HEARD operates between 9 a.m. and 1 a.m. every day, but current staffing levels mean there is typically only one team at a time assigned to respond to 911 calls in a given area. If the team is already in the field when another call comes in, or if a call falls in the 8-hour window when B-HEARD is offline, NYPD and FDNY respond.[28] As such, it is not a true "alternate" response. While B-HEARD aims to provide timely assistance, the reality is that response times are often delayed due to understaffing and high call volumes. By June 2022, B-HEARD's average response time was 15 minutes 30 seconds, compared to the 12 minutes 12 seconds during its first three months of operations[29] and to the 9-minute average for traditional

[22] "B-HEARD, Transforming NYC's Response to Mental Health Crises," First Month of Operations, July 2021, available at https://mentalhealth.cityofnewyork.us/wp-content/uploads/2021/07/B-HEARD-First-Month-Data.pdf.

[23] Id. "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."

[24] Id.

[25] *Id.*

[26] New York City Mayor's Office of Community Mental Health, B-HEARD: Transforming NYC's Response to Mental Health Emergencies, January-June 2023 (FY23 Q3 & Q4)), https://mentalhealth.cityofnewyork.us/wp-content/uploads/2024/01/BHEARD-Data-Brief-FY23-Q3-Q4_2024.pdf

[27] New York City Mayor's Office of Community Mental Health, "911 Mental Health Response - Mayor'S Office of Community Mental Health," June 7, 2024, https://mentalhealth.cityofnewyork.us/b-heard.

[28] Maya Kaufman, "Mental Health Crisis Response Pilot Expands, Despite Ongoing Struggles," POLITICO, April 17, 2023, https://www.politico.com/news/2023/04/17/mental-health-crisis-response-pilot-new-york-00091858

[29] New York City Mayor's Office of Community Mental Health, B-HEARD: Transforming NYC's Response to Mental Health Emergencies, Fiscal 2022, https://mentalhealth.cityofnewyork.us/wp-content/uploads/2022/10/FINAL-DATA-BRIEF-B-HEARD-FY22-TOTAL.pdf

emergency services.[30] Delayed response times may lead to crisis escalation, putting both the individual in need and the responders at risk.

B-HEARD currently handles a mere fraction of the mental health crisis calls to 911 in its areas of operation. 911 dispatchers are trained to triage and assign calls to B-HEARD based on the information provided by the caller. However, many mental health calls do not receive the additional triage truly needed to determine eligibility for B-HEARD.[31] Additionally, B-HEARD teams have struggled with limited capacity to attend all eligible calls routed to them. According to the most recent public data from January to June 2023, there were 20,692 mental health calls to 911 in the B-HEARD participating precincts. Of those, 9,253 calls were routed to B-HEARD, and the teams were able to respond to only 5,095 or 55% of those calls. The rest received a traditional response from the NYPD, EMS or both.[32] Critically, the program has fallen short in reducing the over-reliance on police to respond to mental health crisis calls.

V. DEFENDER PERSPECTIVE

The clients I represent in the criminal legal system are almost always lesser-incomed Black Indigenous People of Color (BIPOC) from marginalized communities.

In my nearly three decades of practice I have seen how poverty exacerbates poor health outcomes, and correlates to greater rates of mental health and substance use concerns among my clients - not just for individuals, but for entire generations.[33] The mostly BIPOC communities I serve also reflect New York's statistical reality where one out of every five people has a mental health concern;[34] and one out of every four of those impacted by mental illness also has a substance use issue.

Yet due to the shameful legacy of racism, and because of ignorance about and stigma around mental illness, my clients find themselves in the impossible position of being more impacted by poverty, while also having less access to any effective treatment for their underlying mental health or substance use concerns. Mental health diagnoses go undiagnosed and untreated at disproportionately greater rates in majority Black and Hispanic communities.[35] Systemic lapses that propagate generational poverty and mental illness in my clients' communities also create a

[30] The City of New York Mayor Eric L. Adams, Preliminary Management Report, January 2024, https://www.nyc.gov/assets/operations/downloads/pdf/pmmr2024/2024_pmmr.pdf

[31] New York City Mayor's Office of Community Mental Health, B-HEARD: Transforming NYC's Response to Mental Health Emergencies, January-June 2023 (FY23 Q3 & Q4)), https://mentalhealth.cityofnewyork.us/wp-content/uploads/2024/01/BHEARD-Data-Brief-FY23-Q3-Q4_2024.pdf

[32] *Id.*

[33] McLoyd VC. Socioeconomic disadvantage and child development. Am Psychol. 1998; 53:185-204.

[34] NY State Department of Health,. "Priority Area: Mental Health/Substance Abuse - Mental Health," 2017. https://www.health.ny.gov/prevention/prevention_agenda/mental_health_and_substance_abuse/mental_health.htm

[35] Racial Disparities In Diagnosis and Treatment of Major Depression, Blue Cross Blue Shield, May 31, 2022, Racial Disparities in Diagnosis and Treatment of Major Depression (bcbs.com)

dynamic where those left most vulnerable by societal failures are unable to access therapeutic services. Less than 15% of children in poverty who need mental health care receive any services.[36] As a result, hundreds of thousands of those in need fall through the cracks and go without treatment.[37]

While psychiatric diagnoses are *medical* diagnoses, my clients with mental illness too often do not have their health needs met with health care. Rather, they are over-policed, and their symptoms criminalized. Over-reliance on law enforcement to address my clients' and their community's mental health crises has yielded the overrepresentation of people with mental illness in our carceral system. More than half (52%) of the people in New York's Department of Correction custody are recommended for mental health services, and according to the most recent census by the Mayor's office, over 20% of incarcerated people were diagnosed with a debilitating "serious mental illness" such as schizophrenia, schizoaffective disorder and bipolar disorder.[38] In some facilities, the number of people with mental health diagnoses exceed those without.[39] New York's jails are the largest mental health providers in our state;[40] Rikers Island Correctional Facility has the dubious distinction of housing more people with mental illness than any psychiatric hospital in the entire country.[41] As our carceral system is not equipped to provide meaningful mental health treatment, we have seen a rise of avoidable deaths among detainees with mental illness. The scores of deaths among incarcerated people with mental health concerns on Rikers Island is an ugly example of this.[42]

The criminalization of mental illness is driven in part by pervasive and powerful fear mongering efforts. Rather than humanely connecting the dots of my clients' historically traumatic experiences with their scant access to housing, education, employment and health care, and then to instabilities that inform their involvement with the criminal legal system; political opportunists and tabloid news instead scapegoat and stigmatize those with psychiatric diagnoses - most especially when they are also people of color.[43] Such "othering" tactics shift us away from seeking humane and healing solutions in the realm of public health, instead centering law enforcement-driven carceral and containment approaches which effectively disappear from public view the "abnormal" Black

[36] Hodgkinson, Stacy, Leandra Godoy, Lee Savio Beers, and Amy Lewin. Improving Mental Health Access for Low-Income Children and Families in the Primary Care Setting. *Pediatrics* 139, no.1 (January 1, 2017), available at https://doi.org/10.1542/peds.2015-1175.

[37] "Mayor's Office of Community Mental Health | Data Dashboard,". https://mentalhealth.cityofnewyork.us/dashboard/

[38] Mayor's Management Report Preliminary Fiscal 2024, The City of New York Mayor Eric L. Adams, Camille Joseph Varlack, Daniel Steinberg, Director Mayor's Office of Operations, https://www.nyc.gov/assets/operations/downloads/pdf/pmmr2024/2024_pmmr.pdf,

[39] NY State Department of Health,. "Priority Area: Mental Health/Substance Abuse - Mental Health," 2017. https://www.health.ny.gov/prevention/prevention_agenda/mental_health_and_substance_abuse/mental_health.htm

[40] https://www.treatmentadvocacycenter.org/key-issues/criminalization-of-mental-illness.

[41] Serious Mental Illness Prevalence in Jails and Prisons - Treatment Advocacy Center (Sept. 2016) , https://www.tac.org/reports_publications/serious-mental-illness-prevalence-in-jails-and-prisons/.

[42] Jonah E. Bromwich, The New York Times, Medical Care at Rikers is Delayed for Thousands, Records Show (February 1, 2022), https://nytimes.com/2022/02/01/nyregion/rikers-island-medical-care.html

[43] https://eji.org/news/report-documents-racial-bias-in-coverage-of-crime-by-media/

and Brown bodies we are brainwashed to fear.[44] Meanwhile, the reality is that only three to five percent of violent crimes are attributed to people with mental illness alone, and people living with such mental health diagnoses are in actuality more likely to be the victim, and not the perpetrator of violence.[45]

The legacy of racism is largely responsible for the current failures in our mental health systems vis a vis people of color, and we should be engaged in identifying and discarding all vestiges of this while atoning for its wrongs - not building our mental health emergency crisis response around it. Modern practices of addressing mental illness experienced by Black and Brown individuals arose from white supremacist frameworks, where police forces were historically dispatched to enforce racist policies.

For example, dating as far back as the 1800s, psychiatry was used to perpetuate the false and racist notions of the genetic inferiority and untreatable nature of Black people, in order to maintain control over them.[46] Treating hospitals afforded Black people no meaningful therapy, segregating them in wretched facilities where they were forced into manual labor.[47] Pro-slavery doctors argued the existence of higher rates of mental illness among the free Black populations of the North than in the South during Reconstruction.[48] While challenges made during the Civil Rights Act era officially desegregated many hospitals, racist and discriminatory practices, designed using the ideals and objectives of white supremacy, remained.

An example of the historical weaponization of psychiatric medicine against BIPOC is in the over diagnosing of schizophrenia in Black men after the definition of this disorder was changed[49] and

[44] "Decarcerating Care: The Pathologizing of Resistance Series," *Taking Police Out of Mental Health Response*, 4/25/24 webinar

[45] Noman Ghiasi, Yusra Azhar & Jasbir Singh, "Psychiatric Illness and Criminality," *StatPearls*, March 30, 2023, available at https://www.ncbi.nlm.nih.gov/books/NBK537064/.

[46] Dr. Kylie M. Smith, https://www.nami.org/african-american/discrimination-and-racism-in-the-history-of-mental-health-care/ A common assertion was that Black people were incapable of complex emotional or intellectual processes, and not suited to agency or self-care. One psychiatrist, Samuel Cartwright, contended slavery to be the "natural state" of Black people given their deficiencies, claiming they actually benefited from the "hard work" under such systems. Cartwright subsequently invented the since-disfavored diagnoses of "draeptomania" and "dysaesthesia" for enslaved people who resisted or tried to escape their bondage.

[47] Id.

[48] https://ajp.psychiatryonline.org/doi/10.1176/ajp.127.6.787 In the years following, psychiatric depictions of Black people as "insane', "idiotic", "primitive" and "savage" were commonly used to argue against former enslaved person's rights of self determination.https://www.nytimes.com/2021/04/30/health/psychiatry-racism-black-americans.html

[49] In 1968, the phrase "protest psychosis" was used to argue that the "Black power" movement made Black men insane:"Not coincidentally did the emergence of codifying mental health as a tool to denigrate Black people occur just as the American Civil Rights movement was transforming society, inciting feelings of threat in many beneficiaries of the Jim Crow system…The purpose of redefining schizophrenia as a disorder to be feared was to support and preserve racial segregation and use the threat of mental illness to control agitators and punish social gains ." Faber, Sonya C, Roy, Anjalika Khanna, Michaels, Timothy I., Williams, Monica T. *The Weaponization of Medicine: Early psychosis in the Black community and the Need for Racially Informed Mental Healthcare* Front Psychiatry. 2023; 14: 1098292. Published online 2023 Feb 9. doi:10.3389/fpsyt.2023.1098292 PMCID: PMC9947477PMID: 36846217. African American/Black communities are diagnosed with schizophrenia-spectrum disorders at a rate that is three to four times higher than White communities: "Reduced empathy on the part of White clinicians toward their Black patients may partially explain how mood symptoms in Black patients are often misinterpreted, or why

more people in that cohort so diagnosed after a backlash to Black Power movements in the late 1960's and early 1970s. Such medical racism is also reflected in the experience of my Black male clients who are misdiagnosed with the more-difficult-to-treat disorder of schizophrenia at alarming rates,[50] rather than with the more easily addressed diagnosis of depression. Over 89% of mental health professionals are White,[51] and the "almost all-white profession's lack of attunement to Black expressions of emotion — and its frequent conflation of distress with anger — has led to an under-diagnosis of major depression, particularly in Black men, and an overreliance upon the use of antipsychotic medications. Black patients are less likely than white patients to receive appropriate medication for their depression."[52] Misdiagnoses prove harmful, contributing to stigma, feelings of hopelessness, fewer treatment choices and overall negative outcomes.[53]

The racist historical bases of policing[54] are well known, and ongoing discrimination negatively impacts the mental health of BIPOC communities,[55] not only those who are directly involved, but

psychotic disorders are overdiagnosed For example, instead of viewing a Black patient as "sad," they are characterized as "mad." Instead of being comforted because they are "afraid," they are labeled as "paranoid." These studies provide a mechanism for how what may traditionally be considered a reliable assessment of psychosis and schizophrenia across racial groups may in fact be biased." Faber, Sonya C., Roy, Anjalika Khanna, Michaels, Timothy I., Williams, Monica T.: *The Weaponization Of Medicine: Early Psychosis in the Black Community and the Need for Racially Informed Mental Healthcare.* Front Psychiatry. 2023; 14: 1098292. Published online 2023 Feb 9. doi: 10.3389/fpsyt.2023.1098292 PMCID: PMC9947477PMID: 36846217https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9947477/ The terms "aggressive" and "being out of control" were relied upon when evaluating Black people. Incapacitating medications were then prescribed to address their so-called inherent pathology, and those who resisted were sought for incarceration or involuntary commitment by sheriffs and police departments. Id. Pharmaceutical companies frequently used fearmongering and conflation of urban crime with social justice efforts to market their drugs to psychiatrists. For example, in 1974, an advertisement published in *The Archives of General Psychiatry* depicted a Black man raising his fist with the caption, "Assaultive and belligerent? Cooperation often begins with Haldol." It is more likely that a Black patient is overmedicated because of racist labeling as "dangerous" by clinicians: "African American patients were more likely to be prescribed psychiatric medications and administered more high-potency antipsychotic medications at higher doses…given significantly less time for evaluations by clinicians…prescribed older medications or first-generation antipsychotic medications, which can have severe side effects…These racial disparities in treatment continue even though second-generation antipsychotics have been prescribed for over 30 years...Overmedication and the side effects associated with first-generation antipsychotics can negatively impact health… contribute to decreased compliance with medication [which] may then result in…coercive treatments … foster[ing] cultural mistrust and…poor patient–clinician relationship. Coercive approaches can also be very harmful, as techniques such as involuntary hospitalization and mandated medication may induce trauma in the patient and their families, leading to greater distrust and avoidance of mental healthcare in the future."

[50] Id. African American/Black communities are diagnosed with schizophrenia-spectrum disorders at a rate that is three to four times higher than White communities: "Reduced empathy on the part of White clinicians toward their Black patients may partially explain how mood symptoms in Black patients are often misinterpreted, or why psychotic disorders are overdiagnosed For example, instead of viewing a Black patient as "sad," they are characterized as "mad." Instead of being comforted because they are "afraid," they are labeled as "paranoid." These studies provide a mechanism for how what may traditionally be considered a reliable assessment of psychosis and schizophrenia across racial groups may in fact be biased." Faber, Sonya C., Roy, Anjalika Khanna, Michaels, Timothy I., Williams, Monica T.: *The Weaponization Of Medicine: Early Psychosis in the Black Community and the Need for Racially Informed Mental Healthcare.* Front Psychiatry. 2023; 14: 1098292. Published online 2023 Feb 9. doi: 10.3389/fpsyt.2023.1098292 PMCID: PMC9947477PMID: 36846217https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9947477/

[51] https://www.nytimes.com/2021/04/30/health/psychiatry-racism-black-americans.html

[52] Id.

[53] Gara MA, Minsky S, Silverstein SM, Miskimen T, Strakowski SM. A naturalistic study of racial disparities in diagnoses at an outpatient behavioral health clinic. *Psychiatric Serv.* (2019) 70:130–4. 10.1176/appi.ps.201800223

[54] https://www.americanbar.org/groups/crsj/publications/human_rights_magazine_home/civil-rights-reimagining-policing/how-you-start-is-how-you-finish/

[55] DeVylder JE, et al. Association of exposure to police violence with prevalence of mental health symptoms among urban residents in the United States. *JAMA Netw Open.* 2018;1(7):e184945–e184945. doi: 10.1001/jamanetworkopen.2018.4945. So

also those who witness or are exposed to information about racist police violence.[56] A person is killed by police in the United States every 7 hours,[57] with Black and Indigenous boys and men being three times more likely to be killed than White boys and men.[58] The injustice around these killings contributes to deleterious negative mental health outcomes: for every 1,000 people killed by police officers, only one is convicted of a crime; and while the homicide indictment rate for regular citizens is 90%, the indictment rate for police officers is merely 1%.[59]

Other factors also influence the rate of BIPOC with unaddressed mental health needs and should be understood when devising any crisis response system. Discordance of ethnicity, language barriers and cultural incompetence between therapist and client may inform the bias among treatment providers,[60] ultimately leading to less BIPOC in treatment. More than "30% of Black people, 20% of Latinx people, and 23% of Indigenous people report avoiding psychiatric care because of experiences of personal discrimination due to their race or ethnicity in health care settings."[61]

Psychiatric inaccessibility for my largely indigent clients is further impacted by their lack of health insurance. Even when clients have Medicaid or Medicare they may still be thwarted from treatment

much so, that social scientists posit that racism by law enforcement is a social determinant of health. DeVylder J, Fedina L, Link B. Impact of police violence on mental health: a theoretical framework. *Am J Public Health.* 2020;110(11):1704–1710. doi: 10.2105/AJPH.2020.305874; Sewell AA. *Sociological Forum.* Wiley Online Library; 2017. The illness associations of police violence: differential relationships by ethnoracial composition; Feldman JM, et al. Temporal trends and racial/ethnic inequalities for legal intervention injuries treated in emergency departments: US men and women age 15–34, 2001–2014. *J Urban Health.* 2016;93:797–807. doi: 10.1007/s11524-016-0076-3.

[56] https://www.nytimes.com/interactive/2023/05/25/well/mind/black-mental-health-police-violence.html A 2021 study from hospitals across five states demonstrated a correlation between police killings of unarmed Black people and a rise in depression-related E.R. visits among Black people.

[57] Thema Bryant-Davis, Thelma, Adams, Tyonna, Alejandre, Adriana, Gray, Anthea A.: The Trauma Lens of Police Violence against Racial and Ethnic Minorities*, The Society for the Psychological Study of Social Issues,* Pepperdine University Press. https://www.riprc.org/wp-content/uploads/2020/06/josi.12251_Trauma-Lens-of-Police-Violence-against-Racial-Ethnic-Minorities-2017.pdf

[58] Swaine J, et al. Young black men killed by US police at highest rate in year of 1,134 deaths. The Guardian. 2015;3

[59] https://www.riprc.org/wp-content/uploads/2020/06/josi.12251_Trauma-Lens-of-Police-Violence-against-Racial-Ethnic-Minorities-2017.pdf; "The lawlessness of law enforcement in punitive interactions with Black persons is ongoing… Not only are Black people targeted simply because of their race, but psychosis-inducing substances are also being used…where police use terms like "excited delirium" to dispense psychosis-inducing drugs such as ketamine. Importantly, such terms are not recognized by major medical organizations; moreover police officers are not trained to diagnose or treat any kind of delirium.Grant JR, Southall PE, Mealey J, Scott SR, Fowler D. Excited delirium deaths in custody past and present. *Am J Forensic Med Pathol.* (2009) 30:1–5. 10.1097/PAF.0b013e31818738a0; Young R, McMahon, S,. Some States Allow Authorities to Use Ketamine to Subdue Suspects in the Field. But is it Safe? WBUR. (2020). https://www.wbur.org/hereandnow/2020/09/08/ketamine-police-safety-elijah-mcclain;. Tompkins L,. Here's What You Need to Know About Elijah McClain's Death. The New York Times. (2022). https://www.nytimes.com/article/who-was-elijah-mcclain.html (accessed January 18, 2022); Appelbaum PS. Excited delirium, ketamine, and deaths in police custody. *Psychiatric Serv.* (2022) 73:827–9. 10.1176/appi.ps.20220204

[60] "Many mental health professionals find race discussions uncomfortable…When mental health professionals do engage, they often do so cautiously, and observed compensatory behaviors include avoiding participation through silence, defensiveness, or claims that racial perspectives are biased." Mensah, M. Ogbu-Nwobodo, L., Shim, Ruth. *Racism and Mental Health.* Published Online**:**12 Jan 2021https://doi.org/10.1176/appi.ps.202000755 https://ps.psychiatryonline.org/doi/10.1176/appi.ps.202000755

[61] Id.

because "psychiatrists [are] the least likely medical providers to accept any type of health insurance."[62]

Informed by such systemic failures and ongoing stigma and racial discrimination, it adds insult to injury that our current use of law enforcement to respond to health crises so frequently results in violent injury or death to the person in need of mental health assistance. That one in four and as many as half of all fatal police shootings involve people with serious mental illness[63] must also inform consideration of ethical and rational options for crisis response.

VI. RECOMMENDATIONS

Our current approach to psychiatric emergencies is not only morally repugnant in light of that racist historical context, but impractical in its operationalization. The unavailability of B-HEARD teams in every part of New York City, 24 hours a day, 7 days a week is one example.

As a Mental Health Specialist, I often receive calls from families of clients in the throes of mental health crises, or the clients themselves. Trauma-informed advocacy dictates that I do not risk a violent experience by involving NYPD or FDNY response,[64] so I have sought help from what is touted as our best alternative response. However, I have witnessed the many harmful aspects of B-HEARD that must be changed.

In many instances, due to the lack of available teams, client's families report having waited a long time after a call for a team to reach them - at which point mental health emergencies have long past escalated, requiring an involuntary hospitalization or arrest which might not have occurred at an earlier intercept point;[65] or, the client is long gone from that location, wandering the city in desperate need of help and often, by this time, experiencing psychosis.

In other situations, client's families report needing immediate help in the middle of the night, and call to request that a B-HEARD team be dispatched to render assistance - only to be told they are not working in the field during those hours. Yet, my clients do not have the luxury of scheduling their psychiatric crises.

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[62] Id.

[63] Faber, Sonya C., Roy, Anjalika Khanna, Michaels, Timothy I., Williams, Monica T.: *The Weaponization Of Medicine: Early Psychosis in the Black Community and the Need for Racially Informed Mental Healthcare.* Front Psychiatry. 2023; 14: 1098292. Published online 2023 Feb 9. doi: 10.3389/fpsyt.2023.1098292 PMCID: PMC9947477PMID: 36846217https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9947477/

[64] Id. It cannot be stated enough that implicit bias and racism on the part of the police are a cause for violence against the BIPOC community in need of mental health assistance, and I would consider it an abdication of my duty as a public defender if I were to unnecessarily expose a client in need to this.

[65] Too often, this results in a client being needlessly arrest for simply exhibiting symptoms of their illness, or worse, in arrest for what is clearly an ignorance of understanding of mental health and biases creating belief that the person in need is dangerous or threatening.

Also, I wonder how many people I've represented over the last thirty years might never have even become my clients or charged with crimes if New York City sought therapeutic versus punitive solutions to psychiatric issues. They could have and should have received medical attention during a psychiatric emergency rather than being met with a response that diverts them to the criminal legal system and jails.

Our city must implement more humane and racially sensitive approaches to crisis response. There are many proven models which inform us about how we can do better towards people who have been systemically harmed and failed.

NYCDS concurs with CCIT-NYC's position that police should be completely removed as first responders to non-violent mental health crisis calls, and for peers to be a mandatory element of B-HEARD teams.

People with lived experience can ensure achievement of B-HEARD goals by shifting the model to a person-centered approach, rooted in genuine connection and communal well-being. Peers are able to more quickly forge trust with people in crisis based on shared experiences and are thus more capable of de-escalating emergencies. Peer involvement is seen to improve the individual in need's quality of life, better their engagement with therapeutic services and community supports, and decrease the need for or frequency of hospitalization.[66] Emerging evidence shows that in some instances, engagement with peers is more positively impactful for people with psychiatric diagnoses in crisis than interaction with discordant or culturally incompetent clinicians: "without lived experience to help understand the current social context, clinicians may have difficulty equitably diagnosing patients from cultures where they have little formal training."[67]

Additionally, while two key goals of B-HEARD are to increase connection to community-based health care and to decrease hospitalizations, only 6% of people in crisis responded to by B-HEARD are brought to a local health care or social service location; nearly 60% are still brought to hospitals.[68]

We also need to incorporate responder availability 24 hours a day, seven days a week, and other best practices of crisis response into B-HEARD. This includes operating with transparency for,

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[66] https://www.mhanational.org/peer-support-research-and-reports#:~:text=improves%20a%20person's%20quality%20of,whole%20health%20and%20self%2Dmanagement. Simmons, Magenta B., Cartner, Sharla, MacDonald, Roxanne, Whitson, Sarah, Bailey, Alan, Brown, Ellie: The effectiveness of peer support from a person with lived experience of mental health challenges, BMC Psychiatry. 2023; 23: 194.Published online 2023 Mar 24. doi:10.1186/s12888-023-04578-2https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10038377/

[67] Faber, Sonya C., Roy, Anjalika Khanna, Michaels, Timothy I., Williams, Monica T.: *The Weaponization Of Medicine: Early Psychosis in the Black Community and the Need for Racially Informed Mental Healthcare.* Front Psychiatry. 2023; 14: 1098292. Published online 2023 Feb 9. doi: 10.3389/fpsyt.2023.1098292 PMCID: PMC9947477PMID: 36846217https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9947477/

[68] https://www.thecity.nyc/2022/07/18/mental-health-911-b-heard-teams/

and oversight by, the community; this is extremely difficult to do when there is no new data reported in a fiscal year as occurred this last year; the City must commit to regular reporting.

B-HEARD must also coordinate with direct services providers; and importantly, ensure that once the psychiatric crisis has passed, the person's other needs are addressed to prevent future emergencies - whether it is stabilizing housing, shoring up community supports, or implementing workable treatment plans. In order to do this, B-HEARD needs a sustained investment in the budget. A good place to start is the full restoration of B-HEARD's Program to Eliminate the Gap (PEG) cuts in the adopted budget.

VII. CONCLUSION

New York City residents with mental health needs experiencing crisis deserve better. In face of historical illegal police violence, incarceration and involuntary commitment - all rooted in stigma and racism - and in light of all we now know about what is effective and economic - continuing as we have is immoral and unjust. People with mental illness deserve to be healed, not harmed further. We as a society must render assistance to those having a psychiatric crisis - especially when their mental health concerns are largely attributable to previous harms done, and failures to right such wrongs. I urge the City Council to consider this testimony in support of CCIT-NY's testimony and take action as recommended.

For any questions, I may be reached at kbajuk@nycds.org.

Testimony to the Joint Hearing of the Committee on Mental Health, Disabilities and Addiction, the Committee on Public Safety, the Committee on Hospitals, and the Committee on Fire and Emergency Management

September 23, 2024

Thank you, Committee Chairs Lee, Salaam, Narcisse, and Ariola for the opportunity to provide testimony. I am Amber Song, Senior Program Coordinator at the Asian American Federation (AAF), where we proudly represent the collective voice of more than 70 member nonprofits serving 1.5 million Asian New Yorkers.

Since 2017, AAF's dedicated advocacy, research, and programming have significantly improved access to culturally and linguistically competent mental health services for Asian Americans. We believe that every individual in our community deserves access to mental health care that respects and understands our unique linguistic and cultural backgrounds. We are here today to discuss the ways New York City can prioritize the needs of the Asian American community into its expansion of the Behavioral Health Emergency Assistance Response Division (B-HEARD) program.

Background on the B-HEARD Program

B-HEARD was launched in New York City to address mental health crises as a health concern, rather than a public safety issue. This program was initiated in 2021 as a pilot to serve East Harlem and parts of Central and North Harlem. Over the years, the program has expanded to areas from East Harlem to the Hudson River, Washington Heights, Inwood, the Bronx, East New York and Brownsville. In March 2023, B-HEARD expanded into additional neighborhoods in Brooklyn and parts of Queens for the first time. That same month, the Mayor announced the City's commitment to expand B-HEARD citywide as part of his Mental Health Plan.

B-HEARD allows 911 call operators to dispatch B-HEARD Teams – consisting of FDNY Emergency Medical Technicians (EMTs)/paramedics and a licensed social worker from NYC Health + Hospitals – to mental health emergencies, instead of relying on the police as first responders. First, 911 call operators triage and assign calls to B-HEARD based on a description of the circumstances, call location, dispatch criteria, and availability of B-HEARD Teams. Then, B-HEARD Teams use their physical and mental health expertise, and experience in crisis response to de-escalate emergency situations and provide immediate care. These teams have the expertise to respond to a range of behavioral health issues, such as suicidal ideation, substance misuse, and mental health conditions including serious mental illness, as well as physical health problems that can be exacerbated by or mask mental health needs. If the person requires emergency medical services, the EMTs/paramedics on the B-HEARD Team provide emergency medical care and call for an ambulance transport. In emergency situations involving a weapon or imminent risk of harm to self or others, a traditional emergency response is dispatched, which includes NYPD officers and an ambulance.

AAF's Mental Health Programming, Research, and Advocacy

This year, AAF released our mental health report: Seeking Help, Finding Hope, highlighting mental health challenges in the Asian community and providing recommendations tailored to these distinct challenges. AAF surveyed 543 Asian New Yorkers of 23 unique ethnic backgrounds, in 10 languages and collaborated with 15 partner organizations that serve Asian New Yorkers. According to our findings, roughly 65% of survey participants indicated that they experience feelings of isolation or anxiety to some extent, with almost 40% describing these emotions as "somewhat strong" or "very strong." The majority of survey respondents reported consistently experiencing symptoms like fatigue, insomnia, headaches, loss of appetite, and heart palpitations over the past 12 months, and 45% indicated that they require assistance with their mental health issues. This report also underscored issues with accessing mental health care for Asian New Yorkers, finding that Asian Americans are less likely to receive mental health treatment compared to other racial/ethnic groups with only 20.8% of Asian adults with mental illness receiving treatment in 2020. Key obstacles to mental health treatment for the community include: language barriers and lack of culturally competent programs; limited mental health literacy; cultural attitudes including shame, stigma and denial; and preference for alternative treatment philosophies.

Furthermore, AAF's 2023 impact assessment of our Hope Against Hate Campaign, AAF's campaign to bring safety to Asian communities amidst rising rates of anti-Asian violence, found that 30% of program volunteers experienced anti-Asian bias incidents, primarily reporting these incidents to 911. However, over half of the respondents doubted their local police's effectiveness in addressing community safety concerns, indicating that law enforcement may not be the best suited resource to adequately address the community's needs.

AAF has seen great success in organizing and mobilizing our member organizations to advocate for our community's mental health needs. AAF is the proud convener of the Asian American Mental Health Roundtable, made up of 12 Asian-led, Asian-serving organizations who work collaboratively to address challenges, create solutions, and share resources to increase access to culturally competent mental healthcare. In partnership with the Roundtable, AAF created a policy agenda that identifies gaps and barriers to access to mental healthcare for Asian New Yorkers and makes recommendations to policy makers, legislators, funders, and the City of New York to help them make informed decisions on how to advance equity and inclusion in mental health policies and practices for Asian New Yorkers.

Additionally, AAF has increased access to mental health care and resources since 2017. In 2022, we released the first-ever online mental health provider database that prioritizes providers who speak Asian languages and understand Asian cultures. In 2023, AAF worked with our mental health partners to provide culturally and linguistically competent clinical and non-clinical services to 8,145 Asian New Yorkers. In June, we created the first-ever, comprehensive Asian American Mental Health Hub, an online resource to increase access to mental health data, services, and resources that are tailored to the pan-Asian community in New York. In FY 2025, we will continue expanding our online mental health directory by adding 50-100 providers to the 400+ already featured, increase the number of in-language resources on

our online hub, and partner with our Roundtable to increase awareness of and implement culturally competent mental health services.

Asian American Mental Health: How B-HEARD Can Help

Asian Americans are the fastest-growing population in New York City, comprising 17% of the city's total population. Of the 1,525,851 Asian New Yorkers, 66% are foreign born and 44% have limited English proficiency. As detailed in the aforementioned AAF Seeking Help, Finding Hope report, many members of the community experience mental health symptoms yet few access mental healthcare services due to a host of cultural, linguistic, and stigma-related barriers. Asian New Yorkers furthermore continue to experience a historic increase in anti-Asian violence, perpetual economic insecurity, and accompanying stress and anxiety in the aftermath of Covid-19, leading to a heightened demand for mental health services within our community that far exceeds the capacity of community-based mental health providers.

Without the care they need to manage their mental health, New Yorkers regularly fall through the cracks until they experience a crisis. During these crises, police officers are too often the first responders. The Treatment Advocacy Center reported that one in four fatal police encounters ends the life of a person with severe mental illness. The recent tragedies of Win Rozario in Queens, Victoria Lee in New Jersey, and Yong Yang in Los Angeles, among so many others, exemplify that police officers should not be the first and only response to instances of mental health crises. Instead, the response to a mental health emergency should come from trained health professionals and those who know the community they serve.

Recommendations

We urge the City Council, as well as members of the relevant Committees and City agencies to consider the following recommendations as the City evaluates the effectiveness of the B-HEARD program:

1. Ensure B-HEARD meets the linguistic and cultural competencies necessary to serve Asian communities.
    - As the City expands B-HEARD into additional neighborhoods and increases the number of hours the program is available, we implore the relevant agencies – the Mayor's Office of Community Mental Health, FDNY/EMS, Health + Hospitals, the Department of Health and Mental Hygiene, and the NYPD – to ensure B-HEARD teams are equipped with the linguistic and cultural competencies necessary to serve Asian communities through translated materials and staff who understand Asian cultures and speak Asian languages. This involves holding these agencies accountable for compliance with Local Law 30, a New York City law adopted in 2017 to ensure that all New Yorkers have access to city services, regardless of their English proficiency.
    - The City must educate the community about B-HEARD and ensure information is available in commonly spoken Asian languages. AAF is informing our member organizations about this innovative and potentially life saving approach to mental health crises, but we learned our mental health partners were previously unaware of this program's existence.

- In addition to translating materials into commonly spoken Asian languages, the City must ensure the translations are culturally relevant and reflect linguistic connotations and nuances. In order for the intended audiences to read, understand, trust and apply information, translated materials must be culturally appropriate. Effective translations must be executed by linguists who take into consideration the context, the background of the people they are translating for, and any cultural factors that might impact its effectiveness with the target audience.

2. Invest in CBOs that provide culturally and linguistically competent services to the Asian American community.
    - We urge the City to allocate funding in the City's budget to provide CBOs with directed funds to target Asian American communities, giving preference to CBOs that have a track record of providing these services and addressing the unique cultural and language needs of Asian Americans. Clients served by B-HEARD are offered follow-up care, which can include support from the Department of Health and Mental Hygiene, the Department of Homeless Services, a hospital-based program, or by connecting clients to community-based healthcare or social service providers. The referral of clients to community based providers increases the demand on these already underfunded organizations to address growing mental health needs. Additionally, high demand for services combined with staffing shortages place strain on resources, which may leave already-marginalized communities, especially those with limited English proficiency, unable to access resources.
    - The City should consult with our partner organizations, at the start of program design, to ensure that the Asian community is served in culturally appropriate ways because our partner organizations play a critical role in the mental health ecosystem. Given the pervasive stigma surrounding mental health in our community, community-based organizations act as trusted ambassadors to not only introduce mental health concepts, but to also provide mental health care in a culturally appropriate manner. The recent deaths of Win Rozario in Queens and Victoria Lee in New Jersey have instilled fear within the Asian community, resulting in further distrust of government emergency response systems, especially those who are from particularly vulnerable populations like the undocumented, survivors of gender-based violence, LGBTQIA+ community, etc. Since community members trust our mental health partners and go to them first, our partners need to be consulted at the start of program design, so they can provide input on the best ways to support the mental health of the Asian community and ensure their needs are centered within this program. Through our work, we have found that this bottom-up approach is the best way to effectively tackle mental health within Asian communities.
    - The City should prioritize investing in preventative mental health treatment, to address mental health needs before they escalate into emergencies. Through our persistent efforts to secure increased funding, we've brought much-needed attention and resources to address the growing mental health care needs of our community, simultaneously breaking

down barriers to care. However, our Asian community based organizations continue to be underfunded and overburdened with addressing the mental health needs in the community.

Thank you for the opportunity to testify on this crucial matter. We look forward to working with the City as it creates innovative solutions to address and support New Yorkers experiencing mental health crises.

Bedford Stuyvesant New Beginnings Charter School
Testimony Presented to the New York City Council Committees on Public Safety, Mental Health, Disabilities, Hospitals and the Committee on Fire and Emergency Management

September 23, 2024

Bedford Stuyvesant New Beginnings Charter School respectfully submits the following testimony. Thank You to the Committee Chairs and Members for providing the opportunity to comment on Security Guard funding on behalf of students attending Bedford Stuyvesant New Beginnings Charter School.

Bedford Stuyvesant New Beginnings Charter School has been serving its school community since 2010 as an elementary and middle school and provides a positive educational option for all families served in our private space located in the original historical campus of St. John's College, which served college and high school students in Bed Stuy prior to becoming a University and moving to Queens.

We proudly serve over 700 students in this private facility and pay rent for this space which is not co-located with a NYCDOE school or otherwise located in a district school facility. We feel that the amendment of Intro 532-2024 would level the playing field for New York City families who want the same access to public funding for school safety enjoyed by nonpublic school students in private space.

The governance model of the school they have chosen should not affect their children's access to this funding and it is important to provide equity and fairness for some of the city's most vulnerable students. 96% of our students are eligible for free-and-reduced lunch, 20% of our students have Individual Education Plans to support their disabilities, over a quarter of students are English Language Learners and 20% are McKinney-Vento eligible due to their housing status in the shelter system, homelessness or being doubled up with multiple families in one residence.

It is an injustice for students who already face these challenges to lack access to funding for school safety agents enjoyed by nearly every other school in NYC, including those who cater to very wealthy students. We are not asking for more than what others receive, simply the same consideration.

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Best,

Bedford Stuyvesant New Beginnings Charter School

Nicholas Tishuk + Anderson Fils-Aime
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Testimony of
Sakeena Trice, Senior Staff Attorney
on behalf of
The Disability Justice Program at New York Lawyers for the Public Interest
before
The Council of the City of New York
Committees on Mental Health, Disabilities, and Addiction, Fire Emergency Management,
Public Safety, and Hospitals
B-HEARD Oversight Hearing and Responses to Mental Health Crises and
Int. 1019- 2024 and Int. 0532-2024

September 23, 2024

My name is Sakeena Trice and I am a Senior Staff Attorney in the Disability Justice Program at New York Lawyers for the Public Interest ("NYLPI"). Thank you for the opportunity to present testimony on behalf of NYLPI regarding the City's Behavioral Health Emergency Assistance Response Division program ("B-HEARD).

This Spring, New York Police Department ("NYPD") officers in Queens fatally shot Win Rozario, a 19-year-old, while he was experiencing a mental health crisis for which he had called 911 for help. How many more individuals must die at the hands of police before we finally adopt a more humane and person-centric approach to mental health crises? NYLPI is deeply concerned about the City's dangerous and illegal practices relating to the involuntary removal of individuals with mental health diagnoses, as well as those perceived to have mental health diagnoses, for psychiatric evaluation. NYLPI urges the City Council to mandate significant changes to B-HEARD, as it is a deeply flawed pilot which merely purports to be a non-police response to people experiencing mental health crises – but in fact is part of the long tradition of

policing, criminalizing, and under- and mis-serving people with mental disabilities. Funding B-HEARD in its current guise diverts money from what we need – a true non-police crisis response system that dispatches teams of peers (those with lived mental health experience) and emergency medical technicians who are not City employees, 24/7 operating hours, calls routed through 988, and above all, prioritizes the self-determination of people with mental disabilities.

THE CITY MUST ENTIRELY REVAMP THE B-HEARD PILOT AS THE PILOT AUTHORIZES EXTENSIVE POLICE INVOLVEMENT AND IS LIKELY TO CONTINUE OR EVEN INCREASE THE RATE OF VIOLENT RESPONSES BY THE NYPD

The City, via its Mayor's Office of Community Mental Health (OCMH, formerly ThriveNYC), introduced a pilot program in 2021 that it contends is responsive to the need to cease the killings at the hands of the police of individuals experiencing mental health crises. Unfortunately, that is simply not the case, despite the City's glowing description of the program. Among B-HEARD's grim statistics are the following:

- In Fiscal Year 2023 (July 2022 through June 2023), about **79% of all mental health calls** in B-HEARD precincts were still **directed to the NYPD**, and B-Heard responded to only about **21% of mental health calls** in the pilot area. This fiscal year, B-HEARD teams responded to **only about 29%** of the mental health-related 911 calls in the areas where it operates. (Note: New data on B-HEARD was provided one business day in advance of the public hearing, which does not allow sufficient time to analyze the data and information.)
- Even when all kinks are ironed out, the City anticipates continuing to have about **50% of all mental health calls directed to the NYPD**.
- Moreover, **all mental health calls continue to go through 911,** which is under the NYPD's jurisdiction.

- As City Council knows and set forth in its Committee Report dated September 23, 2024, data shows that **B-HEARD has little to no impact on the frequency of the use of force** during EDP ("Emotionally Disturbed Persons") responses.[1] In fact, data shows that the percentage of EDP calls in which **NYPD used force is similar between precincts that have B-HEARD and those that do not**.
- The entire **program is run by the Fire Department and other City agencies**, with ***NO* role whatsoever for community organizations**. And there is not even any delineation of the lines of authority and communication among the various city agencies.
- **The crisis response teams are composed of emergency medical technicians (EMTs) who are City employees** (from the Fire Department's Emergency Medical Services unit) **who are deeply enmeshed in the current police-led response system**. Peers do not trust these EMTs. The other team members are *licensed clinical* social workers. The licensure and clinical orientation requirements are unnecessary, and they also preclude a vast array of potential candidates who have excellent skills and a long history of working with people experiencing crises. Moreover, the City itself reports on the difficulty of hiring social workers.
- B-HEARD has ***NO* requirement to hire peers**.
- **The training of the teams does *NOT* require a trauma-informed framework, need *NOT* be experiential, and need *NOT* use skilled instructors who are peers or even care providers.**
- The anticipated **response time for crisis calls could be as long as half an hour**, and when last reported averaged over **fifteen minutes**, which is not even remotely comparable to the City's response times for other emergencies of 8 to 11 minutes – and of course means that many calls had

[1] New York City Council, Committee Report. September 23, 2024. [The New York City Council - File #: T2024-2048 (nyc.gov)]

response times of well over fifteen minutes. Moreover, the City has not tracked its response times in the last two years before FY 2023.

- **The pilot operates only sixteen hours a day.**
- **There are no outcome/effectiveness metrics.**
- **There is no oversight mechanism.**

Most importantly, there is extraordinarily limited public data by which the program can be assessed by the Council and by City residents in the impacted precincts and by NYC taxpayers across the five boroughs. Until the City's provision of data on September 20, 2024,[2] the City had not updated any of the public-facing data on the B-HEARD website since the fourth quarter of 2023. (June 2023).[3]

Correct Crisis Intervention Today – NYC (CCIT-NYC), of which NYLPI is a long-time active member, adopted a proposal for appropriately responding to mental health crises. A comparison of the proposal, which is based on the Oregon CAHOOTS model with a stellar track record the B-HEARD program, which is not aligned with any best practices, is illustrated in the following chart:

[2] The City updated the data on the B-HEARD website on the Friday prior to this Monday's oversight hearing. The new data-reporting metrics differ significantly from previous reports on the B-HEARD website and are not easily analyzed. For instance, the FY 24 data is presented quarterly through bar charts displaying "Total 911 Mental Health Calls in the Pilot Area during Pilot Hours," "Calls Eligible for a B-HEARD Response," and "Calls that Received a B-HEARD Response." However, these bar charts lack specific numbers or percentages, in contrast to the "Historical Data" provided for earlier fiscal years and quarters, which included detailed snapshots dating back to June-July 2021. Instead, there is only a general graphic titled "Fiscal Year 2024 Program Data." Furthermore, the data does not account for how many times B-HEARD teams responded to requests from agency partners in the field, including NYPD and EMS.

[3] The B-HEARD "News" page largely has not been updated since 2023.

Critical Attributes of a Mental Health Crisis Response System	CCIT-NYC's Proposal	NYC's B-HEARD Proposal
Removal of police responders	**YES**	**NO** (currently, around 71% of calls are still responded to by police, and even when all kinks are removed, 50% of calls will still be responded to by police)
Three-digit phone number such as 988, in lieu of 911	**YES**	**NO**
Response team to consist of an independent EMT and a trained peer who has lived experience of mental health crises and know best how to engage people in need of support	**YES**	**NO** (licensed clinical social worker and EMT employed by the New York City Bureau of Emergency Medical Services)
Crisis response program run by community-based entity/ies which will provide culturally competent care and will more likely have a history with the person in need and can intervene prior to a crisis	**YES**	**NO** (run by New York City Police Department and other City agencies)
Peer involvement in all aspects of planning/implementation/oversight	**YES**	**NO**
Oversight board consisting of 51% peers from low-income communities, especially Black, Latinx, and other communities of color	**YES**	**NO**
Creation/funding of non-coercive mental health services ("safety net"), including respite centers and 24/7 mental health care to minimize crises in the first place and to serve those for whom crisis de-escalation is insufficient	**YES**	**NO**

Response times comparable to those of other emergencies	**YES**	**NO** (Most recently reported response time of over 15 minutes -- compared with average response time of 8 to 11 minutes for non-mental health emergencies)
Response available 24/7	**YES**	**NO** (Response only available 16 hours/day)
Training of the teams to use a traumainformed framework, be experiential, and use skilled instructors who are peers	**YES**	**NO**

The NYPD's 2025 Executive Budget provides for an operating budget of $5.8 billion. NYLPI therefore urges the Council to ensure that the money allocated by the NYPD for a mental health crisis response, be utilized for a truly non-police response, by a substantially modified B-HEARD program which includes the critical components of the CCIT- NYC proposal.

The City must join other cities across the country – including Los Angeles, San Francisco, Albuquerque, Denver, New Haven and many more – to ***remove*** **police** entirely from the equation, and **ensure that *healthcare* workers respond to *healthcare* crises**. According to NYLPI and Human Rights Watch's joint-research, there are at least 160+ emergency response programs nationwide that engage in crisis response activities without police as the initial responders or as automatic co-responders.

Closer to home, New York State is already taking action. The state legislators are working to pass a bill known as Daniel's Law (S2398/ A2210), which would establish a statewide emergency and crisis response system where police are no longer the default first responders to health emergencies. Under Daniel's Law, the state will only fund emergency response plans where health experts and peers control the response to a health emergency, and the role of police would be strictly limited to situations involving

imminent risk of serious physical harm to the public – and even then, they would only respond together with a healthcare team. The bill currently has 34 sponsors in the Assembly and 18 sponsors in the Senate.

Likewise, the City must establish a system whereby individuals who experience a mental health crisis receive appropriate services which will de-escalate the crisis, and which will 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 receive such training are peers and health care providers.[4] Police officers, 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 20 individuals who were experiencing crises in the last eight years alone, is sad testament to that. Eliminating the police as mental health crisis responders, on the other hand, 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.[5]

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 around the world. Disability is disproportionately prevalent in the Black community and other communities of color,[6] and individuals who are shot and killed by the police when experiencing mental health crises are disproportionately Black and other people of color. Of the 20 individuals killed by police in the last eight years, 17 – or a whopping 85% -- were Black or other

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[4] 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?ur l_ver=Z39.88-2003&rfr_id=ori%3Arid%3Acrossref.org&rfr_dat=cr_pub%3Dpubmed.

[5] 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.

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

people of color. The City Council simply cannot stand by while the killings continue. Now is the time to remove the police as responders to mental health crises. CCIT-NYC has developed the needed antidote.

Modeled on the CAHOOTS program in Oregon, which has successfully operated for nearly 35 years without *any* major injuries to respondents or responders – let alone deaths -- the CCIT-NYC proposal is positioned to make non-police responses available to those experiencing mental health crises in New York City. The proposal avoids the enormous pitfalls of the City's B-HEARD pilot, which the City inaccurately refers to as a non-police model. Hallmarks of the CCIT-NYC proposal are:

- teams of trained peers and emergency medical technicians who are independent of city government;
- teams run by culturally-competent community organizations;
- response times comparable to those of other emergencies;
- 24/7 operating hours;
- calls routed to 988 rather than the city-operated 911 which is embedded in the NYPD; and
- oversight by an advisory board of 51% or more peers.

The full text of the CCIT-NYC proposal can be found at https://www.ccitnyc.org/ourproposal.

NYLPI SUPPORTS INT. NO. 1019, INSOFAR AS IT MAY HELP CREATE STRONG REPORTING REQUIREMENTS FOR CRISIS RESPONDERS

Int. No. 1019, sponsored by Council Members Brannan, Schulman, Narcisse, and Lee, seeks to amend New York City's Administrative Code to mandate enhanced reporting and publication of mental health emergency response data. This legislation mandates that OCMH provide quarterly reports on 911 calls identified as mental health emergencies, detailing the responses and specifically noting if B-HEARD was involved. Additionally, it requires the NYPD and FDNY to include unique identifiers from their

dispatch systems in their published 911 call data on the Open Portal, along with indications of B-HEARD's responses.

Int. 1019 reflects a step toward improving data collection and transparency regarding mental health emergencies, tackling a critical issue faced by B-HEARD. However, NYLPI advocates for the inclusion of demographic data—such as age, gender, race, and disability—in these reports to gain better insights into trends and disparities in responses. Additionally, while Section 1-b of the bill mandates reporting on "follow-up services," it would be more effective if it specified the reporting intervals, such as one day, one week, and one month after the initial response.

Although this bill lays a foundation for accountability, it also highlights the need for broader considerations in effectively addressing mental health crisis management. Notably, Int. 1019 does not address key issues, such as the ongoing reliance on the NYPD for mental health calls, the lack of community organization involvement, trust issues with response teams, and the absence of trauma-informed training or outcome metrics. These shortcomings underscore the necessity for comprehensive changes to tackle the ongoing challenges within the B-HEARD program and the wider mental health crisis management system – as outlined above.

The City used to easily generate and publicize the sort of data Int. 1019 requires, but no longer does so, which leaves concerned citizens left trying to navigate the NYC Open Data Portal to obtain NYC agency data.

NYLPI supports Int. 1019-2024 insofar as it is intended to at least mandate OCMH to obtain reporting from NYPD and EDNY on the numbers of mental health calls coming into the 911 system and further mandate NYPD and FDNY to establish a B-HEARD data reporting stream in the NYPD and FDNY CADs, or computer-aided dispatch systems, for upload to the Open Data portal.

It remains to be seen, however, that this effort to work a modification of existing NYPD and FDNY CAD reporting streams into the Open Data portal will ultimately provide useful information.

THE CITY COUNCIL MUST ENSURE THAT NEW YORKERS HAVE ACCESS TO A WIDE RANGE OF VOLUNTARY NON-HOSPITAL, COMMUNITY-BASED MENTAL HEALTH SERVICES THAT PROMOTE RECOVERY AND WELLNESS, AS WELL AS A FULL PANOPLY OF COMMUNITY SERVICES, INCLUDING HOUSING, EMPLOYMENT, AND EDUCATION, BY ALLOCATING FUNDING FOR SUCH PROGRAMS

Since NYLPI was established nearly 50 years ago, we have advocated on behalf of individuals with mental disabilities, and we have consistently fought to ensure that the rights of individuals with mental disabilities are protected by every aspect of New York's service delivery system. Core to our work is the principle of self-determination for all individuals with disabilities, along with the right to access a robust healthcare system that is available on a *voluntary, non-coercive* basis.

We have long been on record opposing mandatory outpatient and inpatient services as such services insufficiently safeguard the rights of persons with mental disabilities and fail to offer appropriate healthcare. Quite simply, there is no place for coercion. Forced "treatment" is not treatment at all, and it has long been rejected by health practitioners -- to say nothing of the disability community – in favor of numerous best practice strategies that offer assistance even to those who have previously resisted offers of care.[7] There are multiple less invasive models of care that New York City must invest in to avoid the tragedy and enormous cost of forced treatment. At the heart of these models are trained peers, who are ideally suited to implement effective harm reduction and de-escalation techniques, especially during crises. We know how to help those with the most severe mental illness, but we fail to do so, instead providing services that are insufficient or not held to the highest accountability. We face complete system failure, yet we have done little to correct the failure, and even point our fingers at those most affected by the system failure. We must stop the finger-pointing and fix the system. We must invest in innovative, voluntary health programs. And we must invest in supportive housing and other supports, not cart people off to a psychiatric ward or to jail.

[7] *See, e.g.,* de Bruijjn-Wezeman, Reina "Ending Coercion in Mental Health: The Need for a Human Rights-Based Approach," Committee on Social Affairs, Health and Sustainable Development, Council of Europe, Parliamentary Assembly, Doc. 14895 (May 22, 2019), https://assembly.coe.int/nw/xml/XRef/Xref-XML2HTML-en.asp?fileid=27701&lang=en.

Any proposal that facilitates the ability to force people into in-patient or out-patient "treatment" must be seen in the context of whom we're entrusting to "remove" these individuals. As we now surely know all too well, the police, who are steeped in law and order, are not well-suited to deal with individuals with mental disabilities. The Mayor's policies include outsized roles for the police, and the City Council must halt this immediately. Forced "treatment" must also be seen in the context of existing racial disparities. Of the 20 individuals killed at the hands of New York City police in recent years, 17 were people of color. This systemic racism also underlies the disproportionate prevalence of disability in the Black community and other communities of color.[8] The racial disparities in the application of forced outpatient treatment (also known as Kendra's Law) are also vast. [9]

While there is extensive literature supporting voluntary treatment, there is no support for forced evaluation and forced treatment.

Thank you for your consideration. I can be reached at (212) 336-9321 or Strice@nylpi.org, and I look forward to the opportunity to discuss how best to improve B-HEARD and appropriately serve the needs of individuals experiencing mental health crises in New York City.

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About New York Lawyers for the Public Interest

For nearly 50 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-

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

[9] New York Lawyers for the Public Interest Health Justice Project*: IMPLEMENTATION OF "Kendra's Law" IS SEVERELY BIASED*, April 7, 2005, https://www.nylpi.org/resource/implementation-of-kendras-law-is-severely-biased/.

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. In late 2021, NYLPI and co-counsel filed a class action lawsuit which seeks to halt New York's practice of dispatching police to respond to mental health crises, and in the context of that lawsuit, seeks relief on behalf of individuals affected by the Mayor's Involuntary Removal Policy.

Victor M. Herrera
Freedom Agenda

Committee on B HEARD

9-23-24

In almost every home I am quite positive that there is a concern related to a person experiencing emotional crisis or trauma. However, those of us that have no home, are returning citizens and are the target of structural racism don't have such luxury as access to the resources necessary to be appropriately treated.

I urge the City Council to revise the NYPD Patrol Guide Language, demanding the NYPD and NYC Department of Health and mental Hygiene to end the stigma of criminalization of people experiencing emotional crisis. My own experience of being the subject of the Patrol Guide for illegitimate purposes to cover up misconduct by 2 agencies, DHS and NYPD, and the health and hospital corporation response to NYPD practices that resulted in harm to my mental health is the reason i survive post-traumatic stress disorder. Today people who have no resources are treated with dangerous consequences, injury or death.. NO TO EDP. No to NYPD as first responders or co-responders. Yes, to expanding B HEARD and funding of mental health resources. What I have learned as a client of CUCS IMT is coping skills that many in the community are deprived of on account of no funding sources. DOHMH and the city must do more for the at-risk community and address this epidemic as a serious public health concern.

We've had too many police responding with no de-escalation skills or training; hence the Subway shooting cannot be exempt as it was clear the individual was experiencing a crisis when he asked the officer to shoot him. The fact that these kinds of concerns are ignored raises serious questions whether it is deliberate or negligent in this City doing more for the at-risk community members who deserve treatment, not bullets. Innocent bystanders being in the path of what is clear inadequate responses to people experiencing emotional crisis. Yelling at or threatening a person experiencing an emotional crisis is not de-escalation, more provocation and deliberate to create the idea of the NYPD Patrol Guide definition of threat to themselves or others to justify lethal force.

I implore the City council to review and revise the NYPD Patrol Guide Language on responses to persons experiencing an emotional crisis and the use of force to include language that requires police or law enforcement to await B Heard response and that all means of using the least measure of force be taken in street encounters. Co-response is obvious to fail with the encounters the community has faced. More resources and expand B Heard to include many of the solutions in place like IMT outreach teams and peers.

DATA -
PG -
EDP
USE OF FORCE

HOMELESSNESS

MENTAL HEALTH

COMMITTEE ON B HEARD

Victor M. Herrera -
FREEDOM AGENDA

9-23-24

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ACT UP NY Supports Funding a PEERS NOT POLICE Mental Health Crisis Response in NYC. Stop NYPD Violence!

We residents of New York State rely on you, our City Council, to protect our safety and civil liberties. In the last eight years alone, New York City police have murdered 20 New Yorkers in their botched attempts to help them during their mental health crises. These killings -- in which fear of people with mental health diagnoses intersects with racial profiling -- are unacceptable and preventable. We are calling on you to act as the voice of the people most in need of protection.

ACT UP has served the HIV positive community since 1987, using our own peer support and direct action model, defending a vulnerable population against stigma, governmental neglect, big pharma profiteering and lack of treatment access; we have fought against civil rights violations of all kinds. We know that any New Yorker can experience crisis and that people living with HIV are impacted by your choice in how to address a crisis. We also know that Black and Brown New Yorkers, as well as impoverished New Yorkers, are most at risk for a violent police response. People with HIV are over-represented in each of these groups.

We stand with CCIT-NYC (Correct Crisis Intervention Today - NYC) and their Peers not Police model. We know that the presence of trained peers as first responders to New Yorkers in crisis saves lives, saves dollars and also provides jobs to caring, trained people with lived experience of mental health crisis.

The City has launched B-HEARD – a problematic and underfunded pilot project -- to replace a violent response to mental health crisis calls by New Yorkers with a compassionate and less expensive response, employing social workers and EMTs rather than police. It needs to be improved, including centering the services of peers, and then be expanded citywide.

Similar programs around the country employ even more efficient, effective, and nonviolent responses to mental health crisis calls. These programs (such as CAHOOTS in Oregon) are run by peers who are trained, but even more importantly, informed with their own experiences and recoveries in the mental health system.

Peers are able to approach individuals in a more empathetic way than social workers because of lived experience. This is a reliable finding in the research literature. Peers also increase the numbers of people in crisis who are willing to accept voluntary services they want and need.

We are asking you to tell New York City that mental health recovery is real, and that violence and force is an unacceptable way of resolving medical and social problems.

In order to have the resources to serve all five boroughs, operate 24 hours a day (as opposed to the 16 hours they currently operate), and dispatch its teams substantially more than 15% of the time in response to eligible calls, B-HEARD needs an increase in its budget, not the recurring budget cuts of the past several years.

City Council, please do your part to support and further the values New Yorkers most hold dear: civil rights and fairness in healthcare policy, imbued with reverence for the worth of every individual. No longer should New Yorkers be afraid to call for help when experiencing a mental health crisis.

Signed
ACT UP NYC

Literature supporting the efficacy of peer support includes:

Experiences of Parachute NYC: An Integration of Open Dialogue and Intentional Peer Support - PubMed (nih.gov)

Perspectives of key informants before and after implementing UPSIDES peer support in mental health services: qualitative findings from an international multi-site study - PubMed (nih.gov)

Boston HAPPENS Program: a model of health care for HIV-positive, homeless, and at-risk youth. Human immunodeficiency virus (HIV) Adolescent Provider and Peer Education Network for Services - PubMed (nih.gov)

Peer Support Works in Mental Health as well as in HIV services and prevention!

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NYC Council Committees on Health, Mental Health, Disabilities & Addiction, Fire & Emergency Management, Public Safety, and Hospitals

Oversight - Behavioral Health Emergency Assistance Response Division (B-HEARD) and Responses to Mental Health Crises

TESTIMONY

10:00am, Monday, September 23, 2024

Good afternoon Chairs Ariola, Lee, Narcisse, Salaam, and other Council Committee members. My name is Jeannine Mendez, and I am the Senior Director of Strategic Initiatives & Government Relations at Astor Services, where our mental health and educational programs serve over 4,500 children, adults, and families in the Bronx. On behalf of the staff, children, and families we serve, we want to thank you for your unwavering support of mental and behavioral health resources in our neighborhoods and communities and for holding this important and necessary hearing today. I also want to thank you for the opportunity to testify before you regarding the state of responses and accountability when it comes to mental health crises calls into 911.

For far too long, the mental and behavioral wellness of our most vulnerable New Yorkers has fallen through the cracks. It is no secret that we are facing a mental health crisis that continues to grow and affect our communities and although the City has taken steps to address and bridge the gap in resources and collaborations among City agencies to address the issue, there is still a lot of work to be done. Although the B-Heard initiative is a great first step in combatting the need for trained responders, more investment needs to be done in training first points of contact like 911 dispatchers to know how to adequately and correctly triage mental health calls to ensure timely and appropriate follow up from the respective first responders. Astor operates several community and school-based mental health programs and many times when we dial 911 because one of our clients is suffering a mental health emergency needing immediate medical attention, we are often left to wait an average of two hours before anyone arrives on the scene. As you can imagine, when individuals are suffering a mental or behavioral health emergency, every moment is crucial to ensure a safe outcome. If Astor, being experts in mental health supports and de-escalation, is struggling with long response times to 911 calls, how can we expect the public to have to wait when in most cases, mental health emergency calls can be a difference between life and death from one moment to another.

Having qualified and trained responders is only part of the solution. Although they are crucial in deescalating many mental health calls, the teams are small and far between. Astor's staff is trained to deal with many crisis situations but still find it difficult to get the necessary services and support when we need a helping hand.

Here is an example of a recent incident:

Earlier this summer, we had a situation where a client in one of our school-based day treatment programs was unsafe in program (homicidal/suicidal ideation, attempting to bite staff, attempting to leave, and eating staples). Staff opted to call 911 for EMS. The initial call was placed at 11:07am but no one arrived to provide assistance until well after 3:00pm. That is four hours of

waiting for medical attention for a situation that could have resulted in harm not only to the student but the staff and peers around them.

Here are the call times:

- **11:07am**: Initial 9-1-1 call. Stated client was aggressive and dysregulated. Stated patient has a history of eating staples.
- **11:57am**: EMS called back asking if assistance was still needed. They left a voicemail.
- **12:00pm**: Astor called back 9-1-1 stating assistance is still needed.
    - **School safety was calling asking for updates during this time.**
- **3:00pm**: EMS called back asking if assistance was still needed. We stated that the patient was stable but in crisis and needed to be taken to the hospital.
- **3:06pm**: EMS was seen around the corner. One of the EMT's was sleeping. They stated they were waiting for assistance since they were informed that the patient was violent. School administration told them the patient was calm and they came into the building.
- Our client was taken to the hospital and accompanied by an Astor clinician. This client is already known to ACS. The ACS worker was notified. Parent was not responding to staff. Parent has a history of not showing up to the hospital. ACS contacted an aunt. Aunt did not arrive at the hospital until 7:30 p.m.
- The Astor clinician left the hospital at **7:45 p.m.**

The 8-hour period that it took to address the situation is concerning and unacceptable and we are continuing to struggle with the response times from other similar incidents as well. Just two weeks ago, we made a call into 911 about a male siting in our clinic parking lot with his pants around his ankles refusing to move. It took NYPD 2 hours to arrive and transfer him to the hospital for observation. During that 2 hour wait, several staff and patients, including children, encountered this situation and needed to be rerouted to another entrance so as to not escalate the situation or trigger the individual in crisis. We know that the City's B-Heard Initiative is intended to address situations like this and yet as a city contracted mental health provider, we were never instructed how to request a B-Heard team versus making a general 911 call. There needs to be better integration between and amongst all resources available so that tools like 911 and 988 serve as direct pipelines for mental health emergencies and instances like the ones above and communities are not left to fend for themselves.

We are all aware of the unprecedented challenges ahead but considering the exasperating mental health challenges facing our communities, we must remain optimistic that you will partner with us on this journey by recognizing how imperative it is for us to secure the crucial mental health workforce and systems that will provide the vital services desperately needed to help our city's vulnerable children and families. Your support and investment in additional staffing and training will allow providers like Astor and programs like B-Heard to expand our existing services and community engagement and it is our hope that we can count on your support.

Thank you.

Behavioral Health Emergency Assistance Response Division (B-HEARD) and
Responses to Mental Health Crises Oversight Hearing Testimony

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

Jointly with the Committee on Public Safety, Committee on Hospitals, and the Committee on Fire and Emergency Management

September 23, 2024

Presented by:
Alexandra Nyman, CARC-RPA, RCP, SRCD,
Founder & CEO of the Break Free Foundation
(570) 369-0325 | team@breakfreefoundation.org

Thank you Chairs Lee, Salaam, Narcisse, and Ariola, and to the other members of these committees for convening this critical oversight hearing.

My name is Alexandra Nyman and I am a certified recovery peer advocate, a recovery peer coach, and a NAMI NYC Advocate. I serve as the founder of the Break Free Foundation which provides scholarships for those looking to enter into recovery to do so by removing the financial barrier. I am here today to testify in support of the testimony provided by Correct Crisis Intervention Today - NYC (CCIT-NYC), a coalition of advocacy groups and other community organizations that consist of hundreds of community stakeholders, working to transform how New York City responds to mental health crises.

Thank you for convening this crucial hearing. It is no secret that mental health crises, when met with inadequate or inappropriate responses, often lead to tragic outcomes and increasingly death. Since 2015, 18 individuals experiencing mental health crises in New York City have been killed by police officers. Their names are:

- David Kostovski, age 29 — November 2007, killed in Brooklyn
- Khiel Coppin, age 18 — November 2007, killed in Brooklyn
- Iman Morales, age 35 — September 2008, killed in Brooklyn
- Shereese Francis, age 30 — March 2012, killed in Queens
- Darrius Kennedy, age 31 — August 2012, killed in Manhattan
- Mohamed Bah, age 28 — September 2012, killed in Manhattan
- Rexford Dasrath, age 22 — November 2013, killed in Brooklyn
- David Felix, age 24 — April 2015, killed in Manhattan
- Mario Ocasio, age 51 — June 2015, killed in the Bronx
- Anthony Paul, II, age 29 — July 2015, killed in the Bronx
- Garry Conrad, age 46 — May 2016, killed in Manhattan
- Rashaun Lloyd, age 25 — June 2016, killed in the Bronx
- Deborah Danner, age 66 — October 2016, killed in the Bronx

- Ariel Galarza, age 49 — November 2016, killed in the Bronx
- Dwayne Jeune, age 32 — July 2017, killed in Brooklyn
- Miguel Richards, age 31 — September 2017, killed in the Bronx
- Cornell Lockhart, age 67 — November 2017, killed in the Bronx
- Dwayne Pritchett, age 48 — January 2018, killed in the Bronx
- James Owens, age 63 — January 2018, killed in Brooklyn
- Michael Hansford, age 52 — January 2018, killed in the Bronx
- Saheed Vassell, age 34 — April 2018, killed in Brooklyn
- Susan Muller, age 54 — September 2018, killed in Queens
- Kawaski Trawick, age 32 — May 2019, killed in the Bronx
- Kwesi Ashun, age 33 — October 2019, killed in Brooklyn
- George Zapantis, age 29 — June 2020, killed in Queens
- Eudes Pierre, age 26 — December 2021, killed in Brooklyn

These incidents have exposed the flaws in relying on law enforcement to handle situations that require compassion, understanding, and specialized intervention - which is something that as a peer I have been extensively trained in.

In 2015, the NYPD responded to 146,000 calls relating to a person experiencing a mental health crisis. 1,460 of these incidents between the NYPD and a person in apparent mental health crisis turned violent, meaning every day 4 people in the most vulnerable moment of their life were met with violence by the very people who have taken an oath to protect them. This is unacceptable and avoidable.

The B-HEARD program is a step in the right direction. Responding to mental health calls with trained health professionals, rather than police officers, is essential to reducing violence and saving lives. As a peer who has intervened for persons living with serious mental illness, in my two years of service I have never felt compelled to arm myself with a gun, I instead arm myself with compassion, understanding, and narcan.

It is well-documented that people living with a serious mental illness are 16 times more likely to be fatally shot during an encounter with a police officer. Let’s zoom out on this, nationwide, 25% of people shot and killed by the police live with a severe mental illness.

These statistics alone should compel us to support a program like B-HEARD, which has the potential to shift our crisis response system toward one that prioritizes care over punishment.

However, despite its promise, the current structure of the B-HEARD program has limitations. For one, it is still reliant on 911 dispatching, which places mental health emergencies in the realm of law enforcement. As we know, the new 988 mental health crisis number was designed to be the gateway to appropriate care for individuals in crisis. B-HEARD teams need to be dispatched through this system to ensure that the first response to a mental health crisis is not rooted in criminalization but in care. Additionally, the program has yet to launch citywide and is not available 24/7. This leaves large gaps in the coverage for our most vulnerable citizens and invites the potential for police to be dispatched into a situation that they are not properly trained for.

As a peer, I trained for two years receiving both statewide, national, and international designations for both substance use recovery and mental health recovery. As a CRPA, I had 500 hours of supervision for peer work, for mental health peer training it is 2,000 hours of training. We cannot expect our police officers to grasp the level of education and training I have through a 45 minute video and being randomly quizzed 15 minutes before they interact with the public and patrol.

I want to take a moment to share a personal story. My sibling experienced a mental health crisis a few years ago. In their distress, they were confronted by police officers instead of mental health professionals. Rather than calming the situation, the officers' presence and aggressive demeanor escalated to the point that my brother had a panic attack. The police were responding to my brother's suicide attempt. And instead of offering my brother support and trying to de-escalation the situation, the officers on duty turned it into a terrifying experience that led to unnecessary hospitalization and long-term trauma. The intervention not only delayed my brother's recovery for years, but also broke their trust in seeking help during future crises. I am fortunate that my sibling is still alive and with us today.

This is why we must move toward a system where mental health professionals and peers are at the forefront of crisis response. Peers bring a level of empathy and understanding that law enforcement officials simply cannot provide. The presence of peers on B-HEARD teams will help to reduce hospitalizations and increase connections to community-based care. Right now, only 6% of those who receive a B-HEARD response are transported to a community-based health care or social service location, while nearly 60% are taken to hospitals, often unnecessarily. This is a missed opportunity to connect people in crisis to the care they truly need.

Furthermore, we need greater transparency and data reporting around the B-HEARD program. Since the start of this fiscal year, no new data has been provided on the program's outcomes. Regular reporting is essential for accountability and to inform best practices moving forward. And, of course, for the program to continue expanding and improving, it will require sustained and substantial investment. Restoring funding cuts to

the B-HEARD Program to Eliminate the Gap (PEG) is crucial in ensuring that the program can meet its goals and protect the lives of those in crisis.

I urge the committee to act on these recommendations: fully embrace B-HEARD by expanding its scope, remove the police from nonviolent mental health crisis responses, mandating the involvement of peers, and ensuring sustained investment in the program. New Yorkers in crisis deserve compassion, not confrontation. We can, and must, do better.

Thank you for your time, your leadership, and your commitment to improving mental health crisis responses in our city.

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TESTIMONY OF:

Colleen King
Supervising Attorney, Criminal Defense Practice

BROOKLYN DEFENDER SERVICES

Presented before

The New York City Council Committees on Public Safety, Mental Health, Disabilities and Addiction, Fire and Emergency Management, and Hospitals

Oversight Hearing on Behavioral Health Emergency Assistance Response Division (B-HEARD) and Responses to Mental Health Crises.

September 23, 2024

My name is Colleen King and I am a Supervising Attorney with the Mental Health Unit at Brooklyn Defender Services (BDS). I have represented people in the Brooklyn Mental Health Court over a decade. I am also a member of the New York State Judicial Task Force on Mental Illness. On behalf of BDS, I would like to thank the City Councils, and Chairs Salaam, Lee, Ariola, and Narcisse, for holding today's important hearing on Behavioral Health Emergency Assistance Response Division (B-HEARD) and other emergency responses to people experiencing acute mental health crises.

BDS is a public defense office whose mission is to provide outstanding representation and advocacy free of cost to people facing loss of freedom, family separation and other serious legal harms by the government. We provide multi-disciplinary and client-centered criminal defense, family defense, immigration, civil legal services, social work support and advocacy in nearly 23,000 cases every year.

BDS' Mental Health Representation Team consists of specially trained attorneys and social workers who are experts in working with and for people who have been accused of a crime and who are living with serious mental illness or a developmental disability. We are proud of having played an important role in the creation of the Brooklyn Mental Health Court in 2002. The Brooklyn Mental Health Court works with people accused of crimes who have serious and persistent mental illnesses, linking them to long-term treatment as an alternative to incarceration. BDS continues to collaborate with this court to advocate for its expansion to meet the needs of more people, including people with intellectual disabilities and people who have previous criminal legal system involvement.

B-HEARD and non-police responses to mental health emergencies

We are saddened to appear before you once again in response to more New Yorkers having been tragically killed while in crisis and asking for help.[1] For years, BDS has advocated for the complete removal of the NYPD from all mental health responses, including emergencies, and for the expansion of mobile crisis teams staffed by trained professionals. While the city has made some attempts to reform its approach to serious mental illness (SMI) through piecemeal legislation and pilot programs, these efforts remain insufficient. Despite the growing recognition of the problem, the NYPD and the criminal legal system continue to be relied upon as the default responders in mental health crises. This reliance not only fails to address the root causes of these emergencies but also puts lives at risk. If we are serious about tackling the mental health crisis in our city, we must move beyond fragmented solutions and invest in comprehensive, sustainable care that prioritizes the well-being of all New Yorkers.

The NYPD will tell you that they respond to 200,000 mental health calls a year, and that deadly incidents are rare, but for the families of New Yorkers killed by the police, a single incident is irreversible and devastating. Force is disproportionately used in incidents involving people who have been identified as "emotionally disturbed."[2] Even one preventable death is one too many. These tragedies are not mere statistics—they are profound failures to protect vulnerable individuals. We must view and respond to mental health crises for what they are: medical emergencies that require trained healthcare professionals. Just as any other health-related crisis, like a heart attack, would be met with an ambulance and appropriate medical care, people in mental distress deserve the same level of specialized, compassionate intervention. Allowing the NYPD to continue responding to these calls does not address the real danger that police pose to people experiencing mental health crises. Police are not mental health experts or medical professionals, and they should not be tasked with filling this role.

Even when police receive specialized training to interact with individuals experiencing mental health crises, the presence of an armed officer can escalate tension and trigger fear or distress for those with mental illness or behavioral health conditions. As public defenders, we have seen how these encounters frequently result in harm instead of help. Far too often, individuals in crisis are arrested and incarcerated, leading to further psychological deterioration, rather than being taken to a hospital or care facility for treatment. Worse yet, we know that in New York City, individuals with serious mental illness face a disproportionately high risk of excessive force.[3]

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[1] David Brand, *Horrifying NYPD Footage Shows Speedy Escalation of Ozone Park Police Shooting That Left Teen Dead*, Queens Daily Eagle (May 3, 2024), https://queenseagle.com/all/2024/5/3/horrifying-nypd-footage-shows-speedy-escalation-of-ozone-park-police-shooting-that-left-teen-dead.

[2] Ayobami Laniyonu & Phillip Atiba Goff, Measuring Disparities in Police Use of Force and Injury Among Persons with Serious Mental Illness. BMC Psychiatry. 21, 500 (2021). https://doi.org/10.1186/s12888-021-03510-w

[3] Hyun-Jin Jun, Jordan E. DeVylder & Lisa Fedina, Police Violence Among Adults Diagnosed with Mental Disorders, 45 Health & Soc. Work 81 (2020).

And the risk of police violence when dealing with individuals with mental illness affects *all* New Yorkers- as our city has recently seen, inappropriate and escalatory police responses to individuals experiencing mental illness are not simply unfair and unjust for the person in crisis- this gap in crisis response puts the individual, the police, and all New Yorkers at risk of lethal police responses[4].

BDS supports the implementation and expansion of the B-HEARD, and we encourage the Council to work with the mayor's office to ensure this program is fully staffed and funded to meet community needs:

- Clinicians, EMTs, and peers should be available in all boroughs and all neighborhoods to respond to calls in a mental health emergency.
- B-HEARD responders must be fairly compensated to attract and retain high-quality staff, ensuring that New Yorkers in every borough have access to the care they need.
- EMS dispatchers must also be trained to appropriately prioritize this response, defaulting to B-HEARD for mental health emergencies. Mental health emergencies account for nearly 10% of all 911 calls in New York, and yet B-HEARD, though improving in response, has only responded to about a quarter of those calls.[5]
- B-HEARD must expand its operating hours to become a 24-hour emergency response service.

BDS supports Int 1019-2024, which would require the Office of Community Mental Health (OCMH), in coordination and consultation with other relevant agencies, to report to the mayor and Speaker of the Council and online regarding each 911 call that is identified as involving a mental health emergency, on a quarterly basis. We are deeply concerned with the lack of transparency about emergency response and instances in which police may be involved in mental health calls. We support legislation to ensure that data related to mental health emergency responses- whether by NYPD, EMS, or B-HEARD- is recorded and publicized to monitor whether individuals accepted medical treatment at the scene, voluntary transport to a hospital, mental health and crisis counseling at the scene, or follow-up services offered by the Department of Health and Mental Hygiene or Department of Homeless Services, by community-based healthcare or social service providers, or through a hospital-based program. Additionally, the NYPD should be required to report if, during the response to a mental health crisis, an individual

[4] NYPD Leadership Ties Brooklyn Subway Shooting to Mental Health Crisis, NY1 (Sept. 23, 2024), https://ny1.com/nyc/all-boroughs/news/2024/09/23/nypd-leadership-ties-brooklyn-subway-shooting-to-mental-health-crisis.

[5] Lewis, Caroline. NYC program for non-police 911 response still handles a fraction of eligible mental health calls, Gothamist (Jan. 31, 2024), NYC program for non-police 911 response still handles a fraction of eligible mental health calls - Gothamist.

was subjected to involuntary removal, experienced a use of force incident, was issued a summons, or was arrested.

Every New Yorker deserves safe, compassionate, and expert care in moments of crisis, not a police response that risks escalation.

Non-emergent mental health responses

NYPD is widely involved in city services that should be conducted by civilian and mental health professionals. We have seen wellness checks end in unnecessary arrests, criminalizing individuals in crisis instead of providing them with the care and support they need. When officers respond to wellness check requests, individuals are often scared and confused at the sight of law enforcement at their door. As a result, the person may panic, respond erratically, or attempt to flee, which then leads to serious charges like assault or resisting arrest.

Our office recently represented Ms. S, who was arrested during a wellness check, based on an unsubstantiated, anonymous call. Ms. S had no idea why the police were at her door and refused them entry. Without a warrant, armed NYPD officers broke down her door. This interaction resulted in our client being forcibly removed from her home, separated her from her child, and resulted in a family court case and criminal charges that she fought for six months. Both cases have since been dismissed and she has been reunited with her daughter. However the injustice she faced for months in both court systems is the result of inadequate training and a pattern of aggressive responses by NYPD to those in crisis or even just those alleged to be in crisis.

What should have been a moment for compassionate intervention turns into a criminal case, with someone in need of urgent care instead facing life-altering felony charges. This is the kind of outcome we see far too often—a tragic failure to prioritize care over punishment.

Increase access to care for people with serious mental illness

Many of the people we represent have tried for years to access mental health treatment, but struggle to find providers who accept their insurance, speak their language, or have the skills needed to treat complex conditions. These clients are often discharged from hospitals without proper follow-up care, are pushed out of housing which further exacerbates mental illness, and lack appropriate resources in their communities. People seeking care remain on waitlists for months or years for Assertive Community Treatment (ACT) teams, supportive housing, psychiatric visits or other care they require. Individuals are routinely discharged from psychiatric hospitalization with nothing more than a referral to first-come-first-serve walk-in mental health care and a list of congregate shelters, or are outright denied services for requiring a “higher level of care” or having a co-occurring substance use disorder. Left without viable treatment options, they are funneled into the criminal legal system–policed, arrested, and incarcerated when they should be receiving health care.

New York City has invested over one billion dollars[6] in mental health education, outreach, and resources–but low-income New Yorkers still struggle to access care. New York State and federal legislation require insurance providers to offer comparable coverage for mental illness as they do for physical illnesses.[7] Yet many low-income people struggle to find high quality providers who accept Medicaid or Marketplace insurances, and are unable to cover copays for private insurance provided through an employer. We ask the Council to explore the gaps in services for people living with SMI, especially Black and Brown, low-income, and non-native English speaking New Yorkers. We urge the Council to prioritize a transformative shift in funding from incarceration, surveillance, and punitive measures to comprehensive mental health care, as this investment will not only address the urgent needs of our most vulnerable populations but will ultimately create a safer, healthier, and more just city for all New Yorkers. Without meaningful investment in mental health services and emergency response systems, we risk perpetuating a harmful cycle that criminalizes people living with serious mental illness rather than providing them the support they deserve, which in turn would make all New Yorkers safer.

Continue to work with your in Albany in support of the Treatment Not Jails Act (S2881, A6603)

Over the past few years, the New York State Legislature has championed and won historic legislative change in the criminal legal system. BDS fully supports Res. 156-2022 (Rivera), which calls on the legislature to pass and the governor to sign the Treatment Not Jail Act (S2881B - Ramos/A8524A - Forrest).

As previously stated, New York's current treatment court model has many restrictions on who is able to participate in a diversion program, based on their changes, diagnoses, or personal history. The Treatment Not Jail Act (TNJ) will substantially expand access to judicial diversion and create tangible steps toward ending the criminalization of mental health and cognitive impairments in New York. TNJ will create parity in the court system for vulnerable populations who need support and opportunity, and promote public safety by opening avenues of appropriate, individualized treatment where currently the default is incarceration. TNJ will:

The Treatment Not Jail Act (TNJ) will substantially expand access to judicial diversion and create tangible steps toward ending the criminalization of mental health and cognitive impairments in New York. TNJ will create parity in the court system for vulnerable populations who need support and opportunity, and promote public safety by opening avenues of appropriate, individualized treatment where currently the default is incarceration. TNJ will:

[6] See for example, Amanda Eisenberg, With opaque budget and elusive metrics, $850M ThriveNYC program attempts a reset, *Politico*, 2019, Available at 2https://www.politico.com/states/new-york/city-hall/story/2019/02/27/with-opaque-budget-and-elusive-metrics-850m-thrivenyc-program-attempts-a-reset-873945
[7] https://omh.ny.gov/omhweb/bho/parity.html

- Create equitable access to judicial diversion by making the current judicial diversion law inclusive of people with mental health challenges and neurological, intellectual, and other disabilities.
- Allow New Yorkers to access treatment regardless of where they live. Currently, some counties will not allow people to participate in treatment court unless they are a county resident. TNJ will enable people to engage in treatment court within their county of residence, regardless of where the offense with which they are charged took place.
- Provide due process protection by ensuring that judicial diversion participants are not jailed without due process by requiring there be some substantiation of violations of judicial diversion conditions.
- End automatic exclusions based on level of charge. Currently, some people are excluded from participating in judicial diversion because of the section of the Penal Law with which they are charged regardless of their personal circumstances and background. TNJ will expand access to judicial diversion to people accused of any criminal offense. Research shows that diversion programs promote public safety, and that the nature of the charge does not impact treatment outcomes. TNJ will provide judges with the discretion to give people appearing before them individual consideration.
- Increase likelihood of success by embracing a clinical rather than punitive approach. TNJ will allow individuals to participate in treatment court without requiring them to plead guilty to access treatment. Judges will be trained in the best practices for mental health treatment within the judicial system. These practices will be grounded in providing support for participants and guided by treatment providers' individualized recommendations rather than over relying on punitive sanctions. TNJ will promote collaboration between participants and treatment providers, offering participants the best chance of achieving their treatment goals.

The number of people identifying as living with or having experienced mental health issues is at an all-time high, and jails and prisons have become the de facto mental health facilities across New York State. Treatment Not Jail seeks to put an end to this untenable condition.

Conclusion

It is critical that the city provides timely, meaningful, and compassionate responses to people experiencing mental health crises. BDS' interdisciplinary, wraparound model allows us to provide support to people who may have avoided court involvement if they had access to services sooner. We help people apply for public benefits and supportive housing, refer them to mental health and substance use treatment, and locate beds in respite centers and safe havens. We are committed to providing these critical services to the people who come through our doors

but wish our clients had more opportunities to access these important and life saving support services *before* they have legal system involvement. We urge the City Council to continue to work to ensure New Yorkers have access to meaningful mental health services and support systems before a crisis and, critically, to ensure that arrest, criminal investigation, or court involvement are not the main pathways to treatment.

BDS is grateful to the Committees on Public Safety, Mental Health, Disabilities and Addiction, Fire and Emergency Management, and Hospitals for holding this important hearing. We thank the Council for its continued support of people living with serious mental illness and acknowledge the critical role the Council plays in safeguarding this community and all New Yorkers. Thank you for your time and consideration of my comments. If you have any questions, please feel free to reach out to Colleen King, Supervising Attorney, at cking@bds.org, or Jackie Gosdigian, Supervising Policy Counsel, at jgosdigian@bds.org.

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Courtney Bryan. Executive Director

Center for Justice Innovation
New York City Council
Committees on Public Safety, Mental Health, Disabilities and Addiction, Hospitals and Fire and Emergency Management
September 23, 2024

Good morning, Chairs Salaam, Narcisse, Lee, and Ariola, and esteemed members of the Committees on Public Safety, Hospitals, Mental Health, Disabilities and Addiction, and Fire and Emergency Management. Thank you for the opportunity to testify today on behalf of the Center for Justice Innovation (The Center).

The Center works at the intersection of public safety and behavioral health, working to address the underlying conditions that result in justice system involvement. We recognize the role of services such as substance abuse counseling, mental health treatment, housing and employment help, and more in helping individuals live safely and successfully in community.

The population of New Yorkers with serious mental illness in New York City's jails is rapidly increasing.[1] Over the past few years, we have seen an alarming number of deaths in custody as a result of overdose and suicide. Our carceral system is simply not equipped to address the symptoms of the mental health crisis in New York City.

Ample data shows that incarceration often fails to address the underlying causes of crime, resulting in high rates of reoffending and recidivism.[2] For many, the root cause of their justice system involvement is a treatable issue such as substance use disorder or mental illness. However, it can be very difficult to access treatment while behind bars as facilities often lack the resources and capacity to offer quality services. Additionally, incarceration can exacerbate mental health and addiction issues, resulting in a costly, and largely ineffective revolving door justice system.

In order to achieve true public safety, we need to address the systems that underlie a significant proportion of justice system involvement. Treatment, education, employment, and

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[1] *A Safer, More Effective Option Than Rikers*, A More Just NYC: Independent Commission on NYC Criminal Justice and Incarceration Reform, Oct. 2023, https://static1.squarespace.com/static/5b6de4731aef1de914f43628/t/6530056e07c0614a1a3d6655/1697645934489/1500+Secure+Treatment+Beds+to+Help+Close+Rikers+White+Paper.pdf.

[2] Ly, L. & R. Sanchez (August 2022) "Recidivists fuel New York City's rise in crime, mayor and police officials say." New York, NY: CNN https://www.cnn.com/2022/08/03/us/new-york-city-mayor-police-recidivists-bail-reform/index.html

housing support can all help get an individual on the path to live safely and successfully in community, curtailing the endless cycle of recidivism and harm to the community.

Today I will be discussing two such programs that the Center offers, Community First, which conducts a unique approach to street outreach, and Bronx HOPE, which provides early diversion and mentorship to those suffering with addiction.

Community First

Community First is a holistic, community-based approach to street outreach. It launched in July of 2021 with support from the Times Square Alliance and the Department of Homeless Services. The Community Navigator team heads out into the neighborhood with clothing, socks, blankets, food, and other materials to begin engaging individuals in conversations around their needs. Community Navigators also link people with services that may be difficult, if not impossible, for them to access, like bathroom facilities, general wellness support, haircuts, showers, and laundry services. These may be people who are experiencing homelessness, staying in a local shelter, or are in need of mental health services, harm reduction services, benefits connections, medical treatment, or any number of other services.

During the pandemic, community concerns emerged in and around Times Square. The Center felt it was important not to employ or rely upon traditional policing to solve these issues, but rather to implement an intervention that prevents people from ending up in the justice system, and connects them with much needed services. Our teams of Community Navigators identify with the lived and shared experiences of the community members they work with. In partnership with city agencies and community-based partners, including but not limited to Fountain House, Breaking Ground, and CUCS: Center for Urban Community Services, Community First takes a client-centered, trauma-informed approach, protecting the agency of the client when creating service plans and identifying goals and next steps.

The Community First model differs from existing street outreach initiatives because it focuses on building trusting relationships and meeting community members "where they're at" before making linkages to more meaningful and significant services provided by community-based organizations in the Midtown Community Justice Center's network. The time spent building trust with community members in need results in those individuals confidently engaging in critical services with greater chances for long-term success. Since launching in 2021, the Community Navigator team has engaged 952 individuals and completed over 2,677 interactions through the end of 2023.[3] Currently, Community First's team of Community Navigators operates from 40th Street to 53rd Street, 6th Avenue to 8th Avenue, including Restaurant Row.

Bronx HOPE

[3] Center for Justice Innovation. (2024). Justice Center Application database. [Data file].

Bronx Heroin Overdose Prevention and Education (HOPE), an initiative of Bronx Community Solutions, addresses substance use issues with a harm reduction model at the precinct level. By giving clients the option of accessing community services instead of appearing in court, Bronx HOPE gives residents in the Bronx the opportunity for rehabilitation and connection to community rather than jail or options that fail to address the underlying issues.

The process begins when an individual is issued a Desk Appearance Ticket from the New York Police Department (NYPD). The NYPD will forward this ticket to the Bronx District Attorney's Office, which will review the individual for eligibility. Individuals who receive a ticket for drug possession will have the option to participate in the HOPE program. If an individual is eligible, they will be met at the precinct after their arrest by a peer mentor with similar lived experience. The peer mentor explains the program, provides a Naloxone kit and overdose prevention education, and connects the individual to Bronx HOPE case managers. If an individual chooses to participate, they meet with a Bronx HOPE case manager within seven days of their arrest. Case managers then conduct an assessment and work with the individual to develop an individualized plan of care, help identify services that address an individual's needs, and provide support in the completion of services.

Bronx HOPE demonstrates that people with eligible cases are more likely to engage in programming when there is peer presence at the precinct. In 2023, Bronx HOPE had a contact rate of 86 percent for dispatched cases. Of those cases that were dispatched and began programming, 92 percent completed their services, thereby preventing the need for those participants to appear in court and face criminal charges.[4]

Conclusion

The Center urges Council to rely on humane and effective solutions to address the mental health crisis in New York. Too often, our justice system serves as a default catch-all for those in need of services. At the same time, it is a system that has the capacity to cause harm to those it touches. Preventative services and early diversion programs provide meaningful offramps, serving to curb recidivism, and generate lasting public safety. Thank you for the opportunity to testify today. We look forward to working in partnership with Council to ensure that all New Yorkers have access to these life changing programs.

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[4] Center for Justice Innovation. (2024). Reset/Hope referral database. [Data file].

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Testimony on B-HEARD

09/23/2024

My name is Mbacke Thiam. I am Housing, Health and CAN Community Organizer at Center for the Independence of the Disabled, New York (mostly known as **CIDNY**). We are a nonprofit organization founded in 1978. We are part of the Independent Living Centers movement, a national network of grassroots and community-based organizations that enhance opportunities for people with disabilities to direct their own lives. CIDNY advocates for people with disabilities in the five boroughs of New York City. We strongly support **T2024-2048:** Oversight - Behavioral Health Emergency Assistance Response Division (B-HEARD) and Responses to Mental Health Crises.

When an individual is at risk of hurting oneself or others, or unable to function effectively in the community, bystanders have no option other than calling 9-1-1. Much of the time the calls may end with police brutality. That is why we strongly support **T2024-2048:** Behavioral Health Emergency Assistance Response Division (B-HEARD). We believe that having a mental health counselor along NYPD and NYFD would make a great difference in de-escalating these tumultuous situations with people experiencing mental health crises.

We also support **Int 1019-2024.** This bill would require the Office of Community Mental Health (OCMH), in coordination and consultation with other relevant agencies, to report to the Mayor, Speaker of the Council, and online, regarding each 911 call that is identified as involving a mental health emergency, on a quarterly basis. This will bring more transparency to the data.

This testimony is supported by Dr Sharon McLennon Wier.

Thank you,

Mbacke Thiam

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Testimony of

Coalition for the Homeless

before the
Committee on Mental Health, Disabilities, and Addiction;
Committee on Public Safety;
Committee on Fire and Emergency Management; and
Committee on Hospitals

of the New York City Council

on

Oversight: Behavioral Health Emergency Assistance Response Division (B-HEARD) and Responses to Mental Health Crises

submitted by

Alison Wilkey
Director of Governmental Affairs & Strategic Campaigns

Coalition for the Homeless

September 23, 2024

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The Legal Aid Society, 40 Worth Street, New York NY 10013 www.legal-aid.org 212-577-3300

The Coalition for the Homeless ("Coalition") welcomes this opportunity to testify before the New York City Council's Committee on Mental Health, Disabilities, and Addiction; Committee on Public Safety; Committee on Fire and Emergency Management; and Committee on Hospitals. Founded in 1981, we are the court-appointed independent monitor of the New York City ("NYC") Department of Homeless Services ("DHS") shelter system for single adults, the City-appointed independent monitor of the shelter system for homeless families, and plaintiff in the historic *Callahan v. Carey* case that first guaranteed the legal Right to Shelter. As such, the opinions set forth below are informed by our more than 40 years of experience operating frontline programs for the most vulnerable individuals and defending the fundamental rights of those disproportionately impacted by the intersection of homelessness and mental health challenges.

A History of Needless Violence

The litany of needless tragedies involving the NYPD and those in mental health crisis is long. In March, two NYPD officers shot and killed Win Rozario, who was experiencing a mental health crisis and called 911 for help. Like Mr. Rozario, nineteen other individuals experiencing mental health crises have been killed by the NYPD since 2015. These tragedies are preventable. But the City must do more to reform the response to mental health crises to reduce the incidents of violence and trauma experienced by those who turn to emergency services for assistance.

It is apparent to any New Yorker who has ridden the subways or walked the city's streets that countless neighbors are not connected to the mental health care they want and need. When we see someone in crisis, there is no direct phone number to call to get the assistance of a qualified mental health professional and, particularly, someone with the expertise and wisdom of lived experience.

When former Mayor De Blasio announced the Behavioral Health Emergency Assistance Response Division ("B-HEARD") pilot in November 2020, he said, "For the first time in our city's history, health responders will be the default responders for a person in crisis, making sure those struggling with mental illness receive the help they need."[1] But B-HEARD has failed to fully live up to that promise. The program is hamstrung by its limited scope and funding, lack of clear eligibility, insufficient data, and the failure to include peer responders.

Limited Scope

B-HEARD does not operate in most areas of the city,[2] and responds to only [3] The city has one other non-police option for mental health crises: Mobile Crisis Teams, which are dispatched

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[1] https://mentalhealth.cityofnewyork.us/news/announcements/new-york-city-announces-new-mental-health-teams-to-respond-to-mental-health-crises

[2] New York City Mayor's Office of Community Mental Health, "Re-imagining New York City's Emergency Mental Health Response: Data Overview." https://mentalhealth.cityofnewyork.us/bheard-data. Accessed 23 Sep 2024.

[3] New York City Mayor's Office of Community Mental Health, "Re-imagining New York City's Emergency Mental Health Response: Data Overview." https://mentalhealth.cityofnewyork.us/bheard-data. Accessed 23 Sep 2024.

through the 988 Suicide and Crisis Lifeline. However, Mobile Crisis Teams do not generally work with people who sleep unsheltered in public spaces[4] This leaves the police as the default responders to mental health crisis in most of the city, and particularly for people who are unsheltered.

But even in the areas where B-HEARD operates, it handles only a fraction of the mental health calls to 911. Of the 51,329 mental health 911 calls in B-HEARD's operational areas during FY24, only 40 percent (or 20,528 calls) were deemed eligible for a B-HEARD response and B-HEARD teams responded to only 73 percent (or 14,955) of such referrals[5] Ultimately, this means that B-HEARD was dispatched to only 29 percent of the mental health calls in the areas in which it is operational.

Beyond the limited service area, the program operates only 16 hours each day, closing during overnight hours. In addition, B-HEARD reports that there are only nine teams operating throughout its service area during those hours, which limits the number of calls to which the program can respond.[6]

Simply put, it is clear that the need is far greater than what B-HEARD is able to handle.

Murky Eligibility and Screening Processes

The fact that less than half of the mental health calls to 911 are found eligible for a B-HEARD response raises questions about how eligibility determinations are made. When a person calls 911 regarding a mental health crisis, the caller must first speak with an NYPD call-taker, who decides whether to send the call to EMS in order to assess whether B-HEARD is an appropriate response. The program has not provided data on how many mental health calls are referred by NYPD call-takers to EMS for assessment, which is an important data point given that 60 percent of calls are found ineligible for B-HEARD.

After the initial screening and referral by an NYPD 911 call-taker, an EMS call-taker determines whether B-HEARD can respond to the call. FDNY EMS developed an automated algorithm for call takers to use when they collect information on whether the individual has already been assessed by a mental health clinician.[7] This algorithm prompts the EMS call-taker to ask particular questions to determine the type of emergency response to dispatch. This raises several questions and potential problems:

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[4] New York City Health Department. "About Mobile Crisis Team (MCT): Mobile Crisis Team (MCT) Frequently Asked Questions (FAQs)." https://nyc988.cityofnewyork.us/en/crisis-services/mobile-crisis-teams/. Accessed 16 Sep 2024.
[5] New York City Mayor's Office of Community Mental Health, "Re-imagining New York City's Emergency Mental Health Response: Data Overview." https://mentalhealth.cityofnewyork.us/bheard-data. Accessed 23 Sep 2024.
[6] Kaufman, Maya. "Mental Health Response Pilot Expands, Despite Ongoing Struggles." Politico, 17 Apr 2023, https://www.politico.com/news/2023/04/17/mental-health-crisis-response-pilot-new-york-00091858. Accessed 23 Sep 2024.
[7] New York City Mayor's Office of Community Mental Health, "Re-imagining New York City's Emergency Mental Health Response: Data Overview." https://mentalhealth.cityofnewyork.us/bheard-data. Accessed 23 Sep 2024.

- There is no information about who developed the algorithm and whether its use has been validated to verify that it is performing as intended.
- Algorithms have been shown to be racially biased in a large number of settings, including health care settings.[8] Any validation studies of the algorithm should be available to the public.
- Do the questions that the algorithm prompts take into account the cultural differences in how a mental health crisis is described by the caller?

These questions about eligibility determinations are even more pressing given the aforementioned program data showing that B-HEARD had contact with a person in only 14 percent of the total mental health calls.

These numbers clearly show that B-HEARD is falling significantly short of the goals of the program to provide a non-police response to mental health crises and to connect people to services in the community. Notably, the program does not report on the number of calls that result in the B-HEARD team requesting backup from the NYPD after they arrive at a location, nor do they report on the number of calls where B-HEARD and NYPD show up simultaneously despite the fact that NYPD is notified when B-HEARD will respond.

Troubling Outcomes

When B-HEARD does respond to a call and makes contact with a person, the results of those interactions raise significant concerns based on the most recent data issued by the program. First, when B-HEARD responds to a call and makes contact with a person, they only perform a mental health assessment in 50 percent of cases.[9] It is unclear what services people are receiving if they are not getting a mental health assessment.

Second, and more concerning, is that 57 percent of B-HEARD responses result in the person experiencing a mental health crisis being transported to the hospital, even though the program asserts that "B-HEARD teams do not respond to calls involving individuals who require immediate transport to a hospital."[10] Hospitalization too often leads to a traumatic cycle of moving people between hospitals and public spaces without meeting a person's needs. Similar programs operating in large cities have far lower hospitalization rates. A program operating in

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[8]Grant, Crystal. "Algorithms Are Making Decisions About Health Care, Which May Only Worsen Medical Racism." American Civil Liberties Union. 3 Oct 2022. https://www.aclu.org/news/privacy-technology/algorithms-in-health-care-may-worsen-medical-racism.
[9] New York City Mayor's Office of Community Mental Health, "Re-imagining New York City's Emergency Mental Health Response: Data Overview." https://mentalhealth.cityofnewyork.us/bheard-data. Accessed 23 Sep 2024.
[10] New York City Mayor's Office of Community Mental Health, "Re-imagining New York City's Emergency Mental Health Response: Data Overview." https://mentalhealth.cityofnewyork.us/bheard-data. Accessed 23 Sep 2024.

Toronto reports that only 8 percent of calls led to emergency hospitalization.[11] An evaluation of the Portland Street Response program in Portland, Oregon found that only 2.5 percent of their interventions resulted in hospital transport over a two-year period.[12] Notably, Portland Street Response utilizes peer support specialists paired with community health workers. Like these programs, an explicit goal of B-HEARD is to increase connection to community-based care and to decrease hospitalizations -- a goal at which the program is failing abysmally.

Finally, B-HEARD does not report on how many of the people transported to the hospital were taken there involuntarily. Involuntary hospital commitments are traumatic for individuals and do not result in increased engagement with treatment options.[13] The lack of data on involuntary hospital transports makes it impossible to assess whether the program is part of the Adams' administration's concerted efforts to subject more people to involuntary treatment,[14] instead of increasing the availability of mental health care in the community for those seeking it.

Intro. 1019-2024

The Coalition supports Intro 1019-2024, which would require the city to regularly report data on B-HEARD outcomes. B-HEARD does not currently report data on a regular schedule, and the data reported is not standardized between reports. This makes it challenging to understand how the program is changing and evolving over time, and difficult to evaluate its effectiveness. In addition to the comprehensive reporting required by Intro 1019-2024, we would suggest the following:

- Demographic information (e.g., age, race/ethnicity, gender) disaggregated at the by-record levels.
- Mental health crisis classification to differentiate between types of mental health emergencies (e.g., suicidal ideation, psychosis, substance use) for more targeted response evaluations.
- Caller information, to understand the caller's relationship to person in need of services (e.g., self, family member, passerby, business).
- Location reporting should also include additional detail on the type of location (e.g., street, subway, residence, commercial area).

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[11] The Gerstein Crisis Center presentation to the Daniel's Law Taskforce, New York State Office of Mental Health. 29 May 2024. Recording and Transcript available at: https://totalwebcasting.com/view/?func=VOFF&id=nysomh&date=2024-05-29&seq=1. Accessed 16 Sep 2024.
[12] Townly, Greg & Leickly, Emily. "Portland Street Response Program Evaluation," Portland State University https://www.pdx.edu/homelessness/PSR-Evaluation. Accessed 16 Sep 2024.
[13] Nortz, Shelly. *Fact Check on Homelessness and Mental Health Care*. Coalition for the Homeless. Accessed 23 Sep 2024. https://www.coalitionforthehomeless.org/fact-check-on-homelessness-and-mental-health-care/.
[14] Newman, Andy and Fitzsimmons, Emma G. "New York City To Involuntary Remove Mentally Ill People From Streets," *The New York Times*, 29 Nov 2022. https://www.nytimes.com/2022/11/29/nyregion/nyc-mentally-ill-involuntary-custody.html

- If a person is arrested, the associated penal code charge or whether it was as a result of an outstanding warrant.
- More detailed use of force data, such as type and level of force used.

These additional data points would allow further evaluation of B-HEARD, identify racially disparate outcomes, and help identify patterns that could be used to target mental health resources.

Conclusion

The need for a non-police response to mental health crises that connects people to community care has never been higher. While the creation of the B-HEARD program was a valuable step forward, changes to the program are needed for it to meet the need. B-HEARD response teams should include certified peer specialists, who have the skills and insight to advocate for connections to community-based care and avoid unwanted and unnecessary transports to hospitals. B-HEARD also needs to expand citywide, while at the same time, eligibility for 988 mobile crisis teams must be changed in order that unsheltered residents experiencing mental health crises can benefit from a health-centered, non-police response.

About the Coalition

Coalition for the Homeless: The Coalition, founded in 1981, is a not-for-profit advocacy and direct services organization that assists more than 3,500 homeless and at-risk New Yorkers each day. The Coalition advocates for proven, cost-effective solutions to address the crisis of modern homelessness, which is now in its fifth decade. The Coalition also protects the rights of homeless people through litigation involving the right to emergency shelter, the right to vote, the right to reasonable accommodations for those with disabilities, and life-saving housing and services for homeless people living with mental illnesses and HIV/AIDS.

The Coalition operates 11 direct-services programs that offer vital services to homeless, at-risk, and low-income New Yorkers. These programs also demonstrate effective, long-term, scalable solutions and include: permanent housing for formerly homeless families and individuals living with HIV/AIDS; job-training for homeless and low-income women; and permanent housing for formerly homeless families and individuals. Our summer sleep-away camp and after-school program help hundreds of homeless children each year. The Coalition's mobile soup kitchen, which usually distributes 800 to 1,000 nutritious hot meals each night to homeless and hungry New Yorkers on the streets of Manhattan and the Bronx, had to increase our meal production and distribution by as much as 40 percent and has distributed PPE and emergency supplies during the COVID-19 pandemic. Finally, our Crisis Services Department assists more than 1,000 homeless and at-risk households each month with eviction prevention, individual advocacy, referrals for shelter and emergency food programs, and assistance with public benefits as well as basic

necessities such as diapers, formula, work uniforms, and money for medications and groceries. Since the pandemic, we have been operating a special Crisis Hotline (1-888-358-2384) for homeless individuals who need immediate help finding shelter or meeting other critical needs.

The Coalition was founded in concert with landmark right-to-shelter litigation filed on behalf of homeless men and women (*Callahan v. Carey* and *Eldredge v. Koch*) and remains a plaintiff in these now consolidated cases. In 1981, the City and State entered into a consent decree in *Callahan* through which they agreed: "The City defendants shall provide shelter and board to each homeless man who applies for it provided that (a) the man meets the need standard to qualify for the home relief program established in New York State; or (b) the man by reason of physical, mental or social dysfunction is in need of temporary shelter." The *Eldredge* case extended this legal requirement to homeless single women. The *Callahan* consent decree and the *Eldredge* case also guarantee basic standards for shelters for homeless men and women. Pursuant to the decree, the Coalition serves as the court-appointed monitor of municipal shelters for homeless single adults, and the City has also authorized the Coalition to monitor other facilities serving homeless families. In 2017, the Coalition, fellow institutional plaintiff Center for Independence of the Disabled – New York, and homeless New Yorkers with disabilities were represented by Legal Aid and pro-bono counsel White & Case in the settlement of *Butler v. City of New York*, which is designed to ensure that the right to shelter includes accessible accommodations for those with disabilities, consistent with Federal, State, and local laws. During the pandemic, the Coalition worked with Legal Aid to support homeless New Yorkers, including through the *E.G. v. City of New York* Federal class action litigation initiated to ensure Wi-Fi access for students in DHS and HRA shelters, as well as *Fisher v. City of New York,* a lawsuit filed in New York State Supreme Court to ensure homeless single adults gain access to private hotel rooms instead of congregate shelters during the pandemic.

Behavioral Health Emergency Assistance Response Division (B-HEARD) and Responses to Mental Health Crises Oversight Hearing Testimony

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

Jointly with the Committee on Public Safety, Committee on Hospitals, and the Committee on Fire and Emergency Management

September 23, 2024

Presented by:

Jordyn Rosenthal MSW
Director of Advocacy at Community Access
jrosenthal@communityaccess.org

Thank you Chairs Lee, Salaam, Narcisse, and Ariola, and to the other members of these committees for convening this critical oversight hearing.

My name is Jordyn Rosenthal and I am the Director of Advocacy at Community Access. A nonprofit that expands opportunities for people living with mental health concerns to recover from trauma and discrimination through affordable housing, training, advocacy, and healing-focused services. We believe people are experts in their own lives.

I hold a Masters in Social Work and for over the past two years, I have had the privilege of leading Correct Crisis Intervention Today - NYC (CCIT-NYC), a coalition working to transform how New York City responds to mental health crises. This cause is especially important to me as a lifelong New York State resident and a person living with mental health concerns. I have never had an interaction with police during a mental health

crisis myself because of my ability to tap into care and to some extent race, privilege, and a litany of other factors.

In 2018, I had a job that felt like driving a mack truck with a learners permit. I was on antidepressants prescribed from a general practitioner but was not seeing a therapist or psychiatrist. One day, I reached my limit and I called a mental health crisis line and communicated that the rat race was exhausting and if this was life I don't know if I could keep it up. The person on the line asked me if I had any intention of hurting myself and I instantly felt anger because I felt that what I was saying wasn't being heard. I didn't have a plan, I was tired, stressed, and thinking existentially on top of having high functioning major depression and anxiety. This instance led to me hanging up and having a crisis in my apartment, wailing on the phone to my mom who was hundreds of miles away. She was so unnerved and scared for what I might do that she considered calling the police but ultimately didn't because when she mentioned something like that I made it clear that was not what I wanted nor needed. In the following days, my mom researched and called therapists and psychiatrists on my behalf and helped me connect back into mental health care. While I cannot say for certain, I feel that it is highly plausible that I would have and still can experience a more acute crisis if I did not access a continuum of care that includes supports who respect my wants regarding my own mental health journey.

I am here to say that if I do have a mental health crisis in the City of New York that needs an emergency response, I do not want to be met with police. Nor do I want to be met with a B-HEARD team as they currently operate. What I would want is a peer response, someone who understands what crippling depression, anxiety, and anguish feels like personally rather than through a clinical lens. Peers -- people with lived mental health experience – need to be a *mandatory* element of B-HEARD teams. Response teams that include people with lived experience will help to achieve the B-HEARD pilot goals by shifting the model to a person-centered approach rooted in genuine connection and communal well-being. I want B-HEARD to utilize 988 as a dispatch system rather than utilizing 911. There should be interoperability with 911 and 311 and considers callers request for non-police response options, something B-HEARD currently does not take into account. There are a lot of changes I envision to make the program the gold standard and leader in non-police mental health crisis response in the United States.

For that please reference the formal written testimony of Community Access and that of all my colleagues associated with Correct Crisis Intervention Today (CCIT-NYC). I thank you for this opportunity and am happy to answer any questions you may have.

Behavioral Health Emergency Assistance Response Division (B-HEARD) and Responses to Mental Health Crises Oversight Hearing Testimony

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

Jointly with the Committee on Public Safety, Committee on Hospitals, and the Committee on Fire and Emergency Management

September 23, 2024

Presented by:
Ray Schwartz
Member, Steering Committee, Correct Crisis Intervention Today

Thank you Chairs Lee, Salaam, Narcisse, and Ariola, and to the other members of these committees for convening this critical oversight hearing.

My name is Ray Schwartz I am a NYC resident and have worked in mental health services in both the public and non profit sectors as an employee and a member of nonprofit boards in the mental health field. I am here today to testify in support of the testimony provided by Correct Crisis Intervention Today - NYC (CCIT-NYC), a coalition of advocacy groups and other community organizations that consist of hundreds of community stakeholders, working to transform how New York City responds to mental health crises.

My experience and observations from my more than 40 years in the mental health field leave me still puzzled as to why there is a public safety/ criminal justice response to a public health need. While Bheard has been the NYC government response to altering how a mental crisis is responded to their last minute data dump, when analyzed, still has the police responding to 70% of the 911 calls. Stereotyping and bias about people living with a mental illness is suppressing the development of fully implemented non police response to mental crisis calls. Other localities are doing so much better. The last Friday's update to the Bheard website attempt to provide meaningful data requires real scrutiny. I and my colleagues from CCIT are willing to meet with you and staff to use the provided data to identify what information is missing, unexplained and questionable in order to accelerate the transformation of our City's mental health crisis response so it focused on addressing a public health need and permits the police to use their available resources to address public safety.

Since 2015, 20 individuals have been killed by police officers while experiencing a mental health crisis in New York City. After decades of advocacy by CCIT-NYC and others, we appreciate New York City's attempts to shift crisis response through its Behavioral Health Emergency Assistance Response Division (B-HEARD) pilot.

Responding to mental health calls with health professionals instead of law enforcement is essential—about a quarter of all fatal police shootings in the U.S. involve someone experiencing a mental health crisis. However, we have significant concerns with the program's current structure and outcomes to date.

The current B-HEARD structure is fundamentally flawed and still very much relies on NYPD. B-HEARD teams are only dispatched through 911 rather than 988, the new federal three-digit number for mental health crisis calls. 911 does not accept requests for a B-HEARD team response. Other issues pertaining to scope of service include that the program is not citywide or 24/7, leaving far too many citizens with police as first responders to their mental health crises. We have seen time and time again, most recently with the death of Win Rozario, that it is entirely inappropriate to send police in response to mental health crisis calls and their presence only creates deadly escalation.

CCIT-NYC calls for police to be completely removed as first responders to nonviolent mental health crisis calls, and for peers – people with lived mental health experience – to be a *mandatory* element of B-HEARD teams. Response teams that include people with lived experience will help to achieve the B-HEARD pilot goals by shifting the model to a person-centered approach rooted in genuine connection and communal well-being.

Two key goals of B-HEARD are to increase connection to community-based care and decrease hospitalizations. Yet just six percent of people who receive a B-HEARD response to a mental health crisis are transported to a community-based health care or social service location, and nearly 60% are still transported to the hospital. Peers have the skills and expertise to advocate for connection to community-based care and avoid unwanted and unnecessary transports to hospitals.

Although B-HEARD's geographic bounds have expanded some since its inception, and it is responding to a higher volume of overall calls, the number of calls directed to B-HEARD are not keeping up with the rate of the program's expansion. The most recently-available data shows that only about one in four people who place mental health crisis calls in a qualifying area get a B-HEARD response. In an interview with New York One, the program openly stated that teams only respond to a mere three to five calls per day.

Finally, we need more transparency around the B-HEARD program to inform best practices and investments in crisis response. There has been no new data reported this fiscal year. The City must commit to regular reporting.

Of course, in order to continue to make progress towards its goals, the B-HEARD pilot will require sustained investment in the budget, starting with fully restoring the B-HEARD Program to Eliminate the Gap (PEG) cuts in the adopted budget. We look forward to working with the Chairs and members of these committees to improve B-HEARD and ensure that New Yorkers experiencing a mental health crisis receive the response they deserve.

Questions and comments on the updated Bheard data posted on the website.

1. Why does a call that requests going to a hospital automatically eliminates a Bheard team response? My experience is that often a call asking for transport to a hospital is often based on an individual's consent or request and not having any need for the police. Having the police show up creates difficulties. Other localities do not automatically eliminate a non police response.

2. If the police are sent when a Bheard team is not available then increase the number of teams and hire peers since peers specialists are considered by SOMH as mental health professionals.

3. What percentage of all 911 calls are recorded as mental health crisis calls? How many calls over the past 3 years have been responded to by the police? Has that number increased? The report provided very limited comparative data and makes it difficult (to no surprise) to evaluate the actual results of the Bheard program. Has there

been more police availability to respond to public safety needs over the past 3 years? If so, how much?

4. Consumer satisfaction surveys need to be done by independent researchers not by the FDNY.

5. Apparently information on costs for the program, number of teams available over the 16 hours by station location, number of staffed teams, vacancies and authorized teams are not available.

DREAM

Testimony Presented to the New York City Council Committees on Public Safety, Mental Health, Disabilities, Hospitals and the Committee on Fire and Emergency Management

September 23, 2024

DREAM respectfully submits the following testimony. Thank You to the Committee Chairs and Members for providing the opportunity to comment on Security Guard funding on behalf of students attending DREAM.

DREAM has been an integral part of the East Harlem and South Bronx communities since 1991. Today we serve close to 3000 young people, ages 4-24. Our extended-day, extended-year, highly inclusive schools are at the center of this work. We have a Pre-K-8 school in East Harlem, a K-8 school in Mott Haven, a K-8 school in Highbridge, and a High School and Post-Secondary program in Mott Haven.

DREAM schools reside in private spaces and are not co-located with DOEdistrict public schools. We pay rent for each of our three school buildings. Our school population is diverse and reflects the neighborhoods we serve. We welcome all types of learners, including a higher percentage of students with IEPs than the districts where we work; we serve multi-language learners, and most recently, many students whose families are asylum seekers.

Our students are PUBLIC school students and have the right to a safe and secure learning environment.

DREAM supports Intro 532-2024 which would require, among other things, school safety personnel and officers to receive training on identifying and responding to children in emotional crisis. <u>If passed as written, this bill would assist nonpublic school students but not charter students in private spaces.</u> Since district students and co-located charter students are already served by school safety agents, charter students in public spaces will be the ONLY students - in public, private or religious schools - that are outside of New York City's umbrella of protection. This could and should be remedied with the amendment and passage of Intro 532-2024.

As the latest IBO study shows, charter school students not receiving rental assistance in private space are allotted approximately $6,000 less than their district peers. Not receiving security guard funding places a significant additional financial burden on DREAM, directly impacting the resources available to our students. The funds we currently allocate to security come at the expense of educational programs, extracurricular activities, and mental health services that are vital for our students' development. This shortage affects our ability to invest in additional support staff, learning materials, and enrichment opportunities, creating an inequitable environment compared to district public schools that have access to such funding.

The funds that are currently being diverted to security costs can instead support our students in and out of the classroom. If we could redirect the funds currently used for security costs, we would be able to reinvest in classroom resources, hire more support staff, and expand student programs. This would include adding more teachers for smaller class sizes, enhancing our arts and athletic programs, and providing targeted support for students with IEPs and multi-language learners. Additionally, we could expand mental health services to address the needs of students in crisis, ultimately creating a more supportive and enriching learning environment for every student who has continuously been asked to do more with less.

The safety, security, and education of our students must be non-negotiable. How can the City prioritize the safety of ALL students in ALL types of schools except students in privately sited public charter schools?

We ask that you right this egregious wrong and prioritize the passage of Intro 532-2024 and allow DREAM and other charter schools in private space, to access the security guard fund.

DREAM
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New York City Testimony

Dr. Susan Margaret Murphy
President, Drug Intervention Institute
susan@wvdii.org

September 23, 2024

Good afternoon, I am Dr. Susan Margaret Murphy, president of a national non-profit organization, the Drug Intervention Institute (www.wvdii.org). Our mission is to reduce overdose deaths throughout the country. I am honored to join you today. I recognize I am joining you from Huntington, West Virginia. Please know that I was also born in New York. Both my mother and grandmother were born in Manhattan. I have a brother who lives in New York and works in Long Island City. Although I was raised in Detroit, I spent most of my summers as a child in New York with family.

I am honored to be present today and learn more about what NYC is doing with the Be Heard program and the increased focus on school safety. As has been mentioned in previous testimony, mental health and substance use are often co-occurring. Many crisis response teams across the country are tasked with addressing both when responding to calls. In addition, overdose deaths and drug poisonings are impacting our nation's children significantly. In the U.S., we lose 22 students (an entire classroom) to overdose death each week.

Last week, the CDC released a report indicating that overdose deaths across the United States dropped an average of 10%, with many states dropping well below that average. In New York, for example, overdose deaths declined by 13.79%. However, this is not a time to rest on our laurels. In NYC overdose continues to disproportionally impact black and Latino/a residents, the unhoused, the Veteran population, and young persons.

While this is the first decrease experienced in the U.S. since 2018, the decrease likely reflects the surge we experienced during the COVID-19 pandemic. For example, in March 2020, when the pandemic first hit, the CDC reported an estimated 74,000+ overdose deaths, which increased significantly by January 2022 to almost 110,000 deaths. For April 2024, estimated overdoses were reported by the CDC at over 103,000. This is not cause for celebration but for funding interventions that can reduce these numbers further.

We also have seen the impact of this epidemic, and the proliferation of fentanyl in our nation's illicit drug supply and counterfeit pills has disproportionately impacted our nation's youth. Overdose deaths from opioids increased by 500% among 15-to-24-year-olds since 1999. Overdose deaths among persons aged 14-18 increased 94% from 2019 to 2020 and 20% from 2020 to 2021. These children are not typically active drug users. They overdose from "trying" illicit non-opioid drugs, like cocaine, or taking a counterfeit Adderall pill (laced with fentanyl) to cram for an exam. These increases among youth are a serious cause for concern.

It's difficult to find a correlation between interventions and the drop in numbers (as reported by the CDC), as highlighted by a *New York Times* article (September 21, 2024). The inability to tie the drop in deaths (around 20,000 estimated) may be partly due to the number of interventions. In other words, we are "throwing everything" at the problem to see what "sticks." Naloxone education, saturation, and distribution, as well as other efforts like county and city quick response teams, or QRTs—typically a of team officers, mental health workers, community members, and often faith-based leaders who visit persons 24-72 hours after they have overdosed—offering recovery resources to non-fatal overdose victims and their families are measures that undoubtedly contribute to a decrease in deaths. Others point to more access to medically assisted treatment, 12-step treatment programs, and more residential beds in long-term recovery facilities.

I would argue that all these strategies have certainly impacted the decrease. However, we must continue expanding these measures through funding like opioid settlement dollars, state opioid response monies, and city council budgets. This is not time for celebration, but an indication we need to double down our efforts to combat this crisis.

One intervention that is clearly helping, is increasing naloxone education and access. Naloxone must be made available in public spaces including shelters, transportation hubs, bars/restaurants, schools, universities, and music venues. Communities across the country are deploying ONEbox™, opioid emergency naloxone kits (www.wvdii.org/onebox) next to AEDs and fire extinguishers. These boxes provide on-demand video (in both English and Spanish) so that ANYONE can respond to an opioid emergency.

To date, our organization, has distributed over 13,000 boxes in all 50 states with reports of over 200 lives saved. Municipalities like Nashville and Tampa are working with local law enforcement, community organizations and crisis response teams like Be Heard to place these boxes. These cities are using ODMAPS (overdose mapping available to law enforcement) to determine where best to place these boxes.

The goal is to create a community of bystanders, eliminate stigma around overdose response, and create opportunities for education around how to respond to an overdose (which goes beyond simply administering the drug, naloxone). We would welcome the opportunity to discuss how to place these boxes in New York City as part of your coordinated overdose response or connect you with other communities using these boxes.

Fountain House Written Testimony for the 9/23/2024 Held Jointly with the Committee on Mental Health, Disabilities and Addiction, Committee on Public Safety, Committee on Hospitals and the Committee on Fire and Emergency Management

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Thank you Chairs Lee, Salaam, Narcisse, and Ariola, and to the other members of these committees for convening this critical oversight hearing on Behavioral Health Emergency Assistance Response Division (B-HEARD) and Responses to Mental Health Crises. The people of New York deserve a robust mental health crisis response system that addresses people's needs and Fountain House is appreciative of the Council's efforts already underway to improve the system.

For too long, many New Yorkers have been criminalized and experienced tremendous stigma for living with mental illness. For members at Fountain House and the more than 14 million people in America who live with a serious mental illness, mental illness is an ingrained part of everyday lives. It impacts relationships, ability to work, to finish school, to remain stably housed, and more. It has made people the target of undue harm, particularly in moments of crisis when help is most needed.

Since 2015, 20 individuals have been killed by police officers while experiencing a mental health crisis in New York City, including Deborah Danner, a beloved member of the Fountain House community. Nationally about a quarter of all fatal police shootings involve someone experiencing a mental health crisis.

This is an unacceptable outcome for people in need of assistance, care and services. And, while many encounters with law enforcement responding to these crises are not fatal, they leave people harmed in numerous ways including lingering trauma and horrible encounters with the criminal justice system as well as unnecessary hospitalizations.

From what we have seen of the recent B-HEARD data released, the rate of people being transported to the hospital for care is currently over 50% which is simply too high, especially as compared to the data of other non-police outreach teams in different states.

The City of New York should take every step possible to avoid unnecessary hospitalizations and instead work to connect people to stabilizing community-based care as often as possible.

Emergency response to mental health crises should also avoid violence and jail bookings. Our crisis response system should be the front door to ongoing care, not to punishment and institutionalization.

A crucial piece of this lies in not just including health professionals on these teams in lieu of law enforcement, but also adding peers with lived experience to be part of all mental health response teams. Peers can and should work in numerous parts of the system, from dispatch to onsite response to oversight of the system. To do this and make it a viable career option, the City should also explore raising the compensation for 988 call takers to help retain this critical mental health workforce.

Even more, New York should establish a Peer Oversight Board composed of people living with SMI to offer input and oversight into the crisis response system and its various programs. Specifically, it would be helpful to have this feedback as we continue to build out the 988 system. A potential workstream for this Board could include reviewing and revising call-taker scripts to ensure they invite clear communication and utilize de-escalation tactics. Some other suggestions for this Board's duties are discussed in Fountain House's report, Rebuilding the Mental Health Crisis Response System in New York City, published last year.

On the ground, peer workers can help us to quickly scale up our crisis response system to adequate staffing levels so it can meet the City's needs and promptly serve community members via phone or onsite care. Response teams must be able to come to people quickly to address urgent situations when necessary and they should be able to offer people short-term respite and community-based hospital alternatives if appropriate.

A well-functioning, comprehensive crisis response system will also go beyond only addressing issues occurring at the moment of crisis. Instead, we must see the entire continuum of services holistically with different touchpoints to help people during acute crises, as well as helping them with follow-up care in the community after and resourcing a robust system of programs to help them avoid crises in the first place.

Unfortunately, mental health care is far too hard to find for many New Yorkers. They wait on long waiting lists for community-based clinics or respite care and they have trouble finding providers in their area, especially those who accept their insurance and who deliver culturally competent care. Data from the New York City Department of Health and Mental Hygiene shows that half of the nearly 500,000 New Yorkers who experienced serious psychological distress in

the past year did not get the medication or treatment they needed. The truth is that there are too many barriers preventing access to the ongoing, community-based mental health care that can help people avoid a crisis or stabilize after one.

Closing this gap in care will involve New York City continuing to work on expanding proven, effective community-based models, including respite centers, supportive housing, peer models, and clubhouses like Fountain House. These programs not only meet people where they're at but fill a void in our health care system by supporting the full humanity of a person living with mental illness and opening doors to a meaningful life.

Lastly, we find it very important for the City to work on delivering greater transparency on reporting about the progress and outcomes of our crisis response system and programs. Understanding more about how these encounters happen, what kinds of programs people are ultimately connected to and, crucially, self-reported experiences of individuals and families who receive this care will help us tremendously as we adjust and improve these systems. New York City should commit to publishing this information and more on the programs quarterly and we are grateful for Intro. 1019 for advancing this goal.

We hope New York City will seize this moment as an opportunity to invest in much-needed change in our mental health crisis systems and infrastructure to save lives and get people connected to appropriate care. We encourage you to read our full report of recommendations informed by our community that is the basis for this testimony. We know that those closest to the problem are closest to the solution, especially in working to build a compassionate and helpful system that is responsive to both short- and long-term needs. Thank you very much.

Growing Up Green Charter Schools
Testimony Presented to the New York City Council Committees on Public Safety and Education
New York City Council Fiscal Year 2024 Executive Budget Hearings
October 25, 2023

Growing Up Green Charter Schools (GUGCS) respectfully submits the following testimony. GUGCS thanks the New York City Council Committees on Public Safety and Education for providing the opportunity to comment on the Executive Budget Hearings on behalf of students attending Growing Up Green schools.

GUGCS is an integral part of the Queens community, opening our first school in Long Island City in 2009, followed by GUG II in 2015 in Jamaica, Queens. We serve over 1,500 students in grades K-8. We are not co-located with a district public school. We pay rent for each of our four school buildings. Our school population is diverse and reflects the neighborhoods we serve. We welcome all types of learners, including students with IEPs, multi-language learners, and most recently, many students whose families are asylum seekers. All these students are PUBLIC school students and have the right to a safe and secure learning environment.

GUGCS supports Intro 03-2022, which would require, among other things, school safety personnel and officers to receive training on identifying and responding to children in emotional crisis. If passed as written, this bill would assist charters currently co-located with the Department of Education schools (NYC DOE). However, Growing Up Green students will NOT be covered by this law. A subset of charter schools does not have access to publicly funded security guards. Since the enactment 7 years ago of Local Law 2016/02, which provides a reimbursement program for non-public schools to hire security guards, there has been one glaring inequity in how NYC keeps its students safe, the exclusion of Growing Up Green and other charter schools in private space. This could be remedied with the amending and passage of Int. 70-2018. In 2016, the Council created a $19.8 million School Safety reimbursement fund with taxpayer dollars for non-public schools with over 300 students to cover the cost of keeping their school facilities safe through contracts with private security firms. The Department of Education (NYC DOE) employs school security guards in all of its buildings in partnership with the New York City Police Department. This means that students in private schools with over 300 students, district students, and charter students in DOE buildings have security officers in their buildings. The only group of students attending K-12 schools in NYC who do not receive access to security officers are Growing Up Green students, and other charter students in private space settings. This exclusion has meant GUGCS must fund security costs out of our per-pupil funding or redirect teachers and staff to provide security services. Additionally, our students at our original campus, GUG I Elementary School in LIC, do not receive rental assistance under a 2014 state law. These students are already receiving $4,863 less per pupil than district schools. Our other 3 campuses do receive rental assistance, but we receive $2,057 less

per pupil than district schools. The totality of these realities further demonstrates how schools like GUGCS are further stressed and our resources are stretched.

The funds that are currently being diverted to security costs can instead support our students in the classroom. Since returning from the pandemic, we have made investments in social emotional learning strategies, staff professional development, and a new phonics curriculum for our lower grades. These resources are crucial to our student's growth and development, while supporting our teachers and staff.

GUGCS has continuously been asked to do more with less. The safety, security, and education of our students must be non-negotiable. We ask that you prioritize the passage of Int. 70-2018 and allow Growing Up Green, and other charter schools in private space, to access the security guard fund.

Erin Acosta - Growing Up Green Charter Schools
Testimony Presented to the New York City Council Committees on Public Safety, Mental Health, Disabilities, Hospitals and the Committee on Fire and Emergency Management
September 23, 2024

Growing Up Green Charter Schools respectfully submits the following testimony. Thank You to the Committee Chairs and Members for providing the opportunity to comment on Security Guard funding on behalf of students attending Growing Up Green.

Growing Up Green has been an integral part of the Queens community, opening our first school in Long Island City in 2009, followed by GUG II in 2015 in Jamaica, Queens. We serve over 1,500 students in grades K-8. We are not co-located with a district public school. We pay rent for each of our four school buildings. Our school population is diverse and reflects the neighborhoods we serve. We welcome all types of learners, including students with IEPs, multi-language learners, and most recently, many students whose families are asylum seekers. All these students are PUBLIC school students and have the right to a safe and secure learning environment.

We are not co-located with a district public school. We pay rent for each of our four school buildings. Our school population is diverse and reflects the neighborhoods we serve. We welcome all types of learners, including students with IEPs, multi-language learners, and most recently, many students whose families are asylum seekers. All of our students are PUBLIC school students and have the right to a safe and secure learning environment.

Growing Up Green supports Intro 532-2024 which would require, among other things, school safety personnel and officers to receive training on identifying and responding to children in emotional crisis. If passed as written, this bill would assist nonpublic school's students but not charter students in private space and Growing Up Green students will NOT be covered by this law. Since district students and co-located charter students are already served by school safety agents, charter students in public space will be the only students outside of New York City's umbrella of protection. This could be remedied with the amendment and passage of Intro 532-2024.

As the latest IBO study shows, charter school students not receiving rental assistance in private space are allotted approximately $6,000 less than their district peers. This exclusion has meant GUGCS must fund security costs out of our per-pupil funding or redirect teachers and staff to provide security services. Additionally, our students at our original campus, GUG I Elementary School in LIC, do not receive rental assistance under a 2014 state law. These students are already receiving $4,863 less per pupil than district schools. Our other 3 campuses do receive rental assistance, but we receive $2,057 less per pupil than district schools. The totality of these realities further demonstrates how schools like GUGCS are further stressed and our resources are stretched.

The funds that are currently being diverted to security costs can instead support our students in the classroom. Since returning from the pandemic, we have made investments in social emotional learning strategies, staff professional development, and a new phonics curriculum for our lower grades. These resources are crucial to our student's growth and development, while supporting our teachers and staff.

Growing Up Green has continuously been asked to do more with less. The safety, security, and education of our students must be non-negotiable. We ask that you prioritize the passage of Intro 532-2024 and allow Growing Up Green, and other charter schools in private space, to access the security guard fund.

Growing Up Green Charter Schools
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Testimony before the New York City Council
Committee on Mental Health, Disabilities and Addiction
Jointly with the Committee on Public Safety, Committee on Hospitals and the Committee on Fire and Emergency Management

September 23, 2024

Sabina Saleh, LCSW
Vice President of Behavioral Health
Project Renewal

My name is Sabina Saleh, and I am the Vice President of Behavioral Health at Project Renewal, a nonprofit agency providing homeless services in New York City.

For more than 55 years, Project Renewal has provided shelter, housing, health care, and employment services to hundreds of thousands of New Yorkers experiencing homelessness, with a focus on those affected by mental illness, substance use, and criminal justice involvement. Thank you to Chair Lee, Chair Salaam, Chair Ariola, and the entire City Council for supporting our programs and for this opportunity to submit testimony.

Project Renewal is grateful for the Council's commitment to creating a comprehensive, responsive mental health system and for holding this oversight hearing on the City's Behavioral Health Emergency Assistance Response Division (B-HEARD) program.

Amid conversations around how to best respond to New Yorkers experiencing a mental health crisis, we wanted to highlight a program that is working: Project Renewal's Support and Connection Center, or the SCC, which opened permanently in late 2020.

In partnership with the NYC Department of Health and Mental Hygiene, the SCC provides stabilization and treatment services for adults experiencing mental health and/or substance use crises. It's the first program of its kind in the City. The Center's clients—whom we call "guests"—are often referred to us by the B-HEARD program and the NYPD as an alternative to arrest, summons, or the emergency room. Project Renewal can also now self-refer clients from our own programs to the SCC, which has been helpful for connecting more people to the care they need.

The SCC fills a gap in the city's ecosystem of services for people experiencing homelessness, and acute mental health and substance use crises. We catch people who would otherwise fall through the cracks, provide them a safe space to access the services they need, and then connect them to longer-term support.

We serve up to 18 guests for stays of up to five days, which DOHMH can then extend to 10 if needed. Services and intake are available 24 hours a day, which is imperative as we all know a mental health crisis isn't bound by a workday schedule. Guests have access to an interdisciplinary team of peer counselors and providers, including a psychiatrist and occupational therapist, in addition to meals, showers, and laundry. Our engagement is low-threshold and peer-led, and guests choose the services they receive, which is critical to building trust.

In FY24, we served over 800 New Yorkers at the Center. Upon completion of their stay, nearly 50% of guests have chosen to stay engaged with our after-care services, which include connections to community services, long-term treatment, Safe Havens, and transitional housing. The after-care services allow us to continue to build engagement and trust and ultimately help guests stay connected to the services they need.

The B-HEARD program is an important referral source for us at the SCC. Two key goals of B-HEARD are to increase connection to community-based care and decrease hospitalizations. By referring people to the SCC, our partnership with B-HEARD is helping to make progress towards those goals. But, as the only SCC in the city, we know there are not enough of these kinds of programs that offer alternatives to arrest or hospitalization. The City should consider expanding this model to address this need. We also need an expansion of crisis residences, mobile crisis teams, and IMT Teams, which often have extensive waitlists, leaving many individuals who need immediate assistance out to dry.

In conjunction with expanding the Support and Connection Center model, Project Renewal also supports the expansion of the B-HEARD program to all boroughs and precincts. If expansion does happen, we would be remiss if we didn't emphasize the need for appropriate training and resources for B-HEARD personnel and 9-1-1 dispatchers. The B-HEARD program is a valuable part of our City's emergency response and a trusted partner of the SCC. Still, it can only work if dispatchers are well-versed in categorizing incoming mental health calls. With the appropriate categorization of calls, we can help more New Yorkers get connected to the help they need in times of crisis. Intro 1019, which would require additional reporting on calls that are identified as mental health calls, could help to support efforts to improve categorization.

We urge the Council to continue advocating for the needs of those with mental health concerns. Project Renewal is eager to collaborate with the Council to strengthen programs and bring providers, City agencies, and lawmakers together to fill longstanding gaps in our system and break down barriers to lifesaving care for our neighbors with the greatest needs.

Thank you for this opportunity to submit testimony.

Good morning, Council Members,

I am presenting this testimony today as our company has been in talks with the Council on State Government as our technology can simply move mental health calls/988 calls to a clear, human livestream via phone or computer, allowing people in distress to share what is happening to them while mental health professionals gain invaluable situational awareness through the live stream.

Our technology works on any device and any browser, allowing for instant access at the click of an anonymous URL. There is no download. There is no sign-in. There is no time lost figuring out how to work a newfangled technology while a person is in the midst of a mental health crisis. It's just a simple link to click or type into a browser and a New Yorker can get the human connection the person so needs in one's darkest moments.

I wish I could be there in person, but I am unfortunately double booked with a mental health care professional interested in using our technology.

Our company, Project Vara, can help move mental health calls to a real live person, face to face, over the phone or computer. We'd appreciate the opportunity to follow up with any council member and/or staff member who would like to learn more.

Warmest regards,

Aaron Golembiewski
CEO
Project Vara

Behavioral Health Emergency Assistance Response Division (B-HEARD) and
Responses to Mental Health Crises Oversight Hearing Testimony

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

Jointly with the Committee on Public Safety, Committee on Hospitals, and the Committee on Fire and Emergency Management

September 23, 2024

Written Testimony Submitted

Presented by:
Surveillance Resistance Lab
Cynthia Conti-Cook
Director of Research and Policy

Thank you, Chairs Lee, Salaam, Narcisse, and Ariola, and to the other members of these committees for convening this critical oversight hearing.

My name is Cynthia Conti-Cook, and I am Director of Research and Policy at the Surveillance Resistance Lab. I am here today to testify in support of the testimony provided by Correct Crisis Intervention Today-NYC (CCIT-NYC), a coalition of advocacy groups and other community organizations that consist of hundreds of community stakeholders, working to transform how New York City responds to mental health crises.

We call on the Council to investigate and assess the structure of the B-HEARD program. This includes how it embeds NYPD control over it and the data the program produces. In addition, we will be testifying in more depth next week to the Technology Committee about MyCity. We urge the City Council to stop, study, and assess the costs and serious risks associated with MyCity—particularly for low-income, immigrant, criminalized, and other New Yorkers of color—given the potential harm of MyCity data sharing to New Yorkers with mental health records.

The Surveillance Resistance Lab was founded in 2023 to fight for power and democracy, not just privacy. We investigate and make visible the often obfuscated ways in which tech-fueled governance increases state and corporate power over our lives. Through my work as a civil rights lawyer and advocate in New York City I have relevant insight into how systematically police harm people suffering psychiatric crises.

Since 2015, twenty individuals have been killed by police officers while experiencing a mental health crisis in New York City. After decades of advocacy by CCIT-NYC and others, we appreciate New York City's attempts to shift crisis response through its Behavioral Health Emergency Assistance Response Division (B-HEARD) pilot.

Responding to mental health calls with health professionals instead of law enforcement is essential—about a quarter of all fatal police shootings in the United States involve someone experiencing a mental health crisis. However, we have significant concerns with the program's current structure and outcomes to date.

The current B-HEARD structure is fundamentally flawed and still very much relies on NYPD. B-HEARD teams are only dispatched through 911 rather than 988, the new federal three-digit number for mental health crisis calls. 911 does not accept requests for a B-HEARD team response. Other issues pertaining to scope of service include that the program is not citywide or 24/7, leaving far too many citizens with police as first responders to their mental health crises. We have seen time and time again, most recently with the death of Win Rozario, that it is entirely inappropriate to send police in response to mental health crisis calls and their presence only creates deadly escalation.

This structural control over B-HEARD is a critical point to intervene given the NYPD's recent efforts to embed NYPD officers across civilian agencies (as

reported by *The City* on September 11, 2024).[1] This effort, combined with the existing digital infrastructure that already facilitates access to information about city services people receive, raises concerns about how much insight and control the NYPD will have over all aspects of city services if allowed to continue, including sensitive mental health diagnoses and treatment records.[2]

In addition, new efforts to centralize city services data under MyCity[3] and the "One City" legislation[4] proposed by this administration facilitates even more police access to city service data, undermining New York City's Identifying Information Law (Local Laws 245 and 247 of 2017). This includes authorizing the sharing of personally identifying information for efforts like forcibly removing people from subways and involuntarily hospitalizing them.

The Lab will be submitting in-depth testimony to the New York City Council Technology Committee, along with other advocates, about MyCity related concerns on September 30, 2024.

The historical reliance by the NYPD on mental health and substance use histories to defend and attempt to justify police violence and forcible removal from public spaces of people who are not committing crimes[5] means the structural design of B-HEARD and the Mayor's efforts to embed NYPD across the city undermines the intentions of B-HEARD by continuing to allow NYPD access and control over people experiencing mental health crises and sensitive information about their health histories.

The MyCity and One City technical and legal data sharing frameworks that the administration is building—the "public safety apparatus" with at least 18 other city agencies, a digital cop city—is dangerous to all New Yorkers, but especially to New Yorkers with histories of mental health diagnoses and treatment, and those that love them.[6]

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[1] Katie Honan, Reuven Blau and Yoav Gonen, "NYPD Expands Role in Civilian Agencies as Feds Circle Top Cops", The City, Sept. 11, 2024. https://www.thecity.nyc/2024/09/11/nypd-expands-in-civilian-agencies-as-feds-circle/

[2] Anemona Hartocollis, "Concern for Vast Social Services Database on the City's Neediest." The New York Times, June 17, 2011, sec. New York. https://www.nytimes.com/2011/06/17/nyregion/promise-and-concern-for-vast-social-services-database-on-citys-neediest.html.

[3] The New York City Council Technology Committee will be hosting a hearing on MyCity, a portal to centralize city service data, on September 30, 2024. We will be testifying at length about the potential impact of MyCity and data consolidation on NYPD access to mental health records and other city data for the purposes of justifying force to remove people from subways, collect fines, and more.

[4] https://www.nysenate.gov/legislation/bills/2023/S9124

[5] Ana Levy, Citing Safety, New York Moves Mentally Ill People Out of the Subway, NY Times, May 10, 2024. https://www.nytimes.com/2024/05/10/nyregion/nyc-subway-mental-health-homeless.html?searchResultPosition=1

[6] Cynthia Conti-Cook and Ed Vogel, MyCity, INC: A Case Against "CompStat Urbanism" (New York: Surveillance Resistance Lab, March 18, 2024), https://surveillanceresistancelab.org/resources/mycity-inc-a-case-against-compstat-urbanism/.

The Lab joins CCIT-NYC to call for police to be completely removed as first responders to nonviolent mental health crisis calls, and for peers—people with lived mental health experience—to be a *mandatory* element of B-HEARD teams. Response teams that include people with lived experience will help to achieve the B-HEARD pilot goals by shifting the model to a person-centered approach rooted in genuine connection and communal well-being. **This also means protecting mental health treatment records from police access.**

Two key goals of B-HEARD are to increase connection to community-based care and decrease hospitalizations. Yet just six percent of people who receive a B-HEARD response to a mental health crisis are transported to a community-based health care or social service location, and nearly 60% are still transported to the hospital. Peers have the skills and expertise to advocate for connection to community-based care and avoid unwanted and unnecessary transports to hospitals.

Although B-HEARD's geographic bounds have expanded some since its inception, and it is responding to a higher volume of overall calls, the number of calls directed to B-HEARD are not keeping up with the rate of the program's expansion. The most recently-available data shows that only about one in four people who place mental health crisis calls in a qualifying area get a B-HEARD response. In an interview with New York One, the program openly stated that teams only respond to a mere three to five calls per day.

Finally, we need more transparency around the B-HEARD program to inform best practices and investments in crisis response. There has been no new data reported this fiscal year. The City must commit to regular reporting.

Of course, in order to continue to make progress towards its goals, the B-HEARD pilot will require sustained investment in the budget, starting with fully restoring the B-HEARD Program to Eliminate the Gap (PEG) cuts in the adopted budget. We look forward to working with the Chairs and members of these committees to improve B-HEARD and ensure that New Yorkers experiencing a mental health crisis receive the response they deserve.

Testimony of Sydney Altfield
Executive Director, Teach NYS
To the New York City Council Committee on Public Safety

On Intro 0532-2024 to Expand the School Security Guard Program for Nonpublic Schools
Monday, September 23, 2024

Good afternoon, Chair Salaam and other distinguished chairs and members of the committees here today. My name is Sydney Altfield, Executive Director of Teach NYS. Thank you for giving me the platform to testify today, and thank you to the principals who testified before me during a day of school and those here watching in the gallery.

For years, Local Law 2 has been a lifeline for hundreds of nonpublic schools and thousands of students when it comes to securing their institutions. **Last year, over 170,000 students in 277 New York City were eligible for security guards under this program.**

Also, for years, Local law 2 has been unavailable for **over 500** nonpublic schools enrolling **over 67,000** students.

Because of the threshold requiring there be 300 students or more in order to be eligible for this program, there are schools that have called me and said, “Last year I had 304 students, this year I have 297. I am no longer eligible for Local Law 2. Where am I getting enough money for a new guard? I am going to have to charge my parents more.” **And at the end of the day, either the parents pay, or the children go without security.**

Every year I receive calls from school administrators begging me to do something about school security for schools under 300 students.

But every year is not like this past year.

Since Oct. 7 Hate crimes have risen exponentially. In fact, Teach Coalition conducted a survey where we found that schools have increased security spending by 47% in the months following.

This year, more than any, Jewish and Islamic schools, specifically, are scrapping the bottom of the barrel to ensure their students and families feel safe when sending their students to school. They are turning to families to pay more. This is an antisemitism and islamophobia tax, and this is unacceptable.

Every child, no matter where they go to school, no matter how large or small their school is, should be safe going to school. It is time that the city council lowers the threshold to lift the financial burden of our basic right to security.

Center for Urban Community Services (CUCS)
198 East 121st Street, 6th Floor, New York, New York 10035 www.cucs.org

Re: Oversight – Behavioral Health Emergency Assistance Response Division (B-HEARD) and Responses to Mental Health Crises, INT. NO. 1019-2024

September 24, 2024

Dear members of the Committee on Mental Health, Disabilities and Addiction, the Committee on Fire and Emergency Management, the Committee on Hospitals, and the Committee on Public Safety,

The Center for Urban Community Services (CUCS) is a nonprofit human and social services organization with over 30 years of experience in developing innovative programs. CUCS provides integrated programs that link housing, health and social services for New York City's most vulnerable people. We operate small mental health program shelters, safe havens, permanent supportive housing programs, street outreach and Intensive Mobile Treatment Teams (IMT). Through the CUCS Institute, we provide a broad spectrum of trainings to professionals in the human, behavioral health, judicial and law enforcement sector.

CUCS supports Intro No. 1019-2024, a local law to amend the administrative code of the City of New York, in relation to the reporting and publication of mental health emergency response data. Our Intensive Mobile Treatment (IMT) Teams have offices located in the East Harlem catchment area of the B-HEARD program and our experience of the clinical expertise and care coordination provided by the B-HEARD teams has been overwhelmingly positive. We believe that collecting and evaluating the response data will support efforts to transparently community experience and needs, scale the program, and fine-tune service so that all New Yorkers have a resource for psychiatric emergencies that responds to the clinical needs of individuals in crisis.

CUCS specifically advocates for evaluating and refining the 911 emergency dispatch protocol so that assistance from the B-HEARD team does not duplicate IMT services. When our teams call 911 for emergency transport to a psychiatric ER, it is because the social worker or psychiatrist has already assessed and determined that the client requires emergency transport to the hospital. Our IMT social workers and psychiatric providers are highly trained to perform assessments. When our teams call 911 for emergency transport, dispatching the B-HEARD team to respond and assess our clients a second time duplicates service and delays access to the emergency care our clients need. This delay can also fray the patient-clinician relationship at a moment when trust, timing, and tolerance for a second assessment is both limited and unnecessary. How these moments unfold impacts our efforts to coordinate hospitalizations and resuming service with IMT following a discharge.

We believe that B-HEARD best serves the needs of families and caregivers when psychiatric emergencies occur in homes and community settings such as schools. B-HEARD can be both an immediate response to crisis and a bridge to ongoing support. Our experience in instances when B-HEARD has responded to crises during the off hours of IMT and in the homes of families and caregivers of our clients has been

Center for Urban Community Services (CUCS)
198 East 121st Street, 6th Floor, New York, New York 10035 www.cucs.org

positive. B-HEARD has communicated with our teams about hospital dispositions and provided “warm handoffs” to ensure continuity of care following the emergency.

Calling 911 is a difficult decision and concerns about a police presence and armed response often lead to hesitation which can delay interventions that reduce suffering and risk. Programs like B-HEARD restore the trust of individuals, families, and communities that seek an alternative to police response when there is a mental health emergency.

CUCS supports the expansion of B-HEARD in New York City, and we believe that Intro No. 1019-2024 is a mechanism for ensuring the expansion and growth of the program is well informed, transparent, and appropriately meets the needs of New Yorkers experiencing a psychiatric emergency.

For any questions about our experience with B-HEARD or the broader network of services available for individuals with mental health needs, please feel free to contact me at dawn.pinnock@cucs.org or 212 803-3324.

Sincerely,

Dawn M. Pinnock
Chief Executive Officer, CUCS

Behavioral Health Emergency Assistance Response Division (B-HEARD) and Responses to Mental Health Crises Oversight Hearing Testimony

Before the New York City Council
Committee on Mental Health, Disabilities and Addiction
Jointly with the Committee on Public Safety, Committee on Hospitals, and the Committee on Fire and Emergency Management

September 23, 2024

Presented by:
Bonnie Mohan
Executive Director
The Health & Housing Consortium
bmohan@hhconsortium.org

Thank you Chairs Lee, Salaam, Narcisse, and Ariola, and to the other members of these committees for the opportunity to offer testimony.

My name is Bonnie Mohan, and I am the Executive Director of the Health & Housing Consortium. I am pleased to express support of the testimony provided by Correct Crisis Intervention Today - NYC (CCIT-NYC), a coalition of advocacy groups and other community organizations that consist of hundreds of community stakeholders, working to transform how New York City responds to mental health crises.

The Health & Housing Consortium is a collaborative network of healthcare, housing, homeless and social services organizations, and government partners with the shared goal of improving health equity and housing stability.

We are a strong advocate for peer-led mental health crisis response. At our 2023 Annual Convening, we hosted a panel session titled *From Peers to Policy: Understanding New York's Mental Health Plans*, which featured Deepa Avula, Executive Deputy Commissioner of Mental Hygiene for the New York City Department of Health and Mental Hygiene, and Sheina Banatte, Managing Director of Advocacy at Justice for Eudes Pierre Coalition. During the panel, we learned about the killing of Sheina's cousin Eudes Pierre at the hands of New York City police in 2021, and how alternatives to police response during his mental health crisis could have saved his life. The panel emphasized that both health professionals and peers are essential in community crisis response.

We appreciate New York City's attempts to shift crisis response through its Behavioral Health Emergency Assistance Response Division (B-HEARD) pilot. However, we have significant concerns with the program's current structure and outcomes to-date. Examples include:

- B-HEARD teams are only dispatched through 911 rather than 988, the new federal three-digit number for mental health crisis calls.
- B-HEARD has a limited scope of services, as it is not offered citywide nor operates 24/7.
- 911 does not accept direct requests for a B-HEARD team response.
- Only six percent of B-HEARD recipients are transported to a community-based health care or social service location
- Nearly 60% are still transported to the hospital. Peers have the skills and expertise to advocate for connection to community-based care and avoid unwanted and unnecessary transports to hospitals

CCIT-NYC calls for police to be completely removed as first responders to nonviolent mental health crisis calls, and for peers – people with lived mental health experience – to be a *mandatory* element of B-HEARD teams. Peers have the skills

and expertise to advocate for connection to community-based care and avoid unwanted and unnecessary transports to hospitals. Response teams that include people with lived experience better align with B-HEARD pilot goals by shifting the model to a person-centered approach rooted in genuine connection and communal well-being.

The Consortium envisions a world where all people live healthy, fulfilling lives and experience safety and holistic wellbeing in the housing and communities of their choice, with the support they need to thrive. We support the restoration of B-HEARD Program to Eliminate the Gap (PEG) cuts in the adopted budget, and we advocate for sustained investment, reporting transparency, and program revisions. We look forward to supporting CCIT-NYC to end ensure that New Yorkers experiencing a mental health crisis receive the care they deserve.

Thank you again for the opportunity to provide testimony.

Sincerely,

Bonnie Mohan

Bonnie Mohan
Co-Founder and Executive Director
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New York City Council Committees on Mental Health, Hospitals, Public Safety, and Fire and Emergency Management
Oversight Hearing on Behavioral Health Emergency Assistance Response Division (B-HEARD) and Responses to Mental Health Crises

September 23, 2024

Submitted By:
Julia Kupiec, Chief Public Policy Officer
Bridget McBrien, Director of Government Relations

Hello Chairpersons and members of the New York City Council. Thank you for the opportunity to testify today.

The Jewish Board empowers New Yorkers, providing integrated mental health and social services with compassion and expertise. Broadly speaking, our programs serve low-income individuals and families from three populations: those with mental health challenges, those who have experienced abuse, and those with intellectual/developmental disabilities.

We are here today to express our support for the goals of the Behavioral Health Emergency Assistance Response Division (B-HEARD) and to discuss our commitment to improving the mental health crisis response in New York City.

We commend the City's efforts to shift crisis response away from law enforcement and toward trained health professionals. This approach is essential for ensuring that individuals experiencing mental health crises receive compassionate and appropriate care. We believe that the B-HEARD initiative has the potential to be a transformative model for crisis intervention, and we look forward to working closely with the Chairs and members of these committees to enhance its effectiveness.

We urge the Council to adopt best practices stated by the CCIT-NYC coalition's testimony, including the integration of trained peers into the B-HEARD response teams. Additionally, we ask that the Council restore prior B-HEARD PEG cuts and prioritize community-based care to minimize unnecessary hospital transports.

The Jewish Board provides vital mental health services to over 40,000 New Yorkers each year across every Council district. We offer several innovative programs designed to address mental health crises, including:

1. **Certified Community Behavioral Health Clinics (CCBHCs):** Supported by federal and state funding, we operate three CCBHCs in New York City (CDs 10, 44, 50). These clinics are crucial in providing a continuum of care that addresses escalating needs and connects individuals to ongoing support beyond the immediate crisis.
2. **Zero Suicide Initiative:** Recently awarded a contract by SAMHSA, we are implementing the Zero Suicide model agency-wide over the next five years. This comprehensive approach aims to prevent suicide through a robust framework that fosters a culture of support for care providers and develops a clear Suicide Care Pathway.
3. **Mobile Crisis Services:** Our Children's Mobile Crisis Team (CMCT) responds to children and young adults in Staten Island within two hours of a crisis call. This team operates seven days a week, ensuring accessible and immediate support.
4. **Home-Based Crisis Intervention (HBCI):** Available 24/7 in Staten Island, our HBCI program offers intensive treatment and case management in the homes of children aged 5-20 experiencing severe mental health crises, aiming to prevent hospitalization.
5. **Youth ACT Programs:** Serving children with serious emotional disturbances in Queens, the Bronx, and Staten Island, our Assertive Community Treatment teams provide comprehensive support to families, promoting stability and reducing the need for crisis interventions.
6. **Prevention & Intervention Program (PIP):** This program supports behavioral health in NYC public schools, currently serving ten schools with high rates of suicidality. By integrating one-on-one supports and community-building efforts, PIP aims to reduce crisis situations and the need for police involvement.

We believe that with increased investment and support for initiatives like B-HEARD, combined with peer support, we can significantly improve the mental health crisis response system in New York City. We look forward to collaborating with you to ensure that every New Yorker experiencing a mental health crisis receives the care and response they truly deserve.

The New York City Council

Committee on Public Safety

Jointly with the Committee on Mental Health, Disabilities and Addiction, Committee on Hospitals and the Committee on Fire and Emergency Management

Oversight Hearing - Behavioral Health Emergency Assistance Response Division

(B-HEARD) and Responses to Mental Health Crises

September 23rd, 2024

Presented by:

Cassandra Kelly
Staff Attorney, Policy Unit
Criminal Law Reform
Ckelly@legal-aid.org

The Legal Aid Society
Criminal Defense Practice
49 Thomas Street
New York, NY 10013

Thank you, Chairs Lee, Salaam, Narcisse, and Ariola, and to the other members of these committees for convening this critical oversight hearing. We appreciate the opportunity to testify about the B-HEARD program and city responses to mental health crisis in our communities. This testimony is submitted on behalf of The Legal Aid Society, New York City's oldest and largest public defender organization.

The Legal Aid Society is built on one simple but powerful belief: that no New Yorker should be denied the right to equal justice. We seek to be a beacon of hope for New Yorkers who feel neglected, regardless of who they are, where they come from, or how they identify. From our start over 140 years ago, our growth has mirrored that of the city we serve. Today, we are proud to be the largest, most influential social justice law firm in New York City. Our staff and attorneys deliver justice in every borough, working tirelessly to defend our clients and dismantle the hidden, systemic barriers that can prevent them from thriving. As passionate advocates for individuals and families, Legal Aid is an indispensable component of the legal, social, and economic fabric of our City.

In this testimony, we highlight the need for the City to completely turn away from a police response to mental health crises and to shift to investing in community-based public health solutions and infrastructure that support New Yorkers living with serious mental illness.

We must remove NYPD from Mental Health Crisis Response

At Legal Aid, those we represent routinely experience the needless, alarming harms of disproportional police response, especially because the vast majority are New Yorkers from generationally under-resourced communities. All too often, a 911 call for mental health assistance is met by officers with guns who have no training or insight into how to deescalate the situation and connect that person to recovery-based mental health care and support. Our lawyers then meet these New Yorkers, if they survive the police encounter, now further decompensated by the experience of sudden arrest and detainment, in the squalor of our City arraignment booths, where we must explain what should be impossible: your mental health crisis has resulted in your arrest

and now we must fight to keep you off the irreparably dangerous Rikers Island. This should never be the recourse for our neighbors in crisis and in need of care.

We must remove NYPD from mental health crisis response once and for all and stop using the police and criminal legal system as a catch-all for problems that require a public health response. We must ensure that the City invests in a non-police public–health-based response to mental health crisis that employs harm reduction principles, centers peers as frontline workers, and ensures that New Yorkers get immediately connected to recovery-based mental health care and support. We must also invest in robust community-based mental health services that help prevent escalation and crisis by providing daily, affordable access to mental health services. And we must create an effective system of accountability and consequence for those police officers who escalate a mental health crisis and then kill or injure a New Yorker in need of help.

Legal Aid cannot support the B-HEARD program as it is currently structured. B-HEARD is fundamentally flawed in that it relies inextricably on the NYPD, relies too heavily on hospitalization, and fails to meet standards for best practices for mental health crisis response. Instead, this Council should invest in a public health approach that expands existing and successful behavioral health services that have crisis prevention and intervention components and identify and fill the deleterious gaps that exist for New Yorkers living with serious mental illness. In this testimony, we expand upon our objections to the B-HEARD program and our suggestions for investments to reframe our City response to mental health crisis. We also refer you to the analysis provided by our friends at Communities United for Police Reform,, exhibit A, who have analyzed the gaps and identified the solutions that will transform our current carceral approach to crisis situations to a public–health-based mental health crisis response.

The B-HEARD structure is fundamentally flawed and relies inextricably on the NYPD; an organization that will not hold officers who harm New Yorkers accountable

The current structure of B-HEARD needs a total overhaul and must be stripped of any police involvement. Reform must start with ending the routing of calls through the NYPD 911 system, where operators are insufficiently trained to recognize a mental health crisis that does not involve

"danger" warranting a police response. B-HEARD teams are *only* dispatched through 911 rather than 988, the new federal three-digit number for mental health crisis calls. Even if a caller asks explicitly for a B-HEARD team to respond to a crisis, the operator does not accept these requests; the decision to deploy a B-HEARD team is left to the operator alone.

It is our understanding at Legal Aid that when a caller cites a mental health crisis as the reason for the call, the operator is empowered to send a police response if any "crime" is mentioned, which could of course include substance use or any kind of perceived threat or threatening behavior. Additionally, 911 operators are also directed to send NYPD when they perceive a risk of harm or death by suicide, presumably because B-HEARD responders are not equipped with a vehicle fit for emergency transport. The instructions and breadth of discretion given the 911 operators is unacceptable and has resulted in abysmally low rates of engagement with non-police lead response: in the City's most recently available data, only 22% of calls regarding a mental health crisis were rerouted to a B-HEARD team. Other issues pertaining to scope of service include that the program is not citywide nor available 24 hours a day, leaving far too many of our neighbors with police as first responders to their mental health crises.

We have seen time and time again, most recently with the tragic death of Win Rozario, that it is entirely inappropriate to send police in response to mental health crisis calls and that police presence only creates deadly escalation. The NYPD has a well-documented and unwavering history of violent escalation in situations involving a mental health crisis that has too often resulted in the death of New Yorkers at the hands of police who are sworn to serve and protect.[1] Since 2015, 20 individuals experiencing a mental health crisis have been killed by police officers in New York City, and countless others have been arrested and detained at Rikers Island. After these tragedies transpire, the complete refusal of the NYPD to engage with accountability systems means killer cops stay on the force and no meaningful changes to practice are implemented to prevent future harm or death.

B-HEARD relies too heavily on hospitalization

[1] October 18, 2021, New York Lawyers for the Public Interest "Saving Lives and Reducing Trauma, Removing Police from New York City's Mental Health Crisis Responspe" NY, NY. available at https://www.nylpi.org/wp-content/uploads/2021/10/FINAL_Mental-Health-Crisis-Response-Report.pdf

We know that when New Yorkers are in emotional distress the best approach is to have a peer-based, harm-reduction response that connects them with crisis respite services and long-term care. Instead, B-HEARD lands 54% of individuals they interact with in hospital emergency rooms where they are often subject to involuntary treatment and then released without getting connected to long-term care.

Practitioners who have studied psychiatric hospitalization have observed that hospital care often does not meet patients' needs. According to practitioners, “research has not clearly shown that hospitalization is more effective than alternate treatment methods.”[2] Moreover, hospitalization can have serious consequences for patients, including “the corresponding trauma of institutionalization, stigma, and [a] detrimental impact on the patient’s employment, finances, and personal life.”[3] Experts point out that “[i]nstead of relying on this last-resort method of ‘treating mental illness,’ energy and resources would be better spent on upstream prevention and engaging resources, including housing, equitable community-based services, and peer and street outreach.”[4]

B-HEARD relies too heavily on hospitalization over community-based care. Upon release from these restrictive and isolated hospital settings, individuals aren’t adequately connected to long-term services that would provide meaningful and lasting support. For example, post-encounter HEAT (Health Engagement and Assessment Teams) referrals for follow-up services are limited to 90 days.

B-HEARD fails to meet standards for best practices for mental health crisis response; one where peers lead a crisis response team.

Responding to mental health calls with peers and mental health professionals instead of law enforcement is essential, as about one quarter of all fatal police shootings in the U.S. involve

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[2] Alex Clarke, M.D., and Ira D. Glick, M.D., The Crisis in Psychiatric Hospital Care: Changing the Model to Continuous, Integrative Behavioral Health Care, Psychiatry Online 166 (Feb. 2020), https://psychiatryonline.org/doi/pdf/10.1176/appi.ps.201900259.
[3] Pinals, D. A., Crisis Services: Meeting Needs, Saving Lives. Alexandria, VA: National Association of State Mental Health Program Directors (2020), https://store.samhsa.gov/sites/default/files/pep20-08-01-001.pdf.
[4] Kelly Davis, Involuntary hospitalization proves system failures, Mental Health America (Apr. 10, 2023), https://www.mhanational.org/blog/involuntary-hospitalization-proves-systemic-failures.

someone experiencing a mental health crisis. The recent report, “When There’s a Crisis, Call a Peer: How People with Lived Experience Make Mental Health Crisis Services More Effective”,[5] issued by the Bazelon Center for Mental Health Law, one of the premier mental health advocacy organizations in the country, explicitly calls for peers to lead a mental health crisis response team.

As the report makes clear, “[w]hen peers support those in crisis, individuals who need help are less likely to be admitted to emergency rooms and hospitals to receive inpatient care. They are more likely to participate in community-based services—which can help them avoid future crises and resulting institutionalization or incarceration—and be more engaged in the services they receive. They experience less self-stigma and more self-empowerment and hope. They are less likely to need crisis services in the future.”

The outcomes of peer support also result in taxpayer savings, as community-based programs cost less than in-patient services and are better equipped to reduce hospitalization rates and lengths of stay. Community-based support reduces the frequency and intensity of future crises, which in turn ends the revolving door of recidivism within the criminal legal system.

Our City would be wise to note the success of another peer-led and community-based network that has made our communities safer: our Cure Violence/Crisis Management System, created and funded by the City in an effort to end gun violence. This city-wide network of credible messengers operates across 22 communities and consists of more than 50 community-based organizations and allied organizations like the Community Justice Unit of Legal Aid; all of whom operate with the understanding that early intervention and community involvement can indeed curtail violence. The Cure Violence model of community-led intervention and support does just that: From 2010 to 2019, data shows that Cure Violence and Human Justice Sites have contributed to an average 40% reduction in shootings across program areas compared to a 31% decline in shootings in the 17 highest violence precincts in New York City.[6] Empowering and funding community-led, peer

[5] January 3, 2004, Bazelon Center for Mental Health Law, When There’s a Crisis, Call a Peer: How People With Lived Experience Make Mental Health Crisis Services More Effective; Washington, D.C. 2024. available at https://www.bazelon.org/wp-content/uploads/2024/01/Bazelon-When-Theres-a-Crisis-Call-A-Peer-full-01-03-24.pdf

[6] See https://home.nyc.gov/site/peacenyc/interventions/crisis-management.page

initiatives works and mental health crisis response in our City should draw from the lessons and success of the Cure Violence employees and participants and center peer-led teams.

Additional Investments for New Yorkers Living with a Mental Health Diagnosis

At Legal Aid, we continue to innovate and incorporate best practices to support the people we serve who are living with a mental health diagnosis. In addition to our deeply committed forensic social workers across our trial offices, we also created our pre-arraignment social work program, which has been funded by this council in Manhattan and the Bronx. This essential work ensures that social workers are part of the arraignment process, meeting clients at the first moment possible for us who may be in crisis or on the precipice due to their arrest, detention, and lack of connection to community-based services.

Our social workers and attorneys work closely with mental health professionals who work to keep New Yorkers in their communities and bring much needed services to them, where they are. Connecting clients to one of three types of intensive, assertive community-based mental health treatment often means the difference between achieving long-term stability in the community and facing the destabilizing consequences of incarceration while awaiting trial. At Legal Aid, we have found that Assertive Community Treatment (ACT) teams[7], Forensic Assertive Community Treatment (FACT)[8] and the City-funded Intensive Mobile Treatment (IMT) Teams[9] to be excellent models of successful stabilization for those we serve. These teams include mental health, substance use, and peer specialists who provide support and treatment, including medication, and facilitate connections to housing and additional supportive services. Currently IMT teams—which are easier to access because they do not require active Medicaid — have capacity for 486 New Yorkers, but the need is much greater. Our social workers at Legal Aid are often faced with extensive waiting lists that create a significant barrier to connecting clients to these services, and too often result in prolonged periods of incarceration. We encourage the City Council to fund the Department of Health and Mental Hygiene to facilitate additional

[7] see more info at https://omh.ny.gov/omhweb/act/
[8] See for more info https://store.samhsa.gov/sites/default/files/pep19-fact-br.pdf
[9] See for more info https://mentalhealth.cityofnewyork.us/program/intensive-mobile-treatment-imt

IMT teams and ensure that they operate to provide quality care, as well as further fund the organizations that coordinate ACT and FACT teams, to meet New Yorkers where they are.

Of course, stability in the community also requires the essential component of safe and stable housing. The Mayor's Office on Criminal Justice has long promised to fund a continuum of housing from the essential and easy-to access emergency transitional housing to long-term housing. In fact, even as the Mayor's Office on Criminal Justice closed the COVID-era emergency reentry hotels, the City continued to fund transitional housing, reportedly investing "$50 million per year to provide approximately 1,000 units of transitional housing administered by a network of non-profit organizations."[10] Unfortunately, at Legal Aid, we have not seen the fruits of this investment, as we have long lists of people we represent waiting for a rare housing spot that would serve as a pathway off Rikers Island and back to a safe and stable life. To be serious about best-practice solutions for those in crisis, the City must be serious about investments to expand safe housing and community-based services that help to prevent crisis moments from ever occurring. Only when we have created a network of easy-to-access services and robust housing solutions will we finally cease to use the police and our courts, jails, and prisons as the knee-jerk response to New Yorkers in mental health crisis. We must cease to use police as responders for those crises, and instead center mental health professionals and peers who are able to provide one-on-one support and guidance that stems from similar life experiences, which has proven to be best-practice time and time again.

Conclusion

At Legal Aid, we support a mental health crisis response system that is led by peers and is stripped of police involvement from start to finish; from ending the use of 911 as the number for those in search of help during a mental health crisis, to no longer allowing police officers with guns to escalate a situation and use the criminal legal system or involuntary hospitalization -- or both -- as the only viable response.

B-HEARD requires complete restructuring, starting with removing the NYPD from any mental health crisis response and implementing standards for best practices that center a peer-led model.

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[10] See Mayor's Office on Criminal Justice website, https://criminaljustice.cityofnewyork.us/programs/transitional-housing/

At the same time, the City Council must invest in community-based services that are easy to access and provide ready help for our neighbors living with a mental health diagnosis. Divestments from policing and incarceration must become a reality and must be redirected to housing solutions and direct services for New Yorkers who have too long been denied access to basic mental health care and safe, steady, and affordable housing.

Thank you.

New York City Council
Committee of Public Safety,
Committee on Mental Health,
Disabilities and Addiction,
Committee on Hospitals and the
Committee on Fire and
Emergency Management

September 23, 2024

Re: The Need for Effective Non-Police Responses to Behavioral and Mental Health Crises

Dear Council Members,

The NAACP Legal Defense & Educational Fund, Inc. (LDF) respectfully submits this letter regarding the Behavioral Health Emergency Assistance Response Division (BHEARD) in New York City. It is imperative for the City Council to ensure that New York City has the necessary components of a community-based mental and behavioral health system in place so that New Yorkers have a meaningful alternative to a law enforcement when encountering or experiencing behavioral health emergencies. Unfortunately, BHEARD in its current state fails to provide New Yorkers with the community-based response that is necessary to prevent police encounters and further entrenches officers into mental health crisis response in New York City.

Founded in 1940 by Justice Thurgood Marshall, LDF is the nation's first and foremost civil rights law organization. Through litigation, advocacy, public education, and outreach, LDF strives to secure equal justice under the law for all Americans and to break barriers that prevent Black people from realizing their basic civil and human rights. LDF has long been concerned about the harms of police responses to mental health crises in New York City, especially given the stark racial disparities. In addition, LDF serves as a member of Communities United for Police Reform (CPR), a coalition of legal and advocacy groups dedicated to creating a more equitable criminal legal system, which has identified the problems with police involvement in mental health responses as a priority for New York City.

I. Police Violence is More Prevalent Against People with Mental or Behavioral Health Disabilities or People Experiencing Crises.

Ten percent of calls to 911 involve people with mental and behavioral health disabilities, yet few of those situations actually threaten public safety.[1] In fact, people with serious mental and behavioral

[1] Alexander Black et al., *The Treatment of People with Mental Illness in the Criminal Justice System: The Example of Oneida County, New York*, LEVITT CTR. FOR PUB. AFFS. AT HAMILTON COLL. 9 (June 2019), https://digitalcommons.hamilton.edu/cgi/viewcontent.cgi?article=1005&context=student_scholarship.

health disabilities are far more likely to be victims of violent crime than perpetrators of violent crime.[2] Nevertheless, individuals with mental and behavioral health disabilities are significantly more likely to experience police violence. And people with mental and behavioral health disabilities encountering police are killed at a higher rate than their same-race peers without such disabilities: ten times increase for non-Hispanic white people, six times increase for Latinx people, and four times increase for Black people.[3] Twenty-three percent of people killed by police in the U.S. between 2015 and 2020 had a psychiatric disability.[4]

Black people with a mental or behavioral health disability or those experiencing a crisis are at an even higher risk of police violence. Black people overall are over three times as likely as white people to be killed by law enforcement.[5] Black people with mental and behavioral health disabilities are at greater risk of being perceived as noncompliant or disrespectful to officers.[6] Black men experiencing a crisis or who have a mental or behavioral health disability are shot and killed by law enforcement officers at significantly higher rates than white men who exhibit similar behaviors.[7] At the same time, Black people with mental and behavioral health disabilities are less likely to receive appropriate treatment and care from healthcare professionals,[8] and more likely to experience coerced treatment in the form of involuntary commitment.[9]

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[2] Linda A. Teplin, ET AL., Crime Victimization in Adults with Severe Mental Illness, 62 ARCH. GEN. PSYCHIATRY 911, 914 (Aug. 2005) ("Over one quarter of the SMI sample had been victims of a violent crime (attempted or completed) in the past year, 11.8 times higher than the [general population] rates . . . ."); Heather Stuart, Violence and Mental Illness: An Overview, 2 JOURNAL OF WORLD PSYCHIATRY 121, 123 (June 2003) ("It is far more likely that people with a serious mental illness will be the victim of violence," rather than its perpetrator).

[3] Saleh, A. Z., et al. (2018). "Deaths of people with mental illness during interactions with law enforcement." Int J Law Psychiatry **58**: 110-116.

[4] Amam Z. Saleh et al., Deaths of People with Mental Illness During Interactions with Law Enforcement, 58 INT'L J. OF L. AND PSYCHIATRY 110, 112-14 (2018).

[5] Gabriel L. Schwartz & Jacqueline L. Jahn, *Mapping fatal police violence across U.S. metropolitan areas: Overall rates and racial/ethnic inequities, 2013-2017*, PLOS ONE 15(6): e0229686 (2020), https://journals.plos.org/plosone/article/file?id=10.1371/journal.pone.0229686&type=printable (finding that Black people are 3.23 time more likely to be killed by police than white people); Frank Edwards et al., *Risk of Being Killed by Police Use of Force in the United States by Age, Race—Ethnicity, and Sex*, 116 PNAS 16793, 16793 (2019), https://www.pnas.org/content/pnas/116/34/16793.full.pdf (finding that Black women are 1.4 times more likely to be killed by law enforcement than white women); JUDGE DAVID L. BAZELON CTR. FOR MENTAL HEALTH L., "DEFUNDING THE POLICE" AND PEOPLE WITH MENTAL ILLNESS (Aug. 2020), http://www.bazelon.org/wp-content/uploads/2020/08/Defunding-the-Police-and-People-with-MI-81020.pdf.

[6] Richardson & Goff, supra, at 137.

[7] M.D. Thomas, N.P. Jewell, & A.M. Allen, *Black and Unarmed: Statistical Interaction between Age, Perceived Mental Illness, and Geographic Region among Males Fatally Shot by Police Using Case-Only Design*, 53 ANNALS OF EPIDEMIOLOGY 42, 42 (2021).

[8] Vickie Mays et al., *Perceived Discrimination in Health Care and Mental Health/Substance Abuse Treatment Among Blacks, Latinos, and Whites*, 55 MED. CARE 173, 180 (2017), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5233585/pdf/nihms807350.pdf.

[9] *See, e.g.*, First Amended Complaint at ¶ 2, Disability Rights California v. County of Alameda, 2021 WL 212900 (N.D. Cal. Feb. 22, 2021) (No. 5:20-cv-05256-CRB) ("During a recent two-year period, over 2,300 people were detained at the County's psychiatric facilities more than three times, the majority of whom were Black."); Press Release, Dep't of Justice, Justice Department Finds that Alameda County, California, Violates the Americans with Disabilities Act and the U.S. Constitution (Apr. 22, 2021), https://www.justice.gov/opa/pr/justice-department-finds-alameda-county-california-violates-americans-disabilities-act-and-us (finding that Alameda County failed to provide

II. Crisis Intervention Training and Co-responder Models do not Sufficiently Prevent Police Violence Against People with Mental and Behavioral Health Disabilities.

The increased use of Crisis Intervention Training (CIT) and co-responder models in law enforcement agencies demonstrates growing consensus that incidents involving people with mental and behavioral health disabilities require the involvement of mental health training and professionals. However, crisis intervention training and co-responder models are not effective solutions to police violence against people with mental and behavioral health disabilities because law enforcement officers are still involved in every call. Law enforcement has fundamentally different goals and priorities than mental healthcare providers. Law enforcement's mission is to enforce laws, and officers prioritize immediate resolutions of potential threats—they arrive openly armed with weapons, ready to use force. Overall, research shows that officers who receive CIT do not arrest people with mental and behavioral health disabilities less frequently than non-CIT-trained officers.[10] Research also shows that CIT has no significant effect on officer-use-of-force.[11] Indeed, the mere sight of law enforcement officers may retraumatize people with mental and behavioral health disabilities who had traumatic experiences with law enforcement in the past.[12]

By contrast, mobile crisis responders, including clinicians, social workers, and peer workers, do not involve police and have the professional expertise and training to safely and effectively engage with someone experiencing a crisis or someone with a serious mental or behavioral health disability. Mobile crisis responders take the time needed to resolve the incident, identify and understand the underlying issues, and connect the person experiencing the crisis or having the disability with the additional services they may need. Thus, mobile crisis responders are more likely to successfully deescalate these types of crisis situations, as opposed to law enforcement who often escalate crises.

III. City Council Should Include Mental Health Practitioners in the 911 Call Center and Expand Community-Based Responses and Services for People with Mental and Behavioral Health Disabilities.

The City of New York has an obligation to avoid putting New Yorkers at risk of criminalization through police encounters simply because of their mental or behavioral disability or because they are in crisis. Yet, under the current model of BHEARD, NYPD still responds to 78% of mental health calls[13] with only the remaining 22% re-routed to BHEARD.[14] Instead, consistent with evidence-based, best practices, 911 dispatchers should proactively triage mental health crisis calls towards trained clinicians

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services to its constituents with mental health disabilities and unnecessarily institutionalized them at various psychiatric facilities instead of providing appropriate community-based services).

[10] Sema A. Taheri, *Do Crisis Intervention Teams Reduce Arrests and Improve Officer Safety? A Systematic Review and Meta-Analysis*, 27 CRIM. JUSTICE POL'Y REV. 76, 85 (2016).

[11] *Id.* at 86. Some studies suggest that CIT training may reduce officer stigma towards mental illness, but this is based on the subjective officer experiences rather than objective outcomes of individuals to whom officers are responding. *See*, Gilbert A. Nick, et al., *Crisis Intervention Team (CIT) Training and Impact on Mental Illness and Substance Use-Related Stigma Among Law Enforcement,* 5 DRUG & ALCOHOL DEP. R. 100099 (2022), https://doi.org/10.1016/j.dadr.2022.100099.

[12] Taleed El-Sabawi & Jennifer J. Carroll, *A Model for Defunding: An Evidence-Based Statute for Behavioral Health Crisis Response*, 94 TEMPLE L. REV. 1, 17 (2021).

[13] Some US cities adopt pilot program that sends EMTs, social workers to mental health 911 calls, ABC7 (February 15, 2023) https://abc7ny.com/mental-health-emt-social-worker-b-heard/12819969/.

[14] Id.

and peer support programs. For example, Austin Texas's Expanded Mobile Crisis Outreach Team (EMCOT) functions as an integral part of the 911 dispatch system. When an individual calls the emergency number, they hear "Austin 911, do you need police, fire, EMS or mental health services?" [15] Under this model, hundreds of emergency calls have been diverted away from police within its first year of operation.[16] EMCOT has been successful in helping more quickly de-escalate crisis situations and providing resources to individuals with a mental or behavioral health disability or those who are in crisis. As the New York City Council grapples with modifying BHEARD to serve the urgent needs of the community, it should look to programs like EMCOT to create clear pipelines for connecting individuals in crisis with care and resources that law enforcement is not equipped to provide.

In addition, City Council must ensure sufficient funding for comprehensive, community-based services for people with mental and behavioral health disabilities. This includes a call center reachable through 911, 988, or other hot- or warm-line numbers that can resolve most calls for help. Moreover, New York City needs a continuum of alternative community responder teams from street outreach teams to mobile crisis teams to respond quickly when needed, de-escalate arising situations, and connect people to an array of services. Finally, there must be a robust array of voluntary, community-based services for crisis resolution and stabilization that reduce the occurrence of mental health crises, provide an effective response when they occur, and secure on-going treatment and support after the crisis is resolved. These include Assertive Community Treatment (ACT), supported housing, employment, and peer support services. Importantly, responders and long-term services should be trauma-informed and recovery-based to ensure the highest rate of success for New Yorkers in crisis.

New York City must make accessible, affordable, comprehensive, culturally competent, and traumas-informed behavioral health and substance use services available to all New Yorkers in the communities in which they live. We urge City Council to invest in true community-based responses to calls involving people with mental and behavioral health disabilities and people experience crisis situations.

Thank you for your consideration of these comments. If you have any questions, please contact Kimberly Saltz at ksaltz@naacpldf.org.

[15] https://bpb-us-w2.wpmucdn.com/voices.uchicago.edu/dist/e/2911/files/2024/05/Directory-of-Alternative-Crisis-Response-Programs-v2.1.9.pdf
[16] https://www.fox7austin.com/news/crisis-counselors-responding-to-more-mental-health-calls-in-austin

Behavioral Health Emergency Assistance Response Division (B-HEARD) and Responses to Mental Health Crises Oversight Hearing Testimony Before the NYC Council Committee on Mental Health, Disabilities and Addiction Jointly with the Committee on Public Safety, Committee on Hospitals, and the Committee on Fire and Emergency Management

September 23, 2024

Thank you, Chairs Lee, Salaam, Narcisse, and Ariola, and to the other members of these committees for convening this critical oversight hearing.

My name is Joelle Ballam-Schwan and I am with the Supportive Housing Network of New York. The Network is a membership and advocacy organization representing over 200 nonprofits that collectively run over 62,000 units of supportive housing statewide. I am also a steering committee member of Correct Crisis Intervention Today (CCIT-NYC), a coalition working to transform how New York City responds to mental health crises.

Mental health crisis response is of critical importance to both me and to my organization. On a personal level, I have lost very close loved ones to -- and have supported others during -- mental health crises. At an organizational level, our community has an increasing need for a peer-led, non-police mental health crisis response system.

Supportive housing is permanent, affordable housing with on-site voluntary services for those who have experienced homelessness and face systemic barriers to accessing and maintaining permanent housing. It serves people living with serious mental health diagnoses, substance use disorder, HIV/AIDS, and families and young adults who are homeless or at-risk of becoming so. Black people and people of color are disproportionately affected by housing insecurity because of systemic and institutional racism.

Nationwide, the pandemic exacerbated mental health crises for people of all ages and across the socioeconomic spectrum. As a result, for the past few years, the majority of our members have reported an alarming increase in the incidence and intensity of mental health concerns amongst their new and existing tenants.

Staff and tenants are in real need of a resource to call upon to ensure that an individual in crisis can be met with a person-centered approach, rooted in genuine connection and communal wellbeing, not martial enforcement. B-HEARD, as it currently operates, is not that.

B-HEARD response teams fail to include peers (people with lived mental health experience). We know that, across the country, mental health crisis response systems led by trained peers have proven more successful than police-led responses. For example, the Crisis Assistance Helping Out on the Streets (CAHOOTS) program in Eugene, Oregon has found that fewer than 2% of the calls they responded to required police back-up.

In addition, B-HEARD teams are currently responding to only 29% of mental health-related 911 calls in the precincts in which it operates, leaving police to respond over 70% of the time in those 31 precincts We have seen time and time again that police are not equipped to handle mental health crises. Since 2015, at least 20 people have had fatal encounters with the NYPD when experiencing an emotional or mental health crisis, and 85% were people of color. In order to operate outside of the police dispatch system, B-HEARD should be dispatched to the newly expanded 988 mental health crisis hot-line as opposed to 911.

B-HEARD must also be made available 24/7 rather than the 16 hours per day it currently operates.

And of course, the program must be expanded to operate citywide.

B-HEARD is a very important step in the right direction, but significant changes must be implemented as soon as possible: We must ensure peers are on response teams, route the dispatch system through 988, and fund the program to operate at all hours and across the city.

With the recent killing of 19-year old Win Rosario, we must say enough is enough, and fully invest in and build out a true peer-led mental health crisis response program in New York City. Failing to do so is costing lives.

Thank you for your time.

The New York City Charter School Center
Erik Joerss, Vice President of Advocacy and Government Affairs
Testimony Presented to the New York City Council Committees on Public Safety, Mental Health, Disabilities, Hospitals and the Committee on Fire and Emergency Management
September 23, 2024

The New York City Charter School Center (Charter Center) respectfully submits the following testimony. The Charter Center thanks the New York City Council Committee on Public Safety, Mental Health, Disabilities, Hospitals and the Committee on Fire and Emergency Management for providing the opportunity to comment on behalf of students attending New York City charter schools in non-co-located facilities.

Since the enactment eight years ago of Local Law 2016/02, which provides a reimbursement program for non-public schools for the purpose of hiring security guards, there has been one glaring inequity in how NYC keeps its students safe, the exclusion of charter schools in private space. This should be remedied with the reintroduction, amending, and passage of Int. 532-2024, which closed the year with 19 co-sponsors. In 2016, the Council created a $19.8 million School Safety reimbursement fund with taxpayer dollars for non-public schools with over 300 students to cover the cost of keeping their school facilities safe through contracts with private security firms. The Department of Education (NYC DOE) employs school security guards in all of its buildings in partnership with the New York City Police Department. This means that students in private schools with over 300 students, district students, and charter students in DOE buildings have security officers in their buildings. The only group of students attending K-12 schools in NYC who do not receive access to security officers are charter students in private space settings. This exclusion has meant that the approximately 177 charter campuses must fund security costs out of per-pupil funding or redirect teachers and staff to provide security services. Some of these students at private space charter schools are the same students that do not receive rental assistance under a 2014 state law. These students are already receiving $4,863 less per pupil than district schools.[2] For those private space charter schools that do receive rental assistance, they are receiving $2,057 less per pupil than district schools. The totality of these realities further demonstrates the ways in which public charter schools' stresses are exacerbated and resources are stretched. Charter schools are continuously asked to do more with less, and while the sector has continued to grow and conquer obstacles; the safety, security, and education of children must be non-negotiable.

There is room in the current School Safety reimbursement fund for charter students because the $19.8 million pot has never been depleted. In 2020, $14.2 million was unused; in 2021, $13.6 million was unused; in 2022, $10 million was unused; and in 2023, $7.9 million was unused. These leftover funds amount to money and resources that can be directed to charter schools – we have estimated that the inclusion of the excluded charter schools (where schools have at least 150 or more students at the school) would cost $7.6 million per year. Instead of diverting funds set aside to provide equitable access to security and safety measures and precautions, NYC has chosen to leave charters to fend for themselves in creating a secure environment in which schools can direct their time and attention to providing quality education to some of the most

impacted students in the city. If the Council takes up 532-2024, which proposed to grow the number of eligible schools and double the current reimbursement fund, the city's public charter schools would expect to be included, as well.

All students deserve to feel safe and free to focus their energy on their academic growth, and under current law, public charter schools in private space are the only schools in NYC – public or private – that are forced to divert money and resources out of the classroom to provide the basic security every other school enjoys. Even some of the city's wealthiest private schools like Spence, Dalton, Chapin, and Brearley enjoy access to security funding, whilst the public charters that educate primarily low-income students of color whose families are community members and constituents deserving of the same treatment as all other New Yorkers. The approximately 71,000 students in private space charters are made up of 46% Black/African American, 43% Hispanic/Latinx, 82% Economically Disadvantaged, 10% English language learners and 19% are students with disabilities.

During his career as an elected official, Mayor Adams has been vocal about creating a safe city for all in an ever-changing, and both the Mayor and NYC DOE Chancellor Banks have been vocal about scaling educational excellence. To reimburse public charter schools in private space to hire security guards helps us all achieve these common goals, while centering all NYC students – public and private, alike. In fact, Mayor Adams (then Brooklyn Borough President) advocated for the inclusion of charter schools in Local Law 2016/02 stating, "Our tax dollars should protect all our children," adding that he believed this could be passed by the Council. The NYC Council should amend Local Law 2016/02 to include public charter schools. Absent legislation, the City Council should ask City Hall to add funds into the budget for these already underfunded charter schools, many of whom are among the worst-funded public schools in NYC.

For over twenty years, public charter schools have been an integral part of the public education system in New York City (NYC), and in the 2023-24 school year there are 274 public charter schools operating in the five boroughs. Over 146,200 students, representing 15% of public school students, of which nearly 90% are Black/African American or Latinx. New York's public charter schools are serving primarily low-income NYC families (82% are economically disadvantaged), offering additional high-quality educational options for families.

More and more NYC families continue to choose charter schools as the right public school for their children. In the 2023-24 school year, 37% of NYC's Black kindergarteners (enrolled in a public school) enrolled in a public charter school. Charter school enrollment growth increased 13% between the 2019-20 and 2023-24 school, even as the NYC district schools have seen historic drops in enrollment (12% drop in the same time period). Differences in enrollment between district and charter schools are even more stark in certain areas of NYC. For example, in the Bronx, charter enrollment has increased 32% between 2019-20 and 2023-24. In this same period, district schools in the Bronx have lost 18% of students. Charter schools may well be part of what keeps families in NYC.

In addition, the recent 2023 Math and ELA 3-8 test scores confirmed that students in charter schools experience higher rates of proficiency than their district counterparts. In ELA, Black and Hispanic charter school students outperformed district counterparts by 19 percentage points

(59% vs. 40%) and 16 percentage points (55% vs. 39%), respectively. In math, Black and Hispanic charter school students outperformed district counterparts by 27 percentage points (61% vs. 34%), and 25 percentage points (61% vs. 36%), respectively.

Despite the demand and success of charters, charter school students still remain the lowest funded public schools in NYC. It is nothing more than a myth that charter schools drain resources or cost the district a disproportionate amount of public aid. A NYC student attending a charter school receives much less public funding than their New York counterparts in district public schools. The most recent Independent Budget Office of New York City (IBO) analysis found that NYC charter schools were underfunded between more than a $1,000 to up to almost $5,000 per student.[1]   The magnitude of the disparity differs depending on whether the school is co-located, receives rental assistance, or no rental assistance. While there has not been an updated comparative analysis of New York City's funding for district and charter schools since the new charter school tuition formula was passed in 2017, there is nothing in the funding trends since 2017 to suggest that gaps have gotten smaller; if anything, they are likely to have increased, particularly for students that receive no rental assistance.

We ask that you prioritize the passage of an amended Int. 532-2024.

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Behavioral Health Emergency Assistance Response Division (B-HEARD) and Responses to Mental Health Crises Oversight Hearing Testimony

Before the New York City Council
Committee on Mental Health, Disabilities and Addiction
Jointly with the Committee on Public Safety, Committee on Hospitals, and the Committee on Fire and Emergency Management

September 23, 2024
Presented by:
Helen 'Skip' Skipper
Executive Director
The NYC Justice Peer Initiative
NYCJPIExeDir@cases.org

Thank you, Chairs Lee, Salaam, Narcisse, and Ariola, and to the other members of these committees for convening this critical oversight hearing.

My name is Helen 'Skip' Skipper – I am the Executive Director of the NYC Justice Peer Initiative – A lifelong NYC resident and most importantly – a peer! I am here today to testify in support of the testimony provided by Correct Crisis Intervention Today - NYC (CCIT-NYC), a coalition of advocacy groups and other community organizations that consist of hundreds of community stakeholders, working to transform how New York City responds to mental health crises. I thank you for initiating this opportunity to speak today about the need for NYC to build additional off-ramps for those in crisis without policing involved and prioritizing peer support and community-based treatment. I stand here as the Executive Director of an organization dedicated to building "Justice Peers" – those who have successfully navigated behavioral health concerns and also crimino-legal system involvement. I stand here as someone who has successfully accomplished that and also as someone who has transformed my lived experience to professional lived expertise. But first and foremost – I am a peer – someone whose certification and training has been delineated an evidence-based practice – peer support has been empirically researched – as a criminologist – applying to a Ph.D program this year – I need to rest on that – we have been proven to be beneficial and essential in supporting those with behavioral health concerns. Incorporating those of us with this vital professional expertise should be without question – as there should not be any question about expanding B-Heard city-wide and yes 24/7! I personally have experienced behavioral health crisis's and I am fully recognizant of the fact that if B-Heard was operational when I was in that

period of my life – I would have not been criminalized and forced to spend nearly 25 years of my life cycling through the behavioral health and criminal justice systems!

Since 2015, 20 individuals have been killed by police officers while experiencing a mental health crisis in New York City. After decades of advocacy by CCIT-NYC and others, we appreciate New York City's attempts to shift crisis response through its Behavioral Health Emergency Assistance Response Division (B-HEARD) pilot.

Responding to mental health calls with health professionals instead of law enforcement is essential—about a quarter of all fatal police shootings in the U.S. involve someone experiencing a mental health crisis. However, we have significant concerns with the program's current structure and outcomes to date.

The current B-HEARD structure is fundamentally flawed and still very much relies on NYPD. B-HEARD teams are only dispatched through 911 rather than 988, the new federal three-digit number for mental health crisis calls. 911 does not accept requests for a B-HEARD team response. Other issues pertaining to scope of service include that the program is not citywide or 24/7, leaving far too many citizens with police as first responders to their mental health crises. We have seen time and time again, most recently with the death of Win Rozario, that it is entirely inappropriate to send police in response to mental health crisis calls and their presence only creates deadly escalation.

CCIT-NYC calls for police to be completely removed as first responders to nonviolent mental health crisis calls, and for peers – people with lived mental health experience like myself – to be a mandatory element of B-HEARD teams. Response teams that include people with lived experience will help to achieve the B-HEARD pilot goals by shifting the model to a person-centered approach rooted in genuine connection and communal well-being.

Two key goals of B-HEARD are to increase connection to community-based care and decrease hospitalizations. Yet just six percent of people who receive a B-HEARD response to a mental health crisis are transported to a community-based health care or social service location, and nearly 60% are still transported to the hospital. Peers have the skills and expertise to advocate for connection to community-based care and avoid unwanted and unnecessary transports to hospitals.

Although B-HEARD's geographic bounds have expanded some since its inception, and it is responding to a higher volume of overall calls, the number of calls directed to B-HEARD are not keeping up with the rate of the program's expansion. The most recently-available data (yes I understand new data was just released mere days ago) it still shows flaws - that only about one in four people who place mental

health crisis calls in a qualifying area get a B-HEARD response. In an interview with NY One, the program openly stated that teams only respond to a mere three to five calls per day.

Additionally, more transparency around the B-HEARD program is needed to inform best practices and investments in crisis response. The City must commit to regular reporting – not reporting of new data 2-days before a city council hearing on its progress!

Of course, in order to continue to make progress towards its goals, the B-HEARD pilot will require sustained investment in the budget, starting with fully restoring the B-HEARD Program to Eliminate the Gap (PEG) cuts in the adopted budget. We look forward to working with the Chairs and members of these committees to improve B-HEARD and ensure that New Yorkers experiencing a mental health crisis receive the caring and response they deserve.

Treatment Not Jail Coalition

Behavioral Health Emergency Assistance Response Division (B-HEARD) and Responses to Mental Health Crises Oversight Hearing Testimony

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

Jointly with the Committee on Public Safety, Committee on Hospitals, and the Committee on Fire and Emergency Management

September 23, 2024

Submitted by:
The Treatment Not Jail Coalition

Thank you Chairs Lee, Salaam, Narcisse, and Ariola, and to the other members of these committees for convening this critical oversight hearing.

We offer this testimony in support of the testimony provided by Correct Crisis Intervention Today - NYC (CCIT-NYC), a coalition of advocacy groups and other community organizations that consist of hundreds of community stakeholders, working to transform how New York City responds to mental health crises.

The Treatment Not Jail coalition seeks to vastly expand access to and improve upon our existing treatment court infrastructure, thus creating a critical legal mechanism for people to resolve their criminal cases through court-ordered, community-based treatment, rather than incarceration. In essence, this legislation will create meaningful off-ramps from the grotesque cycle of incarceration, traumatization, and destabilization for those whose charges stem from underlying and untreated mental health and substance use challenges and other disabilities. In our coalition, we know that peer-led intervention and support is proven to work and we urge the city to look to peer-led models for crisis response.

Since 2015, 20 individuals have been killed by police officers while experiencing a mental health crisis in New York City. After decades of advocacy by CCIT-NYC and others, we appreciate New York City's attempts to shift crisis response through its Behavioral Health Emergency Assistance Response Division (B-HEARD) pilot.

Responding to mental health calls with health professionals instead of law enforcement is essential—about a quarter of all fatal police shootings in the U.S. involve someone experiencing a mental health crisis. However, we have significant concerns with the program's current structure and outcomes to date.

The current B-HEARD structure is fundamentally flawed and still very much relies on NYPD. B-HEARD teams are only dispatched through 911 rather than 988, the new federal three-digit number for mental health crisis calls. 911 does not accept requests for a B-HEARD team response. Other issues pertaining to scope of service include that the program is not citywide or 24/7, leaving far too many New Yorkers with police as first responders to their mental health crises. We have seen time and time again, most recently with the death of Win Rozario, that it is entirely inappropriate to send police in response to mental health crisis calls and their presence only creates deadly escalation.

CCIT-NYC calls for police to be completely removed as first responders to nonviolent mental health crisis calls, and for peers – people with lived mental health experience – to be a *mandatory* element of B-HEARD teams. Response teams that include people with lived experience will help to achieve the B-HEARD pilot goals by shifting the model to a person-centered approach rooted in genuine connection and communal well-being.

Two key goals of B-HEARD are to increase connection to community-based care and decrease hospitalizations. Yet just six percent of people who receive a B-HEARD response to a mental health crisis are transported to a community-based health care or social service location, and nearly 60% are still transported to the hospital. Peers have the skills and expertise to advocate for connection to community-based care and avoid unwanted and unnecessary transports to hospitals.

Although B-HEARD's geographic bounds have expanded some since its inception, and it is responding to a higher volume of overall calls, the number of calls directed to B-HEARD are not keeping up with the rate of the program's expansion. The most recently-available data shows that only about one in four people who place mental health crisis calls in a qualifying area get a B-HEARD response. In an interview with NY1, the program openly stated that teams only respond to a mere three to five calls per day.

Of course, in order to continue to make progress towards its goals, the B-HEARD pilot will require sustained investment in the budget, starting with fully restoring the B-HEARD Program to Eliminate the Gap (PEG) cuts. We look forward to working with the Chairs and members of these committees to improve B-HEARD and ensure that New Yorkers experiencing a mental health crisis receive the response they deserve.

For questions, contact **Amanda Jack, ajack@legal-aid.org**.

09.23.24 - Trinity Church Wall Street Testimony – Committees on Mental Health, Disabilities and Addiction, Hospitals, and Fire and Emergency Management – Oversight Hearing on Behavioral Health Emergency Response Division (B-HEARD) and Responses to Mental Health Crises

To Chairs Lee, Narcisse, and Ariola, and Members of the Committees:

My name is Natasha Lifton, Managing Director of External Affairs and Special Projects at Trinity Church Wall Street. Thank you for the opportunity to provide testimony for this oversight hearing on the B-HEARD program.

Trinity Church Wall Street is an Episcopal Church in Lower Manhattan with a congregation of more than 1,600 parishioners, who come from all five boroughs and form an ethnically, racially, and economically diverse congregation. In addition to our ministry, we carry out the mission of faith and social justice through direct services, grantmaking, and advocacy.

Trinity has a long history of advancing social justice in alignment with our belief that every person is created in the image of God and has dignity and value. Trinity focuses on strengthening the well-being of young people, families, and our community, particularly as our city continues to strive for an equitable recovery, recognizing that those hardest hit by the COVID-19 pandemic and its economic fallout are Black and brown New Yorkers. Trinity is a long-time member of the Correct Crisis Intervention Today (CCIT) – NYC coalition which works to transform how our city responds to those experiencing a mental health emergency safely, effectively, and with compassion.

In October 2016, Deborah Danner, a Trinity parishioner, was shot and killed by a New York City police officer in her apartment. Ms. Danner had long suffered from schizophrenia. In a 2012 essay, she wrote that her life in the Episcopal community provided her with a strong support system in which she was accepted and trusted, bringing "me ever closer to God who I know loves me." She also wrote about her fear of ending up dead at the hands of law enforcement. The recent killing of 19 -year-old Win Rozario by NYPD officers is another tragic example of how deadly a law enforcement response to those in crisis can be. Ms. Danner and Mr. Rozario are two of 20 individuals have been killed by police officers while experiencing a mental health crisis in New York City since 2015.

After decades of advocacy by CCIT-NYC and others, we appreciate New York City's attempts to shift crisis response through the B-HEARD program and the City's efforts to extend the geographic bounds of B-HEARD. However, we are deeply concerned about recent budget cuts. These funding reductions must be fully restored, and additional resources allocated to enable the program to reduce response times, respond to more eligible calls, be available 24 hours, 7 days a week, and expand to the communities with the highest number of 911 calls.

Specifically, we are concerned that although B-HEARD is responding to a higher volume of overall calls, it is not keeping up with the rate of the program's expansion. Recent data provided by the Administration show that only 55% of eligible calls received a B-HEARD response.[1]

Further, two key goals of B-HEARD are to increase connection to community-based care and decrease hospitalizations. Yet again according to the Administration, just 6% of people are transported to a community-based health care or social service location, and nearly 60% are taken to hospitals.

To address these deficiencies and in addition to budget restoration and expansion, Trinity, along with our partners in the CCIT-NYC coalition call for trained peer workers with lived mental health system experience to be a mandatory element of B-HEARD teams. Trained peers have the skills and expertise to advocate for connection to community-based care and avoid unwanted and unnecessary transports to hospitals.

This best practice is used successfully in other jurisdictions across the country. For example, the Crisis Assistance Helping Out On The Streets (CAHOOTS) program in Eugene, Oregon, dispatches two-person teams of crisis workers—many with lived experience—and medics to respond to 911 and non-emergency calls involving people in a behavioral health crisis. They provide a person-centered intervention and make referrals to mental health services and other programs without the use of sirens, handcuffs or uniforms which often exacerbate already fraught situations. According to the Vera Institute of Justice, of the 24,000 calls CAHOOTS teams responded to in 2019, only 311 required police backup. The rest were handled without having to involve law enforcement.

Lastly, data released by the administration uses different variables. We therefore call for regular, comprehensive reporting using consistent measurements on all data related to B-HEARD, including hospital commitments and response times.

We look forward to working with the Chairs and members of these committees to improve B-HEARD and ensure that New Yorkers experiencing a mental health crisis receive the response they deserve. Thank you for the opportunity to provide this testimony.

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[1] https://mentalhealth.cityofnewyork.us/wp-content/uploads/2024/01/BHEARD-Data-Brief-FY23-Q3-Q4_2024.pdf

New York City Council
Committee on Mental Health, Disabilities and Addiction
Jointly with the Committee on Public Safety, Committee on Hospitals, and
Committee on Fire and Emergency Management

Behavioral Health Emergency Assistance Response Division (B-HEARD) and Responses to Mental Health Crises Oversight Hearing

Monday, September 23, 2024
Council Chambers, City Hall, New York, NY

Testimony of
Brooke Taylor
Interim Director of Social Work
Urban Justice Center Mental Health Project
(646) 459-3091 • btaylor@urbanjustice.org

Thank you, Chairs Lee, Salaam, Narcisse, and Ariola and the other members of these committees, for convening this critical oversight hearing.

My name is Brooke Taylor, and I am the director of social work at the Urban Justice Center Mental Health Project. The Mental Health Project (MHP) stands with Correct Crisis Intervention Today - NYC (CCIT-NYC) in calling for the New York City Police Department (NYPD) to be removed as first responders to mental health crisis calls and for peers – people with lived mental health experience – to be a *mandatory* element of B-HEARD teams.

MHP's mission is to disrupt and dismantle cycles of hospitalization, homelessness, and incarceration by providing direct legal and social work services and promoting systemic change through litigation, legislation, and community education. We provide legal advocacy and social work support to clients with serious mental health concerns, primarily by helping them obtain and maintain access to benefits like public assistance, Supplemental Security Income (SSI), Medicaid, and supportive housing.

Providing these services, we see the bureaucratic obstacles and communication gaps within and among these various systems which impede our clients' access to essential services. We are

keenly aware of the need for a robust, comprehensive community mental health system, including a mental health crisis response. We are often called upon to support clients in crisis, and we experience firsthand the obstacles that people with mental health concerns and their families face in obtaining immediate assistance to address a mental health emergency.

In New York City, there is no way to request an immediate *mental health* response for a person in crisis that will not involve police officers. Receiving an *immediate* response requires calling 911 for an ambulance, results in police involvement, and potentially leads to a traumatic or even deadly interaction for our clients. We have seen time and time again, most recently with the death of Win Rozario, that it is entirely inappropriate to send police in response to mental health crisis calls, and their presence only creates deadly escalation.

Instead, at any time of the day or night, New Yorkers should be able to call 988, the new federal three-digit number for mental health crisis calls, or 911 to get immediate help for themselves or someone else experiencing a mental health crisis and know that they will be met with a caring response from trained healthcare providers, not law enforcement agents. Calling 988 should result in just as prompt a response for a mental health crisis as calling 911 for any other emergency. Just as we deploy ambulances outfitted with equipment for and personnel trained in responding to a person having a heart attack, we should have a similarly appropriate response for a person in mental health crisis.

As a licensed social worker, I am required to intervene when a client is at risk of harming themselves. Because I know about the harm that can be caused by police responding to a mental health crisis, I am always reluctant to call 911. Many of my clients have disclosed to me that they or their family members have had traumatic interactions with police in the past. I do everything I can to triage the situation in another way. But when an immediate response is needed, I have no other choice. If I were able to call 911 or 988 and request that a B-HEARD team respond – and be assured that a B-HEARD team would actually respond – that would make a tremendous difference. I would know that a trained mental health worker was going to assist my client, and that the client would get the appropriate level of mental health support – whether that was being taken to a hospital or crisis respite center or being connected to ongoing services. Having a mental health peer trained in de-escalation could be even more effective, given that peers are often better able to connect with people with mental health concerns than other mental health workers.

New York City's attempts to shift crisis response through its B-HEARD pilot is an important step forward, but far more is needed for New York City to have a true non-police response to mental health emergencies. Unfortunately, the B-HEARD structure still very much relies on the NYPD. B-HEARD is not available citywide or 24 hours a day, 7 days a week, as any

comprehensive mental health response must be; this means that the police are still first responders for far too many people in mental health crises.
Even in areas in which B-HEARD operates, only 29% of the mental health crisis calls receive a B-HEARD response. There are simply not enough B-HEARD teams available to respond to all eligible calls. Moreover, eligibility for a B-HEARD response is much too restrictive. For instance, individuals who require immediate transport to a hospital or present a risk of imminent harm to themselves are not eligible for a B-HEARD response even though these individuals are much more likely to benefit from having mental health professionals on the scene to assist and support them than police officers. In addition, a B-HEARD team response cannot be requested through 911, and B-HEARD teams are not dispatched through 988, despite the fact that it should be the hub for all mental health crisis calls.

CCIT-NYC calls for peers – people with lived mental health experience – to be a *mandatory* element of B-HEARD teams. MHP is in full agreement with this demand. Response teams that include people with lived experience will help to achieve B-HEARD's goals by shifting the model to a person-centered approach rooted in genuine connection and communal well-being.

Two key goals of B-HEARD are to increase connection to community-based care and decrease hospitalizations. We appreciate that B-HEARD emphasizes getting support for people without transport to the hospital because our clients regularly report that when they go, or are taken, to a hospital emergency room, most often they are not admitted to the hospital and not offered any help to schedule an outpatient appointment or contact their current mental health provider. For example, one of our clients recently went to the emergency room at Beth Israel Hospital and reported that they were having suicidal ideations and was fearful of being alone. The emergency department staff chose to discharge her right away, did not contact her outpatient mental health provider or us, did not offer to refer her to a crisis respite center, and did not schedule her an appointment for outpatient treatment. Later that evening, she went to a different hospital seeking treatment, and she was admitted to the inpatient psychiatric unit.

Despite B-HEARD's goal of decreasing hospitalizations, almost 60% of people who receive a B-HEARD response to a mental health crisis are still transported to the hospital. Including peers on B-HEARD teams could improve this measure because peers have the skills and expertise to advocate for connection to community-based care and avoid unwanted and unnecessary transports to hospitals.

Finally, we need more transparency around the B-HEARD program to inform best practices and investments in crisis response. We urge the Council to require regular, detailed reporting on B-HEARD.

New Yorkers experiencing a mental health crisis deserve a caring, person-centered response that connects them to the appropriate level of care and supports recovery. To achieve that goal, the B-HEARD pilot needs significant improvements and will require sustained investment in the budget, starting with fully restoring the B-HEARD Program to Eliminate the Gap (PEG) cuts in the adopted budget.

Thank you for the opportunity to testify about this critical service.

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New York City Council Committee on Mental Health, Disabilities, and Addiction. Jointly with the Committee on Public Safety, Hospitals, and Fire and Emergency Management

RE: Behavioral Health Emergency Assistance Response Division (B-HEARD) and Responses to Mental Health Crises Oversight Hearing

September 23, 2024

Chairs Lee, Salaam, Narcisse, and Ariola, and members of these committees

Thank you for the opportunity to present testimony for Vibrant Emotional Health (Vibrant). As a leading mental health organization, Vibrant is dedicated to ensuring mental and emotional well-being for all through innovative solutions that provide high-quality support whenever and wherever it is needed.

Vibrant provides a vital support system for mental health across New York City and throughout the United States. As the administrator of the 988 Suicide & Crisis Lifeline (988 Lifeline), Vibrant, alongside the federal agency Substance Abuse and Mental Health Services Administration (SAMHSA), oversees a network of more than 200 independently operated crisis contact centers, including NYC 988, part of Here2Help Connect, the nation's largest metropolitan crisis contact center. We also operate NYC's BRAVEline in partnership with the United Federation of Teachers (UFT), offering confidential anti-bullying support through the BRAVE (Building Respect, Acceptance, and Voice through Education) campaign, which provides children with counseling and intervention strategies to promote emotional well-being. Our community initiatives, like the Older Adult Assertive Community Treatment (ACT) Program in the Bronx, empower older adults with serious mental disorders to live fulfilling lives. These programs, along with our Adolescent Skills Centers and Youth & Family Wellness Services, cater to the diverse needs of New Yorkers, ensuring access to vital mental health resources.

Vibrant is dedicated to advancing efforts to reimagine crisis response nationwide and supports the National Guidelines for Behavioral Health Crisis Care[1], released by SAMHSA in early 2020. We advocate for a

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[1]Center for Mental Health Services, Substance Abuse and Mental Health Services Administration. *National Guidelines for Behavioral Health Crisis Care* – *A Best*

comprehensive, integrated, equitable, and trauma-informed behavioral health crisis system in every community that provides:

1. **Someone To Talk to** (988 Lifeline, available 24/7 and comprised of local crisis contact centers)
2. **Someone To Respond** (mobile crisis teams staffed with behavioral health professionals)
3. **A Safe Place To Go** (crisis facilities that provide an alternative to emergency departments)

Too often, individuals experiencing a mental health crisis do not receive a mental health response. In too many communities across New York City, the responsibility of handling mental health crises has been unofficially shifted to law enforcement, often with devastating outcomes. The lack of sufficient and well-coordinated mental health crisis care has turned local law enforcement into the default crisis response system. This is both unacceptable and unsafe.

The Behavioral Health Emergency Assistance Response Division (B-HEARD), has the potential to disrupt this pattern by funding culturally competent, peer-led crisis response services and ensuring that people receive appropriate follow-up care. However, significant improvements are necessary to ensure the program fulfills its mission effectively.

Concerns with the B-HEARD Program:

- **Disproportionate NYPD Involvement:** 79% of all mental health calls in B-HEARD precincts were still directed to the NYPD, with B-HEARD responding to only approximately 21% of total mental health calls in the pilot area [2].
- **911 Routing:** All B-HEARD calls are routed and deployed through 911, which falls under the NYPD's jurisdiction, perpetuating police involvement.

Practice Toolkit: Knowledge Informing Transformation. 2020, https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf.

[2] NYC Mayor's Office of Community Mental Health, B-HEARD Data Briefs. Fiscal Fiscal Year 23, July 2022 - June 2023, https://mentalhealth.cityofnewyork.us/wp-content/uploads/2023/05/2023_05_23-BHEARD-Data-Brief-FY23-Q1Q2-July22-Dec22.pdf, https://mentalhealth.cityofnewyork.us/wp-content/uploads/2024/01/BHEARD-Data-Brief-FY23-Q3-Q4_2024.pdf

- **Composition of Crisis Response Teams:** B-HEARD has no requirement to hire peers, which limits the program's effectiveness and relatability to those in crisis.
- **Limited Operational Hours:** The pilot operates only 16 hours a day, which is insufficient to meet the needs of individuals experiencing crises.
- **Limited partnerships with trusted community organizations:** Inadequate connections for long-term follow-up care, with minimal roles currently available for these organizations.
- **Insufficient funding for a comprehensive crisis response:** Continued budget cuts threaten the program's success.

***Someone To Talk To*: The City Must Establish a Formal Agreement for NYC 988/911 Interoperability**

The introduction of the 988 Lifeline marked a significant step in reimagining our crisis response, but further efforts are needed to ensure that everyone in crisis receives the help they need and deserve. Currently, many individuals experiencing a behavioral crisis end up in the 911 system, where responses can range from ineffective to dangerous. A concerted effort is required to redirect individuals from the 911 system to the 988 Lifeline. It is vital that 911 call-takers have the ability to divert mental health calls before dispatching law enforcement, significantly reducing the risk of involuntary hospitalization, imprisonment, physical harm, or emotional trauma.

- **Establish a Formal Memorandum of Understanding (MOU):** Establishing an MOU would streamline the process of ensuring systematic and efficient handling of mental health crisis calls. According to the 988 Lifeline’s Suicide Safety Policy, having an MOU is a best practice and strongly encouraged, enabling a coordinated approach between NYC 988 and 911/NYPD to offer alternative crisis responses instead of law enforcement.

  There is a clear need to expand B-HEARD services in terms of both hours and geographic coverage, but B-HEARD will not always be the most appropriate response for every situation. This is why a robust MOU between NYC 988 and NYC's 911/NYPD is crucial—allowing for the seamless diversion of calls that do not meet the criteria for B-HEARD or EMS/NYPD to NYC 988. Once these calls are routed to NYC 988, trained counselors can assess the situation and determine the most appropriate level of care, whether that is dispatching a Mobile Crisis Team (MCT) or providing resources for a

lower level of care. Additionally, for higher-risk situations, NYC 988 can offer follow-up calls to provide further support and assist with connecting individuals to ongoing care.

By increasing the involvement of mental health professionals trained to manage these situations carefully and effectively, the 988 Lifeline can help reduce the role of law enforcement in crisis intervention, enhancing de-escalation efforts, and improving crisis resolution.

Someone To Respond: **The City Must Transform Its Response to Mental Health Crises By Adopting A 24-hour Peer-Led Health Response**

The City must prioritize creating a system where individuals experiencing a mental health crisis receive the appropriate care and support needed to safely de-escalate the situation, ensuring the safety and well-being of both the individual in crisis and the broader community. Reliance on law enforcement for mental health crises can unnecessarily escalate situations and does not align with B-HEARD's goals.

Crisis responses should be handled by professionals trained in de-escalation techniques, with peers and healthcare providers being the most suitable candidates for this training [3]. Evidence shows that when responders are trained in trauma-informed care, they recover quicker from crises, strengthen their connections to ongoing healthcare services and community resources, and help prevent future crises[4].

A significant shortcoming of the B-HEARD program is the need for peer involvement in teams and leadership roles. Incorporating peers with lived mental health experience into crisis response is crucial for providing compassionate, effective care. Peers can relate to those in crisis on a personal level, demonstrating that recovery is possible and offering a unique perspective grounded in experience.

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[3] Bazelon Center for Mental Health Law. "When There's a Crisis, Call a Peer: How People With Lived Experience Make Mental Health Crisis Services More Effective." 2024, https://www.bazelon.org/wp-content/uploads/2024/01/Bazelon-When-Theres-a-Crisis-Call-A-Peer-full-01-03-24.pdf.

[4] Steadman, Henry J., 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.

Peers with lived mental health experience are invaluable in crises. They bring empathy, understanding, and hope to individuals in distress, fostering a sense of trust and connection that is often missing in traditional responses. Peers can help de-escalate situations, provide emotional support, and connect individuals to ongoing care, greatly enhancing the overall effectiveness of crisis response teams.

To align B-HEARD with best practices, we recommend the following steps to incorporate peers into the program:

- Peer involvement in B-HEARD teams and leadership roles.
- Recruit peers with lived experience who reflect the community's characteristics as closely as possible. This includes considerations of gender, race, primary language, ethnicity, religion, veteran status, lived experiences, and age.
- Position a peer as one of the first individuals to greet and support someone.
- Develop Workforce Support: Peer Support Specialists should receive fair compensation that includes comprehensive benefits and opportunities for career advancement.

Additionally, B-HEARD currently operates only 16 hours a day in a limited portion of the city. Crisis Response Teams should be available to reach anyone who needs in-person support anywhere, anytime.

- **Expand B-HEARD to all boroughs and increase operation to 24 hours per day, 7 days per week.**

A Safe Place To Go: Strengthen Partnerships with Local Service Providers

Two key goals of B-HEARD are to increase connections to community-based care and decrease hospitalizations. However, only 6% of people who receive a B-HEARD response to a mental health crisis are transported to a community-based healthcare or social service location, while nearly 60% are still taken to the hospital[5]. To better align with these goals, expanding community-based healthcare options across all boroughs may be necessary if the program is to operate 24 hours a day.

[5] "Transforming NYC's Response to Mental Health Emergencies: Data for January 1, 2023 – June 30, 2023 (FY23 Q3 & Q4)." NYC Mayor's Office of Community Mental Health, 2024, https://mentalhealth.cityofnewyork.us/wp-content/uploads/2024/01/BHEARD-Data-Brief-FY23-Q3-Q4_2024.pdf.

By expanding partnerships and strengthening community-based care options, B-HEARD could serve as a crucial alternative to involuntary holds, offering individuals voluntary, supportive services that address their mental health needs without hospitalization. This would provide a more ethical and person-centered approach and help relieve pressure on an already overwhelmed public hospital system that cannot sustain additional capacity.

- **The program should focus on building quality partnerships with trusted local service providers to ensure comprehensive follow-up care and continuity of support.**

The City Must Adequately Fund B-HEARD

In order to continue to make progress toward its goals, B-HEARD will require sustained investment in the budget. B-HEARD funding is currently insufficient to meet the needs of New Yorkers experiencing mental health crises. The City has long called for improved mental health care but continues to cut services. Adequate funding is crucial to the success of B-HEARD, as it directly impacts the program's ability to provide effective, non-police responses to mental health emergencies. Therefore, it is essential to:

- **Fully restore Program to Eliminate the Gap (PEG) cuts to B-HEARD in the FY25 final budget.**

By incorporating these recommendations, we can create a more responsive, equitable, and efficient mental health crisis system that truly serves the needs of all New Yorkers.

Thank you for considering our testimony. We look forward to continued collaboration with the NYC Council and other stakeholders to enhance the B-HEARD program and improve mental health crisis response in our city.

Please contact Lisa Elder, State Policy Manager, at lelder@vibrant.org with any questions.

Sincerely,

Alison Lewis

Alison Lewis
Chief Operating Officer
Vibrant Emotional Health

Testimony of Bracha Rutner
Head of School, Yeshiva University High School for Girls
To the New York City Council Committee on Public Safety

On Intro 0532-2024 to Expand the School Security Guard Program for Nonpublic Schools
Monday, September 23, 2024

I would like to thank the council for their time especially Council member Brennan. Even before but especially since October 7, I have been worried about my students.

We have seen a continued increase in school shootings and an increase in antisemitic attacks. Our security guards are on higher alert.

The Case for Adjusting the Threshold:

Schools with under 300 students face similar security risks as larger schools but often lack the resources to protect students adequately. Small schools might be perceived as "soft targets" due to insufficient funding for preventive measures like surveillance, secured entryways, and trained

Smaller schools may not have the economies of scale to easily absorb security costs without external funding. Lowering the threshold for security funding will have a tangible impact on schools' ability to protect students, regardless of their size. We have added an extra security guard this year, which has put pressure on our finances and the finances of our families.

Without delving too deeply into political elements, the events of October 7 are a clear sign of escalating global tensions that can have ripple effects locally. These types of events increase anxiety and stress among parents and students, heightening the need for security even in small educational environments.

Mass shootings and school-targeted violence do not discriminate by school size. Every student deserves protection, no matter how small their school is, and policy should reflect this reality.

This is an opportunity for the city to ensure equitable protection for all students, regardless of their school’s size. Security should not be a privilege for larger schools but a right for every child.

We have had suspicious cars drive by and the police have come to visit us more often. These are all signs of increased worry of all of our community.

By adjusting the threshold, the city will be proactively protecting its most vulnerable population — children — and safeguarding the future of the community.

Behavioral Health Emergency Assistance Response Division (B-HEARD) and Responses to Mental Health Crises Oversight Hearing Testimony

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

Jointly with the Committee on Public Safety, Committee on Hospitals, and the Committee on Fire and Emergency Management

September 23, 2024

Presented by:
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[redacted]

Thank you for all for convening the hearing this morning! My name is Aaron Miner and I am a New York City resident. I am a person with mental illness. I am also a sibling, parent, or friend of several people with serious mental illness. Mental health crisis response has been a personally important issue for me for pretty much as long as I can remember. I am testifying in support of the testimony provided by CCIT-NYC, as well as the coalition of advocacy groups and community members they represent.

First of all, I really want to express appreciation for the B-HEARD pilot program. It's so critical to shift mental health crisis response from police to health professionals, and this program is an important step in that direction. But we still have a long way to go. Even as the program's coverage area slowly expands, many calls are still being handled by NYPD. That puts people in crisis at risk, on so many levels. Most seriously and most frighteningly, it puts them at risk of deadly escalation. But I think something we don't always talk about is the enduring impact it can have on people's lives and openness to treatment when their experience of crisis response, their experience of accessing treatment, is itself a source of trauma.

When the police were called to respond to my close friend's nonviolent manic episode, I watched as she was surrounded by a large group of officers, handcuffed with her arms behind her back, and left lying on the floor of our building lobby for almost two hours, as neighbors walked in and out. For my friend, this was terrifying, humiliating, and physically painful. It affected her self-understanding and her relationships with neighbors long after she got out of the hospital. And it was completely unnecessary. My brother is currently suffering pretty intensely with addiction problems that he is afraid to get inpatient treatment for. And the main barrier for him, the main source of that fear, is past experiences that were physically coercive and traumatic.

How many people in our community are afraid to call for help? Afraid to get care? When we are in crisis or someone we love is in crisis, we need to know for sure, to be able to trust, that the response will be safe and compassionate.

With that need in mind, I passionately support CCIT-NYC's call for **police to be completely removed as first responders to nonviolent mental health crisis calls**, and for peers – people with lived mental health experience – to be a *mandatory* element of B-HEARD teams. Peers, people with lived experience, bring so many gifts to crisis response, including a strong person-centered awareness, the skills and knowledge to advocate for community based care, and the ability to help mitigate the affects of fear and stigma. I also strongly support the call for practices that lead to more crisis calls within qualifying areas being directed to B-HEARD, and more of those calls ultimately getting a B-HEARD response; greater transparency around the program, with clearer reporting of data; and for the funding needed for continued expansion, starting with fully restoring the B-HEARD Program to Eliminate the Gap (PEG) cuts in the adopted budget.

Again, I so appreciate your listening, and your work on this incredibly important program. I hope that it will continue to grow, to involve peers more widely and intentionally, and ultimately to bring safer, more compassionate, more trusted crisis response to all New Yorkers at moments when we need it most.

Testimony of Rabbi Yeruchim Silber

Agudath Israel of America

In Support of Intro 532

My name is Yeruchim Silber, and I serve as Director of New York Government Relations at Agudath Israel of America. Agudath Israel is a national organization serving as the arm and voice of large portions of American Orthodox Jewry advocating for its constituents at federal, state, and local levels.

For over 60 years, our organization has been at the forefront of advocating for the nonpublic school community, specifically for yeshivas and day schools in the Orthodox Jewish community

I am here today in support of Intro 532, which expands upon Intro 2 from 2016. Intro 2, originally championed by former Council member David Greenfield was groundbreaking legislation as it allowed the city for the first time to reimburse non public schools for the cost of security guards in the belief that all students are entitled to a safe school environment whether they go to a public or non public school.

However at this time this law is in need of crucial upgrades. Unfortunately, as we all know anti Semitism and other hate

crimes have risen to unheard of levels - even more so since the Hamas terrorist attack in Israel of October 7th. According to recent ADL numbers 64% of those attacks have been aimed at orthodox Jews. Enhanced security in schools is no longer a luxury. Many of the schools represented by Agudath Israel have the majority of their student body on scholarship so they often must choose between educational enhancement or security upgrades.

And so while Intro 2 provides for guards at schools with at least 300 students, it leaves schools with student population of under 300 highly vulnerable. Additionally, the DCAS regulations calculate the number of students based on the BEDS code of the school. However, the NYS Education Department requires unique BEDS codes for each building. Thus, if a school campus consists of multiple buildings each with less that 300 students but the school exceeds 300 in total, they would not be eligible for reimbursement under current law. A fairer way to calculate would be the ORIS code which is a unique number given to each school, even those with multiple buildings.

For these reasons we urge you and your colleagues to pass Intro 532.

Thank You

Dear City Council,

Hi, my name is Garth Harding and I'm a proud member of Fountain House's Clubhouses.

As someone who lives with serious mental illness – born and raised in Brooklyn, New York, and currently living in Hell's Kitchen – it's very upsetting to see how the city has handled mental health crises. Sending police when people need medical support doesn't make sense and has cost us too many lives. We don't send cops to help someone experiencing a heart attack or broken bone — the EMT does that. We send trained health professionals who know what to expect and can assess and de-escalate situations accordingly. The same can and should be done for mental health emergencies.

This isn't a personal attack against police. I have family members in law enforcement. If it wasn't for my mental health diagnosis (USMC-4F), I would have served as a soldier and on the police force. But even for me, I understand why police aren't the best responders. There are good cops, and there are bad cops (mostly good cops). But regardless, they're not trained to handle mental health crises. They don't even want to be deployed in these situations. And our reluctance, as a city and as a community, to invest in real solutions will have deadly consequences.

I am a 6'3", 280-lb Jamaican American. I have experienced all sorts of double standards as a large Black man living with mental illness. Until people get to know me and hear I went to NYU Graduate School, they're often afraid. When people like me are othered, they're prone to be misunderstood and seen as a threat. When this is done by police, these split-second subconscious judgments can and have led to dangerous outcomes.

There are real alternatives: Let's send trained peer specialists and social workers who are equipped to intervene in a mental health crisis in a way that minimizes harm. Let's make 988 as robust and reliable as it should be.

We must end this cycle of violence. I urge City Council to reinvest in the solutions and practices that can make a difference and to work in collaboration with Dr. Ashwin Vasan and the entire Department of Health and Mental Hygiene, their counterparts in Albany and D.C., as well as public health leaders at the WHO and elsewhere to make a difference.

Behavioral Health Emergency Assistance Response Division (B-HEARD) and Responses to Mental Health Crises
Oversight Hearing Testimony

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

Jointly with the Committee on Public Safety, Committee on Hospitals, and the Committee on Fire and Emergency Management

September 23, 2024

Presented by:
Kayla Hackman, MD (kaylahackman@gmail.com)

Good afternoon, Chairs Lee, Salaam, Narcisse, Ariola, and esteemed members of these committees. Thank you for convening this crucial oversight hearing and for the opportunity to speak today.

My name is Dr. Kayla Hackman, and I've been a resident of New York City for over a decade. I come before you today wearing two hats: that of a medical doctor who has worked in psychiatric hospitals, and that of an individual diagnosed with what is considered a chronic, serious psychotic mental illness. This unique perspective compels me to speak out about the critical state we find our city's emergency services' in at the moment, especially in their interactions with individuals experiencing mental health crises, particularly those experiencing psychosis.

The current state of affairs is deeply concerning. The tragic cases of Shereese Francis, Eleanor Bumpurs, and others highlight a systemic problem in how we respond to mental health emergencies. The incidents highlighted during this session underscore the urgent need for reform in our approach to crisis intervention.

As someone who has been both a healthcare provider and a patient in psychiatric facilities, I am intimately familiar with the challenges of our current mental health system. My perspective is not just professional, but deeply personal. I have experienced firsthand the trauma of being forced out from under the covers of my own bed by police during a mental health crisis. This experience was not only frightening and dehumanizing, it also highlighted the urgent need for a more compassionate, health-focused approach to crisis intervention. The fear and confusion I felt when confronted by armed officers in my most vulnerable moment is a feeling I wouldn't wish on anyone, let alone someone in the throes of a mental health emergency. I believe we are obligated to do everything we can to improve this system that, at present,

While institutionalization can be a miserable experience, and while I understand that it may seem challenging to convince people to willingly submit to it, it is eminently preferable to the tragic outcomes we've seen when law enforcement becomes involved in mental health crises. Few people are more qualified to help get mentally ill people the treatment they need than the people who have been there and gotten better themselves. Peer-led policy is the only way forward.

I'm here in support of the testimony provided by Correct Crisis Intervention Today - NYC (CCIT-NYC), a coalition advocating for transformative change in New York City's response to mental health crises. Their work, along with other advocacy groups, has been instrumental in pushing for reforms.

The introduction of the Behavioral Health Emergency Assistance Response Division (B-HEARD) pilot program was a step in the right direction. However, its current structure and outcomes raise significant concerns:

1. B-HEARD teams are only dispatched through 911, not the new 988 mental health crisis line, limiting accessibility.
2. The program is not citywide or available 24/7, leaving many New Yorkers without this specialized response.
3. Police involvement remains a significant component, which can often escalate rather than de-escalate crisis situations.

Recent tragedies, such as the deaths of Win Rozario and Victoria Lee, starkly illustrate why law enforcement should not be the primary responders to mental health crises. They are not trained for this kind of interaction or medical crisis. I can attest that these situations demand empathy, understanding, and specialized de-escalation skills. The presence of law enforcement often escalates these sensitive situations, too often with tragic consequences.

To address these issues, I echo CCIT-NYC's call for:

1. Complete removal of police as first responders to non-violent mental health crisis calls.
2. Mandatory inclusion of peers – individuals with lived mental health experience – in B-HEARD teams.
3. Increased focus on connecting individuals to community-based care rather than defaulting to hospitalization.
4. Expansion of B-HEARD's coverage and availability.

5. Greater transparency and regular reporting on the program's outcomes and effectiveness.

We are the largest, most well-funded city in the greatest country in the world. Our mental health care system should reflect this.

We must recognize that mental health crises can affect anyone, at any time. The line between "us" and "them" is far thinner than many realize. It's crucial that we develop a system that treats all individuals with dignity and compassion, focusing on restoring health rather than employing force.

In conclusion, I urge this committee and our city leadership to take bold steps in reforming our mental health crisis response system and to create and support a model that prioritizes health, safety, and dignity for **all** New Yorkers. Our community deserves nothing less.

Thank you for your time and consideration.

09/23/2024

Good afternoon esteemed members of the Committee,

My name is Kenneth and I am a Peer Specialist who works part-time at Fountain House. I am also a mental health consumer. As a member of Community Access since 2009 I have been attending Legislative Day in Albany NY to advocate on behalf of the Crisis Intervention Team. I have attended several trainings with fellow peers at the Police Academy in College Point Queens. At these trainings we shared our personal experiences with dealing with the police and most of them unfortunately were not that pleasant. Thankfully none of them ended with anyone dying. However some of us did talk about knowing individuals who were involved in tragic situations at the hands of the police. I believe not only funding for CIT needs to be implemented during the 2025 budget but also very important discussions at City Hall as well as on a State level. Even though some officers were trained I was told by a director at Community Access that only 45 % of them actually were going out on the calls. And even more disheartening many police who responded to the calls were not even trained. This is truly unacceptable because one death is too many. I believe the solution can start with what words are used in the training. "EDP" Does not have to mean emotionally disturbed person, but an emotionally distressed person. It's the little things that can lead to big changes and results.

Thank you for your time. Have a great day.

FOR THE RECORD

Monday

Sept 24, 2024

There is a urgent call for systemic change our safety and lives depends on it. A mental health crisis is never resolved in death, In fact the continuation of these incidents continues to cause isolation, oppression/harm, create distrust, and further divide our most vunerable.. When police whom are triggered, inept, racists, fearful, uncertain, sexist, sexual deviants show up to these mental health crisis with a gun and a badge.... The human with the gun walks away. A great contributor to the fact we are continuing to see deaths with 911 calls for mental health and safety is the resistance for on going evaluations of police. Police are humans with a stress filled role. A great sense of empathy is lost when money is placed before human needs and officers show up wanting to protect their JOBS AND THEN CITIZENS.

Police are stressed with case numbers, abuse from commanding officers and humiliation from their colleagues. We can no longer ignore these facts as causes and effects.

We must do more to assure police are stable enough to serve ADN PROTEC CITIZENS

We must be committed to creating safer spaces for Mental Health Wellness.

I am willing to assists in this effort, I am a doula, I am a Family Advocate

at the FEC of Washington Heights. I am a human being. I want to name these concerns and cocreate solutions.

FOR THE RECORD

FOR THE RECORD

The Impact of Disproportionate Police Practices on the Mental Health of Urban Communities: A Case Study of Crown Heights and Morris Heights

Introduction

Disproportionate police practices have long-standing and profound impacts on the mental health of urban communities. This analysis delves into how these practices have specifically affected the mental health of residents in Crown Heights, Brooklyn, and Morris Heights, The Bronx. By examining historical contexts, relevant statistics, and current conditions, this study aims to provide a comprehensive understanding of the ongoing challenges faced by these communities.

Historical Context

Historically, both Crown Heights and Morris Heights have been vibrant, diverse neighborhoods with significant African American and Caribbean populations. However, these communities have also been sites of systemic racism and aggressive policing strategies. The implementation of policies such as "stop-and-frisk" in New York City has disproportionately targeted Black and Hispanic residents, leading to widespread mistrust and psychological trauma.

In the 1990s and early 2000s, the New York Police Department (NYPD) employed aggressive policing tactics, often justified under the banner of the War on Drugs. This led to a significant number of stops, searches, and arrests, primarily affecting young men of color. These practices have left an indelible mark on the mental health of these communities, fostering environments of fear, anxiety, and trauma.

Impact on Mental Health

1. **Chronic Stress and Anxiety**

Frequent encounters with law enforcement have contributed to chronic stress and anxiety among residents. The constant fear of being stopped or harassed by police can lead to hypervigilance and anxiety disorders. Studies have shown that repeated exposure to such stressors can result in long-term mental health issues.

A study conducted by Geller et al. (2014) found that young men who reported being stopped by police multiple times were more likely to exhibit symptoms of anxiety and post-traumatic stress disorder (PTSD) . This is particularly relevant in neighborhoods like Crown Heights and Morris Heights, where high rates of stop-and-frisk incidents have been recorded.

2. **Depression and Hopelessness**

The feeling of being targeted and treated unfairly by law enforcement can lead to depression and a sense of hopelessness. This is exacerbated by the socio-economic disadvantages that often accompany systemic racism. Many residents in these neighborhoods feel marginalized and disenfranchised, further contributing to mental health issues.

Research has shown a clear link between experiences of racial discrimination and depression. A report by the American Psychological Association (APA) highlights that racial discrimination and police violence can significantly increase the risk of depression among African Americans .

3. **Community Trauma**

The collective experience of aggressive policing can lead to community-wide trauma. This trauma is not limited to direct encounters with law enforcement but extends to witnessing the impact on family and friends. In neighborhoods like Crown Heights and Morris Heights, this shared trauma can create an atmosphere of mistrust and fear, undermining community cohesion and support networks.

A study by Alang et al. (2017) discusses the concept of "collective trauma" experienced by Black communities due to repeated police violence, emphasizing the broader impact on community mental health .

Relevant Statistics

1. **Stop-and-Frisk Data**

In 2011, at the height of the stop-and-frisk policy, the NYPD conducted over 685,000 stops, with more than 85% involving Black and Hispanic individuals . In Crown Heights, a predominantly Black neighborhood, residents were disproportionately targeted. Similarly, in Morris Heights, the majority of stops involved young Black and Hispanic men.

2. **Arrest and Incarceration Rates**

Data from the New York Civil Liberties Union (NYCLU) indicates that Black and Hispanic New Yorkers were more likely to be arrested for minor offenses compared to their White counterparts, despite similar rates of offending . This disparity is evident in both Crown Heights and Morris Heights, contributing to higher levels of community stress and anxiety.

3. **Mental Health Outcomes**

According to the New York City Department of Health and Mental Hygiene, neighborhoods with high rates of police encounters also show higher rates of mental health issues. For instance, in 2018, Crown Heights reported higher than average rates of anxiety and depression compared to the citywide average . Morris Heights similarly exhibited elevated levels of mental health problems.

Conclusion

Disproportionate police practices have had a profound and damaging impact on the mental health of residents in Crown Heights and Morris Heights. The legacy of aggressive policing, combined with ongoing systemic racism, continues to foster environments of fear, stress, and trauma.

Addressing these issues requires a comprehensive approach that includes reforming policing practices, providing mental health support, and fostering community resilience.

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PASTOR IBRAHIM AYU

Testimony to the City Council Committees on Mental Health, Addiction & Disability, Public Safety, Hospitals, and Fire & Emergency Management
September 23, 2024
Submitted by Sarita Daftary

Thank you for this opportunity to submit testimony regarding the B-HEARD program. Like many New Yorkers, I was excited when B-HEARD was announced, and particularly glad to hear that it would operate in the 75th Precinct (East New York, Brooklyn) where I live and where it is sorely needed.

In order to make this vital program serve its purpose, for my community and those throughout the City, changes are urgently needed, including the incorporation of peers and expansion of hours as outlined by the CCIT-NYC coalition. I also want to emphasize the need for dispatch to be switched from 911 to 988.

On Thursday May 30th, I saw a neighbor who showed signs of mental health distress. She was sitting on the sidewalk in a busy area, and seemed disoriented. She was trying to speak to people passing by though it was hard to understand what she was saying, and she was inadvertently sitting in a way where she was exposing herself. I wanted to secure emergency mental health support for her, so I called 988. I was told by the dispatcher that 988 does not provide emergency mental health response for people on the streets – they could only send a team out to a residence (not someone in crisis on the street), and couldn't really ensure swift arrival – I was told it could be a few hours. I learned that 988 could not dispatch a B-HEARD team, and was told I should call 911 or the precinct.

In theory, I could call 911, notify them of a person in a mental health crisis, and get a team of mental health professionals to respond. But when Win Rozario made the same type of phone call for himself, 911 chose to send police, and they took his life. That story should haunt all of us. I was certainly not confident that I could call 911 with the intention of summoning a B-HEARD team and actually get a non-police response. Finally, the 988 operator suggested I call 311 to request a homeless outreach team. When I called, the 311 operator asked how I knew the woman was homeless - I had to be honest that I didn't, there just didn't seem to be any other safe options for requesting support services in that situation. I'm not sure if an outreach team eventually came. I saw the same woman again the other day, again in what appeared to be distress. I wish I had the skills to help her myself, but I don't, and I am furious that our City, with all of its resources and creativity, has not figured out a way for her or other people in crisis to safely get help.

Based on this experience, I recommend that 988 should be enabled to directly dispatch a B-HEARD team, and I believe the 911 dispatch function should operate either as an independent agency or under the auspices of a non-law enforcement agency, but not under the NYPD, as it currently does.

Thank you,
Sarita Daftary
Brooklyn, NY

Good afternoon.

Thank you, Chairs Lee, Salaam, Narcisse, and Ariola, and all other members of these committees here today convening for this vital oversight hearing. This is long overdue and this hearing finally happening is a glimmer of hope, to head in the direction of real change, reform, and recovery for many New Yorkers fighting and advocating for dignity, and life.

My name is Sheina Banatte. I am the Managing Director of Advocacy at Justice for Eudes Pierre Coalition, and I am also a proud Steering Committee Member and Peer Advocate with Correct Crisis Intervention Today NYC (CCIT-NYC). I am also a directly impacted family member whose life and family's life has woefully changed forever because NYPD responded to a 911 call to a person experiencing crisis, which ended fatality.

When Eudes Pierre was killed at 26 years old, after NYPD fired 10 shots at him, after he called 911 himself, while experiencing a mental health crisis, the NYPD took my family's heart but left us alive. This is our new reality now, fighting for awareness, change, accountability, and reform. NYC must fix its mental health crisis response NOW!

There's no experience, there's no consolation, and there's no justice for Impacted Families like mine when these situations happen. And they keep happening, too many times. Eudes is the 19th person out of 20 since 2015 killed while experiencing a crisis. Bheard is supposed to be an alternative. Treating mental health crisis response as a public health issue instead of a public safety threat.

I am at this oversight hearing because in fact, Bheard is not operating the way it presents to be. I don't want another person or family to go through what my family and I have had to endure.

I was prepared to share all these numbers and information I've learned about Bheard and how NYPD is still responding to mental health calls at a very high rate, but the Mayor released never seen data Friday, basically a day before this hearing. I'll leave that to the experts and my colleagues to speak about it. I'll speak for the one that matters most to me, Eudes Pierre.

Eudes is what everyone refers to as the life of the party. Eudes is so personable, extremely funny, compassionate and kind, so talented. He plays basketball, writes and performs music, is a poet, a dedicated and hardworking person. He was a mama's boy and a renaissance man. He was the coolest person and so supportive of everyone's hopes and dreams. Eudes was a Peer. Eudes should be here with us. In his final moments alive, what Eudes was experiencing was medical, not criminal. He needed care; person-centered approach, trauma informed, culturally responsive individuals to help him. He needed someone to meet him at that moment to treat him with dignity. He needed peers.

This system is already failing New Yorkers because there aren't adequate and accessible resources to prevent crisis to begin with. Now is a chance to at least save those who reach that breaking point. A true non-police public mental health response system, that is peer-led, so moments of crisis no longer end in injuries and fatalities. The opportunity to keep living and breathing beyond crisis as opposed to the death sentence it is today. Please look to the CCIT-NYC model which is a guide aimed at achieving exactly this. #PeersNotPolice

I ask you all, elected officials, here to represent our best interests, I ask you to ask the necessary questions and request the necessary data needed to implement real change in transforming Mental Health Crisis Response.

Thank you.

Hi my name is Susan Shervington and I am a community leader with VOCAL-NY. I also live in Harlem and am a life-long New Yorker.

A few years back, a loved one had a nervous breakdown after an argument where I needed to call the police. At that time there was no 988. So I called 911. The resources I needed were not there so my only option was the cops.

Within a few minutes, there were a lot of cops came to my house. My loved one was locked in the bathroom with a knife. I was banging on the door but he wouldn't come out. I was worried because he would not respond to my pleas and all I heard was running water.

The cops banged on the door, and started to break down the door while their guns were drawn. They yelled at him to drop the knife but he would not drop it because he wanted to die.

When I heard yelling I ran towards the door and the cops pushed me out of the way; my glasses went one way and I went the other way.

My daughter heard me as I screamed please don't kill him.at this time she ran down the hallway and jumped in front of my loved one so they wouldn't shoot him. If she didn't he wouldn't be alive today.

I never called them again. Still to this day he deals with mental health issues but I'll never call the police again.

Police should never be involved in mental health calls. Period.

Behavioral Health Emergency Assistance Response Division (B-HEARD) and Responses to Mental Health Crises Oversight Hearing Testimony

Before the New York City Council

Committee on Mental Health, Disabilities and Addiction

Jointly with the Committee on Public Safety, Committee on Hospitals, and the

Committee on Fire and Emergency Management

Sept 23, 2024

Thank you Chairs Lee, Salaam, Narcisse, and Ariola, and to the other members of these committees for convening this critical oversight hearing.

Good Morning! My Name is Tamara Begel, and I am an independent advocate for people of all ages including youth and young adults who experience mental health crises and/or developmental disabilities. I support my clients who are/have been in family homes and Residential Treatment Facilities in New York City and all individuals that need a peer response to a mental health crisis not a police.

I also serve on the Healthy Minds Health Kids Caregiver and Youth Council which is a statewide group who raise the voices of youth and caregivers to effect and improve policy and legislation to increase access to quality affordable mental health care.

I am here today to testify and support of the testimony provided by Correct Crisis Intervention Today - NYC (CCIT-NYC), a coalition of advocacy groups and other community organizations that consist of hundreds of community stakeholders, working to transform how New York City responds to mental health crises.

Individuals in the BIPOC community are disproportionately mis-treated by police, receive more severe responses that are punitive and forensic, not diagnosis, care, and treatment. A peers model has been shown to de-escalate mental health crises, care for individuals, and prevent discriminatory outcomes that plague the current response.

It is imperative that a cahoots style initiative as CCIT-NYC has called for it to be enacted as soon as possible as B-HEARD. I know from personal experience that an individual in crisis due to mental health disorders needs de-escalation, time, options, and connection. They often need a therapeutic approach and sometimes evaluation and medication. This is not the role of the police and in fact often directly conflicts with their training and mission. This is also not the job of EMTs. EMT's are charged with quick stabilization for transport to the hospital. But these are the groups generally tasked with supporting individuals and families during a behavioral health

crisis. Furthermore, while we have a few mobile crisis units, my experiences with them fell into two categories: either they were unable to show up in the midst of our actual crisis, but were only able to come to our home a few days later. Or they came at the time of the crisis but were staffed with recently graduated social workers. The team was not equipped with the appropriate level of training to handle our situation.

Importantly, the B-heards mission must include youth and people of all ages with developmental disabilities. While a peer must be a member of the team, we must ensure that the peer and whole team is able to work with a child in crisis including those with developmental disabilities who may be non-verbal. We have found that youth, young adults, individuals with disabilities and mental health disorders must be directly written into the plans, policy, legislation and included on task forces and oversight committees in order to ensure proper service.

Special consideration must be given to transition aged youth. The science shows that impulse control and decision making doesn't fully develop until age 25. Furthermore, there are several severe mental health conditions with typical onsets between late teens early twenties including bipolar disorder and schizophrenia.

While HIPPA laws are important, B-Heard teams must relay and voice and concerns of the family, friends, and household residents. Ensuring that proper weight is given to medical and treatment professionals when making care decisions. It is not an easy thing for families to ask for help. By the time families are asking for help they are desperate and often have endured hours, days, weeks, months, years of trauma. They likely also are in need of care.

Family/friend/housemate collateral must be considered and heeded during safety situations and Peer feedback supported. The opportunity for recidivism and unfortunate outcomes is too great when it comes to collateral not being considered.

My clients have developmental disabilities and/or mental health issues. When they need to be transferred to the hospital whether for severe depression, autistic meltdowns, or agitation they are always met by police and an ambulance, B-heard has not been called. If they are being transported by police they are cuffed. People with severe depression and other mental health conditions should not be treated as criminals. They deserve care, de-escalation, and support not handcuffs, guns and bully sticks. People with disabilities including children with developmental disabilities are 2.5 times more likely to have police involvement.

Even worse is the tens of thousands of kids across the city who encounter police when schools and parents need help with de-escalation, but these kids are cuffed and even processed when they are having tantrums, melt downs, and mental health crises. I highly recommend Dr. Karen Baptise's Documentary the Preschool to Prison Pipeline which details the severity and problem with Police response to youth and young adults in NYC. Children being transported to a hospital or in a mental health crisis should not be handcuffed, they should be de-escalated and receive supportive care. Our schools need more Graduate level behavior consultants (BCBA), peers, and mental health professional responses not handcuffs, fingerprinting, and take downs. Interestingly, there is a residential treatment facility in Queens that specifically treats individuals with developmental disabilities and mental illness, which is overseen by DHOMH and there aren't any BCBAS on staff!

Mental health care is health care! Mental health crises are a biological response to trauma, chemical imbalances, and electrical impulses within our bodies and they deserve a trauma-informed de-escalation by health care and treatment specialists including peers, not a justice or forensic system response.

Since 2015, 20 individuals have been killed by police officers while experiencing a mental health crisis in New York City. After decades of advocacy by CCIT-NYC and others, we appreciate New York City's attempts to shift crisis response through its Behavioral Health Emergency Assistance Response Division (B-HEARD) pilot. Responding to mental health calls with health professionals instead of law enforcement is essential—about a quarter of all fatal police shootings in the U.S. involve someone experiencing a mental health crisis. However, we have significant concerns with the program's current structure and outcomes to date.

The current B-HEARD structure is fundamentally flawed and still very much relies on NYPD. B-HEARD teams are only dispatched through 911 rather than 988, the new federal three-digit number for mental health crisis calls. 911 does not accept requests for a B-HEARD team response. Other issues pertaining to scope of service include that the program is not citywide or 24/7, leaving far too many citizens with police as first responders to their mental health crises. We have seen time and time again, most recently with the death of Win Rozario, that it is entirely inappropriate to send police in response to mental health crisis calls and their presence only creates deadly escalation.

I have had to call the police on my own son with Autism in the midst of a mental health crisis. I have training as a behavioral health technician, but one individual is not always able to de-escalate a situation. It is scary, heartbreaking, and done in desperation that you call the police, because you lose control of the situation. You worry that the police will only treat your child as a threat and not see the child desperately dysregulated in need of support and connection that only another individual can provide. Families today are isolated from family and neighbors. That extra pair of hands sometimes needs to be a stranger even if you are connected to mental health services, because in-home services are severely understaffed, under funded, and not open and available in the midst of a crisis. A few years after the police response, when my son was in a better place, we were talking about how he felt during those times. He was terrified that they were going to hurt him. He received more trauma from seeing guns, bully sticks, and handcuffs. This only reinforced that he was bad, a criminal, and his self-hatred. He had nightmares from those experiences. People in mental health crises deserve treatment and care not forensic, cold, hard justice, and binding.

CCIT-NYC calls for police to be completely removed as first responders to nonviolent mental health crisis calls, and for peers – people with lived mental health experience – to be a mandatory element of B-HEARD teams. Response teams that include people with lived experience will help to achieve the B-HEARD pilot goals by shifting the model to a person-centered approach rooted in genuine connection and communal well-being. Two key goals of B-HEARD are to increase connection to community-based care and

decrease hospitalizations. Yet just six percent of people who receive a B-HEARD response to a mental health crisis are transported to a community-based health care or social service location, and nearly 60% are still transported to the hospital. Peers have the skills and expertise to advocate for connection to community-based care and avoid unwanted and unnecessary transports to hospitals.

Although B-HEARD's geographic bounds have expanded some since its inception, and it is responding to a higher volume of overall calls, the number of calls directed to B-HEARD are not keeping up with the rate of the program's expansion. The most recently-available data shows that only about one in four people who place mental health crisis calls in a qualifying area get a B-HEARD response. In an interview with New York One, the program openly stated that teams only respond to a mere three to five calls per day. Finally, we need more transparency around the B-HEARD program to inform best practices and investments in crisis response. There has been no new data reported this fiscal year. The City must commit to regular reporting.

Of course, in order to continue to make progress towards its goals, the B-HEARD pilot will require sustained investment in the budget, starting with fully restoring the B-HEARD Program to Eliminate the Gap (PEG) cuts in the adopted budget. We look forward to working with the Chairs and members of these committees to improve B-HEARD and ensure that New Yorkers experiencing a mental health crisis receive the response they deserve.

FInally, I urge the city council to ensure that both youth and young adults are expressly written in and included in the B-HEARD pilot, program, and response. It is even more urgent that our young people receive Peers not Police. I urge you to adopt a more Cahoots model of crisis intervention and finally treat mental health care crisis as a medical/therapeutic/treatment problem not a justice or forensic concern. Please ensure that the peers and professionals on the team are trained for the unique needs of youth and young adults with mental health disorders and/or developmental disabilities. Additionally, because youth by definition are dependents and rely on a family system for housing and support, we need to adequately support the extended family system at the time of crisis. Attention needs to be paid to their needs and concerns in order to ensure the safety of the family unit and the longterm best outcomes for the youth, young adults, adults, and families. Mental health crisis response requires de-escalation, care, peers, and support, not forensic justice, handcuffs, and take downs.

Written testimony for B-HEARD oversight hearing
9/25/24

Non-police mental health crisis response is one of the greatest safety and wellbeing needs of New York City. As a community organizer canvassing in various neighborhoods, both talking to members of the public as well as workers in small businesses, one of the top issues that comes up in these conversations in the need to effectively manage individuals experiencing mental health disorders who may be untreated or who may be in a moment of crisis. Almost every single person I have spoken to does not think the police help these situations. The facts bear this out as we know that people with untreated mental health disorders are much more likely than the general population to be killed by a police officer.

And yet, from its inception the City's pilot was designed to default to the police to handle mental health crisis. I spoke with a couple of the people in the Mayor's office who designed B-HEARD and it was their intention that B-HEARD teams would respond to the majority of EDB 911 calls. This appears naive given that B-HEARD only responds to 911 calls or requests from police officers. 911 triaging systems are not built to appropriately manage mental health crises. Recently updated data provided on the City's B-HEARD website shows that a small percentage of EDB calls are responded to by B-HEARD teams and a very tiny percentage of individuals receive a behavioral health assessment, despite the fact that this type of assessment is evidence-based practice.

I would echo the sentiments of others that there is an appalling lack of transparency around the B-HEARD program and the process and outcomes evaluation data. The data are incomplete in a number of regards, such as why are so few calls triaged to a B-HEARD team, why are so many recipients still being routed to a hospital, and why are so few being assessed comprehensively? I also agree that the design of B-HEARD to prioritize 2 EMTs and 1 credentialed social worker on B-HEARD teams has been a problem from the start. People with lived experience should be at the core of these teams. No amount of training is going to have a police officer replace a person with lived experience. And the requirement of a social worker, while nice in intention, is not practical. The City, like most of the county, has a shortage of mental health professionals with licensed credentials.

Please redesign this program in the following ways: separate mental health crisis response from 911 (such as through 988 or another dedicated number), require a person with lived experience on B-HEARD teams that could either replace the social worker role or, if available, be a team member in addition to a social worker, expand B-HEARD hours/number of teams/catchment areas, revise the algorithm for who gets sent to an EBP situation because too many are ending up at the hospital or otherwise not comprehensively assessed in the field, and create a community advisory board of interested members of the public that reviews B-HEARD data and gives input on program design and problem-solving at least quarterly.

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ________ Res. No. ________
☐ in favor ☐ in opposition

Date: ________

(PLEASE PRINT)

Name: Chaplain Dr. Victoria A. Phillips - Dr. V
Address: 99 Wall St, ste 813, NY, NY 10005
I represent: Visionary V Ministries, Souls Action Co...
Address: ________

THE COUNCIL
THE CITY OF NEW YORK

61

Appearance Card

I intend to appear and speak on Int. No. ________ Res. No. ________
☐ in favor ☐ in opposition

Date: ________

(PLEASE PRINT)

Name: PRISCILLA GRIM
Address: [redacted] Brok...
I represent: self.
Address: ________

THE COUNCIL
THE CITY OF NEW YORK

60

Appearance Card

I intend to appear and speak on Int. No. 0532 Res. No. ________
☑ in favor ☐ in opposition

Date: ________

(PLEASE PRINT)

Name: IMANI MOORE
Address: 55-11 QUEENS BLVD
I represent: RAZI SCHOOL
Address: SAME AS ABOVE

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ______ Res. No. ______
☐ in favor ☐ in opposition

Date: 9/23/24

(PLEASE PRINT)

Name: Amber Song

Address: 120 Wall Street, New York, NY 10005

I represent: Asian American Federation

Address: 120 Wall Street, New York NY 10005

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ______ Res. No. ______
☐ in favor ☐ in opposition

Local Law #2

Date: 9/23/24

(PLEASE PRINT)

Name: Dr. Khadejah Jean Pryce

Address: 222 E. 97th St NY NY

I represent: Teach Coalition.

Address: ______

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 586-24 Res. No. ______
☐ in favor ☐ in opposition

Date: 9/23/24

(PLEASE PRINT)

Name: Logan Clark

Address: ______

I represent: NYC Independent Budget Office

Address: ______

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ______ Res. No. ______
☐ in favor ☐ in opposition

Date: 09/23/2024

(PLEASE PRINT)

Name: Arlene Machado

Address: 1535 University Ave Bronx NY 10453

I represent: The Center for Justice Innovation

Address: ______

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 532 Res. No. ______
☑ in favor ☐ in opposition

Date: 9/23/24

(PLEASE PRINT)

Name: Deanna Philippe

Address: ______

I represent: Cristo Rey Brooklyn High School

Address: 710 East 37th Street, Brooklyn NY 11203

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ______ Res. No. ______
☐ in favor ☐ in opposition

Date: 9/23/24

(PLEASE PRINT)

Name: JOELLE BALLAM-SCHWAN

Address: 247 W 37th St

I represent: The Supportive Housing Network of NY

Address: [redacted] Brooklyn 11222

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ________ Res. No. ________
☐ in favor ☐ in opposition

Date: ________

(PLEASE PRINT)

Name: Jonathan Chung

Address: ________

I represent: National Alliance on Mental Illness-NYC

Address: ________

THE COUNCIL
THE CITY OF NEW YORK 5d

Appearance Card

I intend to appear and speak on Int. No. ________ Res. No. ________
☐ in favor ☐ in opposition

Date: ________

(PLEASE PRINT)

Name: Kimberly Saltz

Address: 211 east 13th street

I represent: Legal Defense Fund

Address: ________

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ________ Res. No. ________
☐ in favor ☐ in opposition

Date: ________

(PLEASE PRINT)

Name: Leah Faria

Address: 8 W 126th St ny ny 10027

I represent: The Womens Community Justice Association

Address: 8 W 126th St ny ny 10027

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ______ Res. No. ______
☑ in favor ☐ in opposition

Date: ______

(PLEASE PRINT)

Name: Annalicia Williams
Address: ______
I represent: ______
Address: ______

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ______ Res. No. ______
☐ in favor ☐ in opposition

Date: 9/23/2024

(PLEASE PRINT)

Name: Sasha Myrie
Address: ______
I represent: ______
Address: ______

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ______ Res. No. ______
☐ in favor ☐ in opposition

Date: ______

(PLEASE PRINT)

Name: Bholan Pierre
Address: 1090 Eastern Parkway
I represent: Eudes Pierre
Address: ______

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ______ Res. No. ______
☐ in favor ☐ in opposition

Date: 9/23/24

(PLEASE PRINT)

Name: Alex Blass

Address: 255 West End Ave Apt 8A

I represent: CCIT Colleges Cities Innovation Job-[illegible]

Address: ______

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ______ Res. No. ______
☐ in favor ☐ in opposition

Date: ______

(PLEASE PRINT)

Name: Erin Acosta

Address: 3

I represent: Growing Up Green Charter Schools

Address: ______

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ______ Res. No. ______
☐ in favor ☐ in opposition

Date: ______

(PLEASE PRINT)

Name: Aaron Miner

Address: [redacted] Bronx, NY 10468

I represent: ______

Address: ______

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ______ Res. No. ______
☐ in favor ☐ in opposition

Date: ______

(PLEASE PRINT)

Name: Peggy Herrera
Address: Inwood
I represent:
Address:

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ______ Res. No. ______
☐ in favor ☐ in opposition

Date: ______

(PLEASE PRINT)

Name: Ramon Leclerc
Address:
I represent: New Alternatives for Homeless LGBTQ Youth
Address:

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ______ Res. No. ______
☐ in favor ☐ in opposition

Date: ______

(PLEASE PRINT)

Name: Michael Nugent
Address: Queens, NY 11375
I represent: [illegible] Street Wellness Solutions
Address: 9 Bond St Brooklyn NY

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ________ Res. No. ________
☐ in favor ☐ in opposition

Date: 9/23/24

(PLEASE PRINT)

Name: Jim Bohovich
Address: 235 Ocean Pkwy, 11218
I represent: Community Access
Address:

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ________ Res. No. ________
☐ in favor ☐ in opposition

Date:

(PLEASE PRINT)

Name: Clarisa Alayeto
Address:
I represent: DREAM CHARTER School
Address: 1991 Second AVE

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ________ Res. No. ________
☐ in favor ☐ in opposition

Date:

(PLEASE PRINT)

Name: RAYmond Schwartz
Address: 309 W. 104th St
I represent: CCIT NYC
Address:

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ______ Res. No. ______
☑ in favor ☐ in opposition

Date: 9/23/24

(PLEASE PRINT)

Name: Robin Graham

Address:

I represent: Peers to help during 988 & 911 calls

Address:

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ______ Res. No. ______
☐ in favor ☑ in opposition

Date:

(PLEASE PRINT)

Name: Jordyn Rosenthal

Address: 1 State Street

I represent: Community Access

Address:

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ______ Res. No. ______
☐ in favor ☐ in opposition

Date:

(PLEASE PRINT)

Name: Bella Sotong Pane

Address:

I represent: Korean American Family Service Center

Address:

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 532 Res. No. ______
☑ in favor ☐ in opposition

Date: 9/23/24

(PLEASE PRINT)

Name: YERUCHIM SILBER
Address: [redacted] Brooklyn
I represent: Agudath Israel
Address: 42 BROADWAY

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ______ Res. No. ______
☐ in favor ☐ in opposition

Date: ______

(PLEASE PRINT)

Name: Kayla Hackman
Address: [redacted] New York, NY 10038
I represent: myself
Address: ______

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ______ Res. No. ______
☐ in favor ☐ in opposition

Date: ______

(PLEASE PRINT)

Name: Sakeena Trice
Address: 151 W. 30th Street NY, NY 10001
I represent: New York Lawyers for Public Interest
Address: ______

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ______ Res. No. ______

☑ in favor ☐ in opposition

Date: 09/23/24

(PLEASE PRINT)

Name: Alexandra Nyman

Address: 97 Margaretta Ct SI, NY

I represent: Break Free Foundation

Address: ______

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ______ Res. No. ______

☐ in favor ☐ in opposition

Date: 9/23/2024

(PLEASE PRINT)

Name: Rev Terry Troia

Address: 100 Park Ave Staten Island NY

I represent: Project Hospitality + Supportive Housing Network of NY

Address: 100 Park Ave SINY

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ______ Res. No. ______

☐ in favor ☐ in opposition

Date: 9/23/24

(PLEASE PRINT)

Name: Galloway

Address: NY, NY

I represent: ______

Address: ______

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ________ Res. No. ________
☐ in favor ☐ in opposition

Date: ________

(PLEASE PRINT)

Name: Helen Skipper
Address: 1575 Odell St
I represent: NYC Justice Peer Initiative
Address: ________

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ________ Res. No. ________
☐ in favor ☐ in opposition

Date: 09/23/2024

(PLEASE PRINT)

Name: Alison Wilkey
Address: ________
I represent: Coalition for the Homeless
Address: 129 Fulton st NY NY

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ________ Res. No. ________
☐ in favor ☐ in opposition

Date: 9/23/24

(PLEASE PRINT)

Name: MARK LASTER, LCSW
Address: [redacted] 11372
I represent: MYSELF
Address: ________

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ________ Res. No. ________

☐ in favor ☐ in opposition

Date: 9/23/24

(PLEASE PRINT)

Name: Cassandra Kelly

Address: 40 Thomas St

I represent: Legal aid

Address: ____________

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ________ Res. No. ________

☐ in favor ☐ in opposition

Date: 9/23/24

(PLEASE PRINT)

Name: Tamara Begel

Address: ____________

I represent: ____________

Address: ____________

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ________ Res. No. ________

☐ in favor ☐ in opposition

Date: 9/23/24

(PLEASE PRINT)

Name: KATHERINE BAJUK ("BYE-YOOK")

Address: NYCDS

I represent: ____________

Address: ____________

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ______ Res. No. ______
☑ in favor ☐ in opposition

Date: ______

(PLEASE PRINT)

Name: Grace Nichols
Address: [redacted] Augusta ME
I represent: Act Up
Address: NYC

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ______ Res. No. ______
☐ in favor ☐ in opposition

Date: ______

(PLEASE PRINT)

Name: Andrew Smith
Address: ______
I represent: SELF
Address: ______

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 332 Res. No. ______
☑ in favor ☐ in opposition

Date: ______

(PLEASE PRINT)

Name: Sydney Altfield - Exec Director
Address: Tech NYC
I represent: 150 Broadway, NY NY
Address: ______

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 532 Res. No. ______

☑ in favor ☐ in opposition

Date: ______

(PLEASE PRINT)

Name: Joseph Rosenberg - Exec Director

Address: 191 Joralemon St

I represent: Catholic Community Relations Council

Address: ______

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 532 Res. No. ______

☑ in favor ☐ in opposition

Date: ______

(PLEASE PRINT)

Name: Khadijah Pryce - Principal

Address: Islamic Cultural Center School

I represent: ______

Address: 222 E 97th St, Manhattan

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ______ Res. No. ______

☑ in favor ☐ in opposition

Date: ______

(PLEASE PRINT)

Name: Bracha Rutner - Principal

Address: Yeshiva University High School for Girls

I represent: 86-86 Palo Alto St

Address: Holliswood, Queens

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 532 Res. No. ______
☑ in favor ☐ in opposition

Date: ______

(PLEASE PRINT)

Name: Deanna Philippe - Principal
Address: Cristo Rey Brooklyn High School
I represent: 710 E 37th St, Brooklyn
Address: ______

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ______ Res. No. ______
☐ in favor ☐ in opposition

Date: 9/23/24

(PLEASE PRINT)

Name: Nicholas Tishuk
Address: ______
I represent: Bedford Stuyvesant New Beginnings
Address: 82 Lewis Ave, Brooklyn, NY

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ______ Res. No. ______
☐ in favor ☐ in opposition

Date: ______

(PLEASE PRINT)

Name: Princess Benn James
Address: [redacted]
I represent: ______
Address: ______

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ________ Res. No. ________
☐ in favor ☐ in opposition

Date: ________

(PLEASE PRINT)

Name: Mohammad Razvi
Address: 1081 Coney Island Ave
I represent: Council of Peoples Org.
Address: ________

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ________ Res. No. ________
☐ in favor ☐ in opposition

Date: ________

(PLEASE PRINT)

Name: Captain Michael Butler
Address: Interagency Operations
I represent: NYPD
Address: ________

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ________ Res. No. ________
☐ in favor ☐ in opposition

Date: ________

(PLEASE PRINT)

Name: Deputy Chief Ebony Washington
Address: Communications
I represent: NYPD
Address: ________

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ________ Res. No. ________
☐ in favor ☐ in opposition

Date: ________

(PLEASE PRINT)

Name: Joshua Levin
Address: NYPD Director of Legislative Affairs
I represent: NYPD
Address: ________

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ________ Res. No. ________
☐ in favor ☐ in opposition

Date: ________

(PLEASE PRINT)

Name: Chief Olufunmilola Obe
Address: Training
I represent: NYPD
Address: ________

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ________ Res. No. ________
☐ in favor ☐ in opposition

Date: ________

(PLEASE PRINT)

Name: Chief Cesar Escobar
Address: Emergency Management Systems Operations
I represent: NYC FDNY
Address: ________

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ________ Res. No. ________

☐ in favor ☐ in opposition

Date: ________

(PLEASE PRINT)

Name: Jaime Neckles

Address: Assistant Commissioner of Mental Health

I represent: NYC DOHMH

Address: ________

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ________ Res. No. ________

☐ in favor ☐ in opposition

Date: ________

(PLEASE PRINT)

Name: Jason Hansman

Address: Senior Advisor of Behavioral Health Communications and Policy, Office of Behavioral Health

I represent:

Address: NYC Health + Hospitals

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ________ Res. No. ________

☐ in favor ☐ in opposition

Date: ________

(PLEASE PRINT)

Name: Laquisha Grant

Address: Deputy Executive Director of Mental Health Access

I represent:

Address: Mayor's Office of Community Mental Health (OCMH)

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ________ Res. No. ________

☐ in favor ☐ in opposition

Date: ________

(PLEASE PRINT)

Name: Eva Wong

Address: Executive Director

I represent: Mayor's Office of Community Mental Health (OCMH)

Address: ________

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ________ Res. No. ________

☐ in favor ☐ in opposition

Date: ________

(PLEASE PRINT)

Name: Chaplain Dr. Victoria A Phillips / - Dr. V

Address: 99 Wall St Ste 813 NY, NY 10005

I represent: Visionary V Ministries / Saints Action Coalition / Mental Health Project / Urban Justice Center

Address: ________

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ________ Res. No. ________

☐ in favor ☐ in opposition

Date: ________

(PLEASE PRINT)

Name: Monica Harris

Address: ________

I represent: My community

Address: ________

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ________ Res. No. ________
☐ in favor ☐ in opposition

Date: 9-23-2024

(PLEASE PRINT)

Name: Victor N. Herrera
Address: 22-44 Jackson Ave
I represent: Freedom Agenda
Address:

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ________ Res. No. ________
☐ in favor ☐ in opposition

Date:

(PLEASE PRINT)

Name: Jenna Schuzert
Address: Brooklyn, NY
I represent:
Address:

Please complete this card and return to the Sergeant-at-Arms