

**June 9, 2020**

**Testimony of**  
**Ruth Lowenkron, Disability Justice Director**  
**on behalf of**  
**New York Lawyers for the Public Interest**  
**before**  
**the Council of the City of New York**  
**Committee on Public Safety**  
**regarding**  
**New York City's Response to**  
**Individuals Experiencing Mental Health Crises**

Good morning. My name is Ruth Lowenkron and I am the Director of the Disability Justice Program at New York Lawyers for the Public Interest (NYLPI). Thank you for the opportunity to present testimony today regarding the critical issue of how New York City must reform its system for responding to individuals who are experiencing mental health crises by eliminating the police from the equation entirely.

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

to respond are health care providers and mental health advocates<sup>1</sup>. Police, who are trained to uphold law and order are not suited to deal with individuals experiencing mental health crises, and New York’s recent history of its police killing 15 individuals who were experiencing crises, and seriously injuring two others, in the last four years alone, is sad testament to that. Eliminating the police as crisis responders will result in people who experience mental health crises recovering more quickly, becoming connected with long-term healthcare services and other community resources, and averting future crises<sup>2</sup>.

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

The recently-renamed [Correct Crisis Intervention Today – NYC](#) (CCIT-NYC), of which NYLPI has long been a member, has developed the needed antidote. Modeled on the [CAHOOTS](#) (Crisis Assistance Helping Out On The Streets) program in Eugene, Oregon, which has successfully operated for over 30 years without any major injuries to respondents or responders, CCIT-NYC has drafted a proposal which will provide 24/7 responses to mental health crises by emergency medical technicians and trained

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<sup>1</sup> Martha Williams Deane, *et al.*, “Emerging Partnerships between Mental Health and Law Enforcement,” *Psychiatric Services* (1999), [http://ps.psychiatryonline.org/doi/abs/10.1176/ps.50.1.99?url\\_ver=Z39.88-2003&rfr\\_id=ori%3Arid%3Acrossref.org&rfr\\_dat=cr\\_pub%3Dpubmed&doi/abs/10.1176/ps.50.1.99?url\\_ver=Z39.88-2003&rfr\\_id=ori%3Arid%3Acrossref.org&rfr\\_dat=cr\\_pub%3Dpubmed](http://ps.psychiatryonline.org/doi/abs/10.1176/ps.50.1.99?url_ver=Z39.88-2003&rfr_id=ori%3Arid%3Acrossref.org&rfr_dat=cr_pub%3Dpubmed&doi/abs/10.1176/ps.50.1.99?url_ver=Z39.88-2003&rfr_id=ori%3Arid%3Acrossref.org&rfr_dat=cr_pub%3Dpubmed).

<sup>2</sup> 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](http://ps.psychiatryonline.org/doi/10.1176/appi.ps.52.2.219?utm_source=TrendMD&utm_medium=cpc&utm_campaign=Psychiatric_Services_TrendMD_0).

<sup>3</sup> Mayor’s Office for People with Disabilities, “Accessible NYC” (2016), [https://www1.nyc.gov/assets/mopd/downloads/pdf/accessiblenyc\\_2016.pdf](https://www1.nyc.gov/assets/mopd/downloads/pdf/accessiblenyc_2016.pdf).

<sup>4</sup> CCIT-NYC, Testimony before the Committee on Public Safety (June 9, 2020).

“peers” – those with lived mental health experience. The police would not be permitted to respond unless the mental health crisis response contacts the police for assistance because the person experiencing the mental health crisis is taking action which is causing serious bodily harm to self or another person, or the person wields a weapon to credibly threaten imminent and serious bodily harm to self or another specific person. More details about the proposal are attached as Exhibit A. Notably, the proposal was drafted prior to the pandemic and the massive protests of police abuse, and the proposal suggests a slow phase-in with a pilot in two police precincts to be studied over five years. Given the current need to reform the New York Police Department en masse, NYLPI strongly urges immediate implementation of the CCITNYC proposal in all precincts city-wide.

Thank you for your consideration. I can be reached at (212) 244-4664 or [RLowenkron@NYLPI.org](mailto:RLowenkron@NYLPI.org), and I look forward to the opportunity to discuss the implementation of the CCIT-NYC proposal to eliminate the police as first responders to individuals experiencing mental health crises.

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### About New York Lawyers for the Public Interest

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

NYLPI’s Disability Justice Program works to advance the civil rights of New Yorkers with disabilities. In the past five years alone, NYLPI disability advocates have represented thousands of individuals and won campaigns improving the lives of

hundreds of thousands of New Yorkers. Our landmark victories include integration into the community for people with mental illness, access to medical care and government services, and increased accessibility of New York City's public hospitals. Working together with NYLPI's Health Justice Program, we prioritize the reform of New York City's response to individuals experiencing mental health crises. Last week we celebrated our second court victory forcing the New York Police Department to turn over the body-worn camera footage from the officers who shot and killed an individual experiencing a mental health crisis.

# EXHIBIT A



CORRECT CRISIS INTERVENTION TODAY

FIGHTING TO TRANSFORM RESPONSES TO MENTAL HEALTH CRISES

## **Piloting a Peer-Driven Mental Health Crisis Response Program**

### **The need:**

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

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

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

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

In response to the taskforce’s suggestions, the City proposed adding only five mobile crisis teams to respond to crisis calls. However, the minimal increase in mobile crisis teams does not even come close to serving a city of 9,000,000 people and countless visitors. And critically, the mobile crisis teams cannot respond to 911 emergency calls. Mobile crisis teams also do not have a means to transport people to drop-in centers, hospitals, or other appropriate healthcare resources. If transport is required, mobile crisis team members must call 911.

In addition, mobile crisis teams at best respond to the immediate crisis at hand, and do little to ensure the mental health recipient is connected to longer- term community resources. Mobile crisis teams do not always have a peer on staff and utilize the no-longer acceptable "medical model," which often focuses narrowly on medication rather than a person's ability to recover and live well. Moreover, mobile crisis teams consist of five staff members and are relatively expensive.

New York also has Health Engagement Assessment Teams (HEAT teams) which consist of one peer – an individual with lived mental health experience – and one clinician. But HEAT teams are only used by police for areas of outreach that do not involve any active risk, and, like mobile crisis teams, they cannot be deployed to 911 mental health crisis calls and they cannot transport anyone.

#### **Where would the pilot be located?**

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

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

The new mental health crisis response team would embody existing best practices in non-police alternative mental health crisis response, and consist of one peer trained as a crisis counselor and one emergency medical technician (EMT). Having a peer on the team is essential, as a person with lived experience, a person who has "been there," can best relate to the fear of an outsider responding in a moment of crisis, and can prove that recovery works. An EMT worker is needed as many crisis calls may involve physical health issues which are masked by the mental health crisis.

The mental health crisis response team would be recruited in accordance with established hiring guidance developed by the New York City Department of Health and Mental Hygiene (DOHMH).

The mental health crisis response teams will consist of peers who have worked with people in crisis, such as those who have worked in crisis respite centers, and also have experience in de-escalating crises. It would be desirable for the peers to either have lived or worked in the areas in which they are hired to serve.

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

In addition, the pilot requires 1 Project Director, 2 Supervisors and 1 Administrator.

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

**What type of training will the pilot provide?**

The consumer affairs office of DOHMH will be responsible for training all mental health crisis response teams, as well as all NYC Well staff involved in the pilot. In addition, DOHMH's consumer affairs office will be responsible for training all 911 operators as the operators are likely to respond to mental health crisis calls.

DOHMH's consumer affairs office can contract with an independent, peer-driven entity that delivers training such as the New York Association of Psychiatric Rehabilitation Services (NYAPRS) or People, Inc.

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

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

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

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

**Under what circumstances may the operator at NYC Well or the mental health crisis response team involve the police?**

The presumption is that all calls to the 988/WEL line will go to the new mental health crisis response teams. If one calls the 988/WEL line, one wants a non-police health response, and one should receive a non-police health response.

However, once the NYC Well operator refers the call to the mental health crisis response team, and the mental health team believes police are required, the team may contact the police. The

team may only contact the police when the following exception applies: the person is taking action which is causing serious bodily harm to self or another person, or the person wields a weapon to credibly threaten imminent and serious bodily harm to self or another specific person (hereinafter referred to as “the Exception”). Items such as a pocket knife or scissors do not constitute such a weapon.

In instances where the Exception applies, mental health teams should be dispatched *in conjunction* with the NYPD.

When there is doubt in the call taker’s mind as to whether the Exceptions applies, a mental health team should be sent -- *not* the police. The mental health team on the scene can then determine if police are needed.

When two callers describe the circumstances differently, and one of the callers describes the circumstances as constituting the Exception, the police should not be sent; the mental health team should be sent instead. If there are more than two callers, and the majority describe the circumstances as constituting the Exception, the police should be sent – together with the mental health team.

Call takers should not automatically take the word of a caller over the word of the person in crisis, in terms of when to send police, but rather must carefully weigh any differences in descriptions of the crisis to determine the appropriate response. The person experiencing the mental health crisis should be believed as much as the person calling 911.

Mental health teams will respond if a person experiencing a mental health crisis is alleged to be likely to cause imminent and serious bodily harm to self or to a specific other person, and the person making the allegation is at a different location from the individual experiencing the crisis.

For a mental health crisis in a residential setting, the relationship between the individual calling 911 and the person experiencing the crisis is an important factor to weigh, in order to respond to the crisis. The caller may have instigated the person experiencing the crisis or made false allegations about the person.

It is up to the mental health crisis response teams to call for police back-up, and they may only do so if the above Exception is met.

All mental health crisis response team members will carry police radios hooked into the police dispatch system which permit immediate calls for police back-up when needed.

**How will calls to 911 be diverted to the mental health crisis response teams?**

Although the new mental health crisis number will be highly publicized (see below), individuals may, out of habit or lack of knowledge of the new number, call 911.

Mental health crisis calls received by 911 will be routed to the mental health crisis response teams under the same protocols as are used by NYC Well and as set forth above.

If it is determined by the 911 dispatcher that a police response is required pursuant to such protocol, NYPD must dispatch a co-response team -- a police officer together with a healthcare worker. The police must advise the caller whether it will be a mental health crisis response team or a co-response team which will respond to the call.

The radios that the mental health crisis response teams wear will also allow police to call the mental health teams if the police become aware of a person experiencing a mental health crisis.

The police *must* call the mental health crisis response team if the police became aware that the person involved is experiencing a mental health crisis and the Exception is not met. The police must advise the caller whether it will be a mental health crisis response team or a co-response team which will respond to the call.

**How long will the pilot last?**

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

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

**How much will the pilot cost?**

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

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

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

**Which city agency will run the pilot?**

The pilot will be run by the Consumer Affairs Department of the New York City Department of Health and Mental Hygiene.

### **Who will monitor the pilot?**

The pilot will be monitored by an oversight board consisting of peers (constituting 51% of the board) and staff of NYC Well, the support and connection centers, the crisis respite centers, DOHMH, NYPD, the New York State Department of Health (DOH), the New York State Office of Mental Health (OMH), the New York City Department of Homeless Services (DHS), the New York City Human Resources Administration (HRA), the New York City Department of Corrections (NYC-DOCS), New York State Department of Corrections (NYS\_DOCS), the New York City Fire Department (FDNY), the District Attorney for the relevant borough, the Public Defender for the relevant borough, the Office of the Comptroller, the Community Board for the relevant precinct, the Public Advocate, the relevant Borough President, City Council, and the New York State Legislature.

### **How will the pilot be monitored?**

The oversight board will:

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

There will be one oversight board for all pilot precincts.

### **How will data be collected?**

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

### **How will the pilot be funded?**

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

**How will the pilot be publicized?**

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