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

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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

[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

[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).
- If a person is arrested, the associated penal code charge or whether it was as a result of an outstanding warrant.

[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

- 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.