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IMPROVING NEW YORK CITY’S RESPONSES TO INDIVIDUALS IN MENTAL HEALTH CRISIS
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EXECUTIVE SUMMARY

This report investigates how New York City responds to individuals experiencing mental health crisis. Examining the flaws in current protocols and the best practices of approaches applied in other cities, it presents a framework for an improved response system that would provide those in crisis with the services that they need and minimize the negative outcomes that are currently far too common.

Mental health impacts us and all who surround us, in a very intimate way. Yet, we are not as attentive and diligent with our mental health care as we are with our physical health. In fact, suicide rates in our country are up overall.¹ Further, NYPD officer suicide rates are significantly outpacing this already increasing national average.² While this report focuses on how New York City can aid individuals in mental health crisis, it is our responsibility to acknowledge NYPD officers are impacted and deserve treatment free of stigma or shame.

In 2018, the New York City Police Department (NYPD) received 179,569 emergency calls involving individuals in mental health crisis.³ NYPD officers are usually the first to arrive on the scene in spite of the fact that most officers are not properly trained to deal with these difficult situations. These circumstances run the risk of escalating, leading to unnecessary uses of force and involvement with the criminal justice system.

In the past three years, at least fifteen individuals in mental health crisis have been shot and killed by NYPD officers, demonstrating the failures of the City’s current approach all too clearly.⁴ In defaulting to a law enforcement response to mental health crises, the City applies the lens of criminality to what is first and foremost a health issue. In order to rectify this pressing issue, New York City must address mental health crises with public health solutions.

A crucial first step is to minimize the occurrence of mental health crises on the front end. By investing fully in respite care centers; drop-in centers; mental health urgent care

⁴Ibid.
centers; and safe havens, the City can proactively improve the mental health of its communities. These services provide real alternatives to emergency rooms and jail cells for vulnerable New Yorkers.

When mental health crises do occur, the City must focus its efforts on providing those in crisis with the services they need to avert immediate danger and advance to quick recovery. These services are best provided by those who specialize in them: social/crisis workers, medics, and mental health peers; not law enforcement officers who specialize in addressing crime. Thus, models for non-police responses to non-criminal emergencies should be researched and implemented.

In order to address the problem in the immediate future, New York City must ensure that all police officers who interact with the public receive Crisis Intervention Training (CIT) within an expedited time-frame and on a regular basis. Further, protocols and technology must be developed so that 911 operators, police dispatchers, and responding officers are able to identify mental health crisis situations and respond in an appropriate manner that prioritizes de-escalation.

A FAILING RESPONSE SYSTEM

From 2009 to 2018, calls for so-called “Emotionally Distressed Persons” (EDPs) have nearly doubled, rising from 97,132 to 179,569 citywide. Despite the increased prevalence of these calls, New York City has yet to develop a comprehensive strategy for responding to people experiencing mental health crises.

Source: NYPD and New York City Council Budget. Kazi Awal / The City.
As a response to both community dissatisfaction and the recommendations of Mayor de Blasio’s Task Force on Behavioral Health and Criminal Justice, the NYPD launched the Crisis Intervention Team (CIT) training program in 2015.\(^5\) The purpose of CIT training is to give NYPD officers better tools and experience to safely and properly handle calls for individuals in mental health crisis. Yet even after the launch of the CIT training program, unnecessary use of force by police dealing with individuals in mental health crisis persists. In the past three years, at least fifteen individuals in mental health crisis were shot and killed by NYPD officers.\(^6\)

One victim, Deborah Danner, a 66 year old woman from the Bronx who lived with mental illness for 30 years, was fatally shot by a police sergeant during a confrontation in her apartment on October 18th, 2016.\(^7\) Officers from Ms. Danner’s local precinct were familiar enough with her that they visited her apartment multiple times to intervene when she engaged in erratic behavior, yet the officer who shot her was not trained to deal with people in mental health crisis.

Another victim, Dwayne Jeune from Brooklyn was killed on July 31st, 2017 in an NYPD encounter after Jeune's mother called 911 saying her son was acting erratically and requesting help. While three of the four officers on site had been trained in CIT, the singular officer who had not been trained in CIT pulled out his gun and opened fire on Jeune five times, killing him.\(^8\) Following this tragedy, a coalition of community members, mental health advocates, and elected officials called for the administration to form a Task Force that would address the issue of mental health crisis response. However, the administration rejected these calls.

In the wake of this inaction, on April 4th, 2018, Saheed Vassell from Brooklyn was killed in another incident. Vassell was known by community members and the local precinct to have a mental health condition, but had not previously demonstrated threatening or dangerous behavior. Three calls were made to 911 to report concerns about Vassell, who was walking on the street holding a metal pipe in a similar fashion to a gun. In an ideal response system, officers from the local precinct who had knowledge of Vassell’s

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5 NYCDOT, “Putting Training into Practice: A Review of NYPD’s Approach to Handling Interactions with People in Mental Crisis,” ibid.
8 Eli Rosenberg and Ashley Southall, ibid.
diagnosis and history of police interactions would have responded to the situation. Instead, the NYPD dispatched five officers to the scene from the anti-crime unit and the strategic response group that is nominally tasked with counter-terrorism efforts. Members of this unit opened fire within seconds of their arrival, resulting in Vassell’s death.

After Vassell’s death, the administration finally launched Crisis Prevention and Response Task Force on April 19, 2018. This Task Force was meant to develop a comprehensive citywide strategy for EDP situations within 180 days. However, more than 500 days after its creation, this Task Force failed to present a report and propose recommendations. This inaction helps keep the city at risk for even more tragedies. Since the Task Force was convened, two additional New Yorkers have died.

One of these incidents occurred on September 17, 2018, when police in Queens shot and killed Susan Muller - a woman living with a mental health condition - who was known by the police in her local precinct and for whom there was a “history of police calls.” On the day she was shot, police dispatchers sent four officers, none of whom were from her local precinct. Three of the four officers had not received specialized training to handle people in mental health crisis.

STATISTICS ON POLICE ENCOUNTERS

In contrast to public perception, the vast majority of people with mental health problems are no more likely to be violent than anyone else. As the U.S. Department of Health & Human Services explains, “Most people with mental illness are not violent and only 3%–5% of violent acts can be attributed to individuals living with a serious mental illness. In fact, people with severe mental illnesses are over 10 times more likely to be victims of violent crime than the general population.”

The likelihood of being killed by a police officer also increases dramatically for individuals living with a mental illness. Data on police shootings nationwide highlights

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the significantly higher rate of police shootings of individuals who have mental health diagnoses, which, along with young men of more color, is extraordinarily high.

- *The risk of being killed during a police incident is 16-times greater for individuals with untreated mental illness than for other civilians approached or stopped by officers.*
- *Black men and boys are more than 2.5 more likely than white men and boys to die during an encounter with police.*

The stark reality of these statistics is more dramatic when considering the higher rates of African Americans who live with mental health conditions. Nationally, African Americans are 20 percent more likely than any other Americans to experience serious mental health problems.

Even where police interactions do not lead to fatalities, many such encounters lead to arrest or detention of individuals in mental health crisis, as opposed to being referred for mental health services. The criminalization of individuals with mental health conditions is one more facet of the American epidemic of over-incarceration that has had an extremely damaging impact on those in crisis and their families. New York City should be better equipped at guiding individuals in distress to mental health resources and other social service supports rather than jail.

**REDUCING THE NUMBER OF MENTAL HEALTH CRISSES THAT REQUIRE EMERGENCY RESPONSE**

The first step that New York City needs to take to improve its response to mental health crises is to minimize the number of incidents that require emergency response. By investing in respite care centers, mental health urgent care centers, drop-in centers for those with mental health concerns, and safe havens for people with mental health concerns, New York City can put systems in place for folks to mitigate mental health issues before they become crises that require a 911 call.

**Respite Care Centers**

Respite Care Centers provide an alternative to hospitalization for those in crisis. They offer stays for up to one week in supportive settings that allow individuals to maintain their regular schedules and have guests visit. Trained staff provide the following services that help resolve crisis situations:

- 24-hour support from peers (individuals with lived experience of receiving mental health services and trained to provide support to others)
- self-advocacy education
- self-help training
- group and one-on-one activities, including: yoga, art, poetry, wellness self-management, meal planning, and meditation¹⁶

Currently, there are only eight centers operating in New York City. Increasing funding for and developing new respite centers in areas with high volumes of 911 calls would provide these critical services to those who need them.

**Drop-In Centers**

Drop-ins centers are multi-service facilities for homeless New Yorkers that provide a variety of services including food, social work, and referrals to needed programs. Five of these centers currently exist in the City. Expanding the number of centers is an important step, as currently the entire borough of Queens does not have one.

**Mental Health Urgent Care Centers**

Mental health urgent care centers are a yet to be implemented idea in New York City. They would provide people experiencing a mental health crisis with a short-term alternative to a hospital, with services specifically tailored to the mental health concerns.

Los Angeles County has opened five of these centers to great success, handling 27,000 visits last fiscal year. In addition to providing superior care, these centers have created a reduction in overcrowding in emergency rooms and in the number of crises that escalate. County supervisor Mark Ridley-Thomas said of the centers, “Not only is it more humane, it is more cost effective, makes us better stewards of public resources, to build more urgent care centers than to build more jails.”¹⁸

¹⁸ Ibid.
Safe Havens for Those with Mental Health Concerns

Safe Havens are a type of immediate temporary housing for homeless individuals that offer supportive services, including mental health and substance abuse programming. Notably, individuals are not required to be sober upon entry or during their stay and individuals are typically referred to safe havens by homeless street outreach teams rather than through the city’s central shelter intake. These characteristics, in addition to the absence of additional restrictions put in place at traditional shelters, are designed to help the large population of homeless people who have intentionally avoided shelters in the past. Case managers work with those staying at Safe Havens to secure permanent housing.  

As of 2015, there were 10 Safe Haven locations in New York City with a total of 667 beds. Expanding the scope of the Safe Haven program would help in preventing mental health crises.

Further Investment in Community-Wide Mental Health

While this report focuses specifically on immediate prevention and responses to mental health crises, it is important to acknowledge that there are broader socioeconomic factors that negatively impact mental health, including poverty, lack of housing, and discrimination in all of its forms. In order to comprehensively address the issue of mental health crisis, it is imperative that New York City invest in community based organizations that mitigate these factors.

A NON-POLICE RESPONSE TO NON-CRIMINAL EMERGENCIES

With the understanding that mental health crises must be addressed through a public health framework rather than a law enforcement one, the City must introduce a model for non-police response to non-criminal emergencies.

CAHOOTS (Crisis Assistance Helping Out on the Streets) is a program administered by the community group White Bird Clinic that partners with the police departments of Eugene and Springfield, Oregon to provide specifically tailored mental health resources in case of crisis without involving law enforcement. While the CAHOOTS model has not been implemented in a city as large and diverse as New York, it provides an extremely valuable case study in how a system for non-police response to non-criminal emergencies can be successfully implemented. Details on this model are provided below.

Dispatching Teams

CAHOOTS teams are dispatched in two ways. The first is directly through the 911 dispatching system, which will identify when a situation is appropriate for a CAHOOTS team to respond rather than police, or alternatively if both CAHOOTS and police should respond.

The second is a non 911 dispatch line, designed specifically for non-emergency mental health situations. Having this line allows for people experiencing mental health crises or those around them to feel comfortable calling for response to get needed services, while knowing that it won’t initiate a full-blown police response that could escalate the situation or criminalize the person in crisis.

Per department statistics, CAHOOTS responds to 17 percent of all emergency calls in Eugene and Springfield.21

Services Provided

CAHOOTS teams are made up of a mental health crisis worker and an emergency medical technician. Once on site, these teams can provide a number of services including but not limited to

- Crisis Counseling
- Suicide Prevention, Assessment, and Intervention
- Conflict Resolution and Mediation
- Grief and loss
- Substance Abuse
- Housing Crisis
- First Aid and Non-Emergency Medical Care

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• Resource Connection and Referrals
• Transportation to Services²²

Coordination with Police

CAHOOTS is designed to provide an alternative to law enforcement whenever possible in crisis situations.²³ Tim Black, Operations Coordinator for CAHOOTS, estimates 80% of CAHOOTS dispatches do not have law enforcement involvement.²⁴ However, CAHOOTS and the Eugene and Springfield Police Departments coordinate closely with one another, in case either entity needs the other’s presence. For example, in the rare instances in which the threat of violence emerge during a CAHOOTS case, CAHOOTS responders can directly radio the police and request backup. Similarly, when the police respond to a case and determines that a mental health crisis is occurring and requires a health-oriented response rather than a law enforcement one, it radios CAHOOTS and requests their assistance on site.

Using Learnings from Past Encounters to Inform Future Ones

Each encounter a CAHOOTS team has is logged detail, noting the names and addresses of the people who were a part of the interaction, any mental health diagnoses they might have, and important behavioral patterns.

The teams utilize these logs every time they are dispatched, to cross reference the incoming call with past interactions. This allows responders to identify what type of help a person might need based on past experience. This practice is crucial in minimizing unproductive and potentially violent encounters.

Benefits

In addition to providing more appropriate services, a public health oriented response to mental health crisis has two other important benefits. First, with CAHOOTS primarily tasked with addressing mental health crises, police are free to do what they do best: tackling crime.

Police officers have incredibly difficult jobs. Their jobs are unnecessarily made even more difficult when they are asked to act as social workers and mental health professionals, specialized roles that they are not trained to perform. A law enforcement

²² White Bird Clinic, “Mobile Crisis Services in Eugene and Springfield”
²³ Ibid.
driven response model to mental health crisis fails to provide vulnerable people with the care that they need and pulls police officers away from their crucial public safety, law enforcement, traffic management, counterterror, and emergency response roles.

The second benefit is cost. Though CAHOOTS has administrative costs, diverting people experiencing crisis from the emergency room or the criminal justice system provides significant savings. New York City spent a total of $302,269 per detainee in fiscal year 2018.  

Limitations

While the success of the CAHOOTS program demonstrates the functionality of a non-police response to mental health crises, there are limitations in its applications thus far. First, with a combined population of less than 250,000, Eugene and Springfield are relatively small cities when compared with a city like New York. Significant considerations would need to be made when considering how to implement a similar program at scale. Additionally, the relative racial homogeneity of these cities also stand in stark contrast to New York’s diversity-- Eugene is 84% White and Springfield is 87.5% White. Given the historically fraught relationships that many communities of color have with policing, this complicates how a model like CAHOOTS could be implemented in New York.

Implementing a Non-Law Enforcement Model in New York City

Recognizing the success of the CAHOOTS program in Oregon, many cities have begun looking at how to adopt a non-law enforcement model. Denver recently launched a pilot

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27 United States Census, “Quickfacts Springfield, city Oregon”, 2018. [https://www.census.gov/quickfacts/eugene/or](https://www.census.gov/quickfacts/eugene/or)

28 United States Census, “Quickfacts Eugene, city Oregon”, 2018. [https://www.census.gov/quickfacts/eugene/or#qf-headnote-a](https://www.census.gov/quickfacts/eugene/or#qf-headnote-a)

29 United States Census, “Quickfacts Springfield, city Oregon”, 2018. [https://www.census.gov/quickfacts/springfield/or#qf-headnote-a](https://www.census.gov/quickfacts/springfield/or#qf-headnote-a)
program based on CAHOOTS and Oakland has allocated $40,000 to studying how to.\textsuperscript{30}

New York City has developed a Mobile Crisis Team program, through NYC Well, that is similar to CAHOOTS model. It sends out a team of health professionals, such as nurses, social workers and psychiatrists, who can provide mental health services including assessment, crisis intervention, supportive counseling, and information and referrals. There are currently approximately 24 Mobile Crisis Teams across Brooklyn, the Bronx, Manhattan, and Queens.\textsuperscript{32}

However, Mobile Crisis Teams can currently only be accessed through the 11-digit long NYC Well phone line and online form. None of the hundreds of thousands of calls to 911 regarding mental health crisis that occur annually will result in one of these teams being deployed. This results in the City not using this crucial resource when they are most needed.

Additionally, these Crisis Teams do not currently have the resources to respond immediately to crises, instead responding within 48 hour window of time from when the initial referral takes place. New York City must improve the response times of these teams, so that they can provide emergency services. Partnering the teams with local community based organizations could be an effective way to make this happen.

Research should begin on how New York City can integrate non-police Mobile Crisis Teams to the 911 dispatching system. Additional research should be done on non-law enforcement response models to mental health crisis that explicitly differ from the CAHOOTs model. Following this research, the city could launch a pilot program in neighborhoods with particularly high call volume and then expand citywide.

When considering how non-police teams can best serve New York in all of its diversity, an initial proposal is to hire staff who are individuals from the communities that the teams serve, speak their languages, and are steeped in their cultural norms.

\textbf{Considerations for Moving Forward}

\textsuperscript{31} Sigal Samuel, “Calling the cops on someone with mental illness can go terribly wrong. Here’s a better idea,” 1 July. 2019, Vox, \url{https://www.vox.com/future-perfect/2019/7/1/20677523/mental-health-police-cahoots-oregon-oakland-sweden}
\textsuperscript{32} NYC Department of Health, “Crisis Services/Mental Health: Mobile Crisis Teams” \url{https://www1.nyc.gov/site/doh/health/health-topics/crisis-emergency-services-mobile-crisis-teams.page}
It is critical that the voices of peers, people with direct involvement with mental health crisis, are included in discussions the City has moving forward on the issue. Through their lived experience, peers bring an important point of view that will be essential in developing a more effective response system to crises.

Additionally, the families of directly affected people must have their voices in these conversations.

Further, given the disproportionate impact that this issue has on Black and Brown communities and concerns around the composition of the Crisis Prevention and Response Task Force, any future bodies convened around this issue must prioritize racial representation and equity.

**IMPROVING CRISIS INTERVENTION TRAINING AND ADDITIONAL NYPD PROTOCOLS**

The New York City Police Department’s Crisis Intervention Team training, launched in 2015, is designed to build capacity and provide appropriate tools for patrol officers dealing with individuals in mental health crisis. In partnership with the City’s Department of Health and Mental Hygiene, the training emphasizes de-escalation strategies, active listening skills, and reducing officers’ fear and anxiety of individuals in mental health crisis.

As New York City’s current primary response system to mental health crisis, it is crucial that this program function effectively. If the City were to adopt a non-police response model to mental health crises, ensuring that police officers are equipped to deal with these situations would remain integral.

**Expanding CIT Training**

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33 NYC DOI, “Putting Training into Practice: A Review of NYPD’s Approach to Handling Interactions with People in Mental Crisis,” Ibid.
While the NYPD’s CIT training is a positive reform, the program in its current iteration is simply not enough. As of March 2019, approximately 11,970 of the NYPD’s 36,753 uniformed officers have completed CIT training. With close to 200,000 911 calls concerning individuals in mental health crisis each year, the current number of officers trained in CIT cannot bring about meaningful changes citywide in how police officers handle these interactions.

The consequences of this lack of training can be tragic as in the case of Dwayne Juene, who was killed by the singular officer, of the four on site, who had not been trained in CIT. In order to avoid future tragic events like this, the NYPD must train all of its officers who interact with the public in CIT. In order to ensure the efficacy of this training, the NYPD must retrain these officers in CIT annually.

Monitoring and Evaluating the CIT Program

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35 New York City Police Department, About NYPD, https://www1.nyc.gov/site/nypd/about/about-nypd/about-nypd-landing.page

The New York City Department of Investigation’s (DOI) January 2017 report called “Putting Training Into Practice: A Review of NYPD’s Approach to Handling Interactions with People in Mental Crisis” identified the NYPD’s current inability to collect adequate data to analyze the CIT initiative. This inability significantly hinders the City’s ability to effectively respond to mental health crises.

Monitoring and evaluation can help improve the impact of the comprehensive CIT program in the City. This includes information gathered from past 911 calls concerning individuals with mental health crisis to identify trends and better predict specific areas where future incidents are likely to occur. By measuring positive outcomes and the efficiency of the program, the City can best allocate its resources to components that are successful and set realistic goals towards achieving its objectives of helping every single New Yorker who may be going through mental health crisis.

In this aim, the Office of the Inspector General for the NYPD should evaluate and report on the efficacy of CIT training on a regular basis.

Further, accountability mechanisms must be developed in order to ensure that CIT standards are upheld.

**Appropriately Dispatching CIT-Trained Officers**

The DOI report identified another serious problem with the current CIT program: the inability of the 911 dispatching system to direct CIT-trained officers to situations in which they are specifically needed.  

It is essential that the City’s 911 technology has the capacity to identify calls that require CIT and dispatch the officers who have appropriate training to the locations where they’re needed. Without changing this critical aspect, there is no way to ensure that appropriately-trained officers will be on the scene of these incidents.

**Further Improving Dispatching**

Additionally, when officers are dispatched, they need to be receiving more context-specific information so that they can know if they are responding to an EDP situation. In order for this to occur, 911 operators, police dispatchers, and responding officers all need to be able to identify and effectively relay when a mental health crisis is occurring. Additionally, all known information about past police encounters, documented

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37 NYC DOI, “Putting Training into Practice: A Review of NYPD’s Approach to Handling Interactions with People in Mental Crisis,” Ibid.
mental health diagnoses, and current behavior patterns must be conveyed to responding officers.

A tragic example of this need is the death of Bronx man, Kawasaki Trawick on April 14, 2019. The security guard in Trawick’s building called 911, repeatedly saying that Trawick was “losing his mind all day.”38 Despite this, the incident was never designated as an EDP situation, which likely contributed to the situation escalating once NYPD arrived. Without having the full knowledge of the situations they are entering, NYPD officers cannot resolve these situations to the best of their ability.

**Integrating Neighborhood Coordination Officers**

One mechanism that can be used to improve the flow of information to officers in the immediate future is the integration of Neighborhood Coordination Officers (NCOs). As the NYPD describes,

> “The NCOs serve as liaisons between the police and the community, but also as key crime-fighters and problem-solvers in the sector. They familiarize themselves with residents and their problems by attending community meetings with neighborhood leaders and clergy, visiting schools, following up on previous incidents, and using creative techniques and adaptive skills.”39

Given this unique role, NCOs are well positioned to provide the NYPD with precinct and sector level information regarding neighborhood residents who have a history of mental health crisis and may be at risk of experiencing similar crises in the future. By ensuring that responding officers have crucial relevant information, the NYPD can better provide at-risk New Yorkers with the help that they need.

**RECOMMENDATIONS**

1. New York City must aid in reducing the number of mental health crises, as well as the number of people calling 911 regarding mental health crises, by funding the following services: respite care centers, mental health urgent care centers, drop-in centers for those with mental health concerns, safe havens for people with mental

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39 New York City Police Department, “Neighborhood Policing.”

https://www1.nyc.gov/site/nypd/bureaus/patrol/neighborhood-coordination-officers.page
health concerns. These services must be easy to access, open to the public 24/7, and prioritize serving those neighborhoods that struggle most with crises.

The best way to manage mental health crises is to prevent them from occurring in the first place. A well-funded system of the services above would provide people with mental health conditions resources and support that can stop crisis situations from emerging. When crises do occur, these centers offer alternative pathways to recovery that do not necessitate a stay in the emergency room or a jail cell.

Further, investment in community based organizations that improve overall quality of life subsequently improve citywide mental health, and must be prioritized.

2. New York City must increase funding for the Mobile Crisis Team program so that response times can improve.

The services offered by Mobile Crisis Teams are crucial to successfully managing difficult situations. However, given the current fiscal constraints of the program, these teams cannot offer immediate emergency response, severely limiting their efficacy. Fully equipping these teams with the resources that they need is extremely critical.

Additionally, the City should explore how partnering this program with local community based organizations could further this aim.

3. New York City must create an alternate non police department number to call for those in mental health crisis to get urgent immediate treatment.

Whether by assigning NYC Well with an easier to remember three digit number and equipping it with emergency response capabilities, or by creating an entirely new phone number and system, this is a crucial step to ensuring that New Yorkers can easily request emergency response to mental health crises.

4. New York City must research and evaluate models for responding to 911 calls that do not involve the police.

Developing a citywide non-police response system to non-criminal emergencies would improve services and minimize the negative consequences associated with unnecessary escalation in mental health crisis situations. New York City must study the CAHOOTS model first implemented in Eugene, Oregon and other models that center impacted people in order determine how a public health-oriented approach can be implemented in New York City in all of its size and diversity. When implementing a model, peers, people with lived mental health experience, must be included as non-police respondents.
5. New York City must ensure that all police officers who interact with the public receive Crisis Intervention Training (CIT) within an expedited timeframe, and that all officers receive annual retraining in CIT. In addition, the Office of the Inspector General for the NYPD must evaluate and report on the efficacy of CIT training on an annual basis. Further, accountability mechanisms must be put in place to ensure that CIT standards are upheld, and ensure there are correspondingly appropriate consequences when these standards are violated.

Since the NYPD launched the Crisis Intervention Team (CIT) training program in 2015, less than one-third of police officers have received this training. Given the large 911 call volume on mental health crises, this is unacceptable. By learning and reinforcing de-escalation strategies, active listening skills, and reducing officers’ fear and anxiety of individuals in mental health crisis, CIT provides a crucial framework for all members of the NYPD who interact with the public. Annual reporting and accountability mechanisms around the CIT training will ensure that scope and efficacy of the program.

6. New York City must improve its training, protocols, and technology so that operators and dispatchers are able to identify mental health crisis situations and send CIT-trained officers on site.

The NYPD’s current flow of information for mental health crisis situations is insufficient at multiple levels. In the interactions between 911 callers and 911 operators, 911 operators and police dispatchers, and police dispatchers and responding police officers, crucial information regarding mental health are often either not identified or not relayed. This creates situations in which non CIT trained officers respond to mental health crisis incidents without knowing the full context of the incident, increasing the risk for escalation and tragedy. Improved dispatching practices could be an important factor in improving police response.

7. New York City must include peers on all advisory councils and task forces moving forward.

Peers, people who have lived experience with mental health conditions, have distinctly valuable insight into these issues at hand. This must also take into account the disproportionate impact felt in communities of more color. Yet, too often their voices are excluded in the important discussions that have serious implications for how the City addresses mental health crises. In order to develop a truly comprehensive plan on this issue, the City must include peers on all advisory councils and bodies relating to mental health crisis response. Additionally, the families of directly affected people must have their voices in this conversation.
CONCLUSION

In the past three years, at least fifteen individuals in mental health crisis have been shot and killed by NYPD officers. It could not be clearer that the City’s current approach to addressing mental health crisis is failing. We do not have enough systems in place to help prevent New Yorkers with mental health issues from experiencing crisis, and when these crises do occur, we respond to them punitively.

By investing in crucial mental health services on the front end, we can work to reduce the constantly growing number of calls to 911 regarding mental health crisis. When crises occur, the services of mental health crisis workers and emergency medical technicians are needed. In the immediate future, we need to expand the scope and increase the frequency of the NYPD’s Crisis Intervention Training and improve dispatching communications, so that when police engage with these situations, they are equipped to resolve them effectively. Moving forward, we need to research how to implement a non-police response to non-violent mental health emergencies.

Mental health crises are health issues not criminal ones, and New York City has a duty to respond to them as such. By adopting the recommendations of this report, New York City can reduce the number of mental health crises, provide people in crisis with the help that they need, and ensure that calls meant to save lives do not end them.

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