Mayor's Office of ThriveNYC

Committee on Mental Health, Disabilities, and Addictions
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Testimony of Susan Herman, Senior Advisor to the Mayor and Director of the Mayor's Office of ThriveNYC

Good morning, Chair Louis and members of the Committee on Mental Health, Disabilities, and Addictions. My name is Susan Herman and I am a Senior Advisor to the Mayor and Director of the Mayor's Office of ThriveNYC. I am joined by several colleagues: Dr. Myla Harrison, Acting Executive Deputy Commissioner of the Division of Mental Hygiene at the Department of Health and Mental Hygiene; Chief Terri Tobin, Chief of Intergovernmental Operations at the NYPD; Dr. David Prezant, Chief Medical Officer for the FDNY; and Dr. Rebecca Linn-Walton, Assistant Vice President, Behavioral Health at NYC Health + Hospitals. Thank you for the opportunity to testify.

First, I would like to extend a warm welcome to Chair Louis. We enjoyed a close and productive partnership with former Chair Ayala, and we are very much looking forward to working with you as you take over chairing this important committee.

The Mayor's Office of ThriveNYC, created in 2019, is the first Mayoral office devoted to promoting access to mental healthcare for New Yorkers. We currently oversee 30 programs designed to close critical gaps in mental healthcare through innovation. Our programmatic budget as well as data about the reach and impact of our work are all on our website.

In addition, we promote cross-agency collaboration and help shape mental health policy in the City. This work includes chairing the Crisis Prevention and Response Task Force of over 80 experts from the nonprofit sector, elected leaders, and City government. We also chair the Mental Health Council, which includes the leadership of over 30 City agencies working together to maximize the City's mental health-related initiatives.

PROGRESS ON MENTAL HEALTH CRISIS PREVENTION AND RESPONSE SINCE 2014

Over the last seven years, the City has made great progress strengthening how we prevent and respond to mental health crises. We appreciate that the City Council has been a critical partner in this effort. The legislation we are discussing today should be viewed in the context of what we have seen work and the progress already underway.

I would like to begin by discussing crisis prevention. Many mental health crises can be prevented if people are able to access and stay connected to needed care. Yet for decades, too many New Yorkers have gone without mental health treatment or support when and where they have needed it. There are 17 federally designated mental healthcare shortage areas in New York City. Like food deserts, these are neighborhoods without sufficient access to mental healthcare. One way we have worked to increase access to care is by changing the mental healthcare landscape.

Thrive programs have added hundreds of new service locations across the City, over 70% of which are in the federally designated mental healthcare shortage areas.

We have partnered with 13 City agencies and nearly 200 community-based organizations to add new, onsite support in over 200 high-need schools, 100 shelters for families, 45 centers for older adults, every precinct and PSA in the City, and all runaway and homeless youth residences. We also support 57 mobile treatment teams that bring intensive, ongoing clinical care to people with serious mental health needs, right in their communities.

We have also expanded access to services through NYC Well, the City's comprehensive mental health helpline that serves as a gateway to care thousands of times every week. Starting out as a suicide hotline, NYC Well now answers calls, texts and chats for a wide range of behavioral health needs. It offers immediate support, referrals for ongoing treatment, and when appropriate, deploys mobile crisis teams to respond to urgent concerns in person. In 2020, NYC Well answered an average of 6,200 requests for support every week.

These new services build on a strong foundation. Apart from its partnership with ThriveNYC, the Department of Health and Mental Hygiene spends nearly $500 million annually for people with mental health concerns, substance misuse, and intellectual and developmental disabilities. Among other services, this includes supportive housing, crisis respite centers, mobile treatment, and school-based mental health services.

NYC Health + Hospitals, apart from its partnership with ThriveNYC, invests about $800 million every year in acute inpatient and outpatient behavioral health services. The Department of Homeless Services street outreach teams and Safe Havens increasingly connect people to behavioral healthcare. And, NYC Care, our citywide guarantee of health care, includes behavioral health services.

The City has made significant progress over the last seven years. A lot of new work began in 2014 with the Task Force on Behavioral Health and the Criminal Justice System, which brought together over 300 advocates, practitioners, academics, and government officials to develop recommendations to reduce the number of people with behavioral health needs who cycle through the criminal justice system. All of these recommendations are now underway-- including new support for people awaiting trial or detained in the City's jails, Crisis Intervention Training for police officers, and Support and Connection Centers (formerly known as Diversion Centers), which offer short-term stabilization services to people with mental health and substance use needs. The East Harlem Support and Connection Center, which opened a year ago, gives police officers an alternative to avoidable emergency room visits or enforcement interventions.

The City's collaborative work on mental health crises continued through the recommendations of the Crisis Prevention and Response Task Force, approved by the Mayor in 2019.

Even with the COVID-19 pandemic and a fiscal crisis, we have brought many of these recommendations to life. While we could not add more ACT mobile treatment teams as we had

planned because of the State's cap on Medicaid, we have added 4 new Intensive Mobile Treatment Teams-- fully funded by the City-- bringing the total capacity of all the mobile treatment teams functioning in the City to almost 4,000 clients at any given time. These teams continue to make a profound difference in people's lives. For example, during the first 3 months of the fiscal year, we could see that of those clients who began receiving IMT services while homeless – many of whom were experiencing street homelessness – 47% moved into permanent housing during their engagement with IMT and 90% of clients stayed connected to treatment for 12 or more months. Mobile treatment teams serve people who otherwise might never have been connected to either housing or treatment – and they are no doubt helping to prevent crises.

The result? Right now, with all of the new services in place, New York City provides more mental health support – to more people, in more places, and in more ways – than ever before.

STRENGTHENING CRISIS RESPONSE IN 2021

Now I would like to discuss crisis response.

Not all crises require an emergency response. Some mental health crises require an urgent, but not an immediate response. For that reason, we have also enhanced our mental health urgent response infrastructure. Mobile Crisis Teams include clinicians and peers who provide in-person assessments and connection to care for people experiencing behavioral health crises. These teams are deployed about 20,000 times a year by NYC Well, public hospitals and healthcare providers. Because of the Crisis Prevention and Response Task Force, they will soon be able to respond to people within a few hours during the day and early evening, every day of the year. This reflects great improvement from only a year ago when most responses were the next day and weekend calls resulted in significant delays.

As more New Yorkers become aware of this service and experience it, we hope to see more and more people turning to NYC Well and Mobile Crisis Teams – rather than 911.

As we enter 2021, following several years in which more mental health services have been available to New Yorkers, and we are both preventing and responding to crises more effectively, we are beginning to see the tide turn.

Mental health emergencies are declining. From 2008 to 2018, the number of mental health 911 calls in New York City nearly doubled, increasing every year and in every precinct. In 2019, the total number of calls dropped for the first time in a decade, by 5% or over 8,000 calls. In 2020, the number of calls fell by another 6% or over 9,000 calls. And, according to a recent evaluation of NYC Well, more than 20 percent of surveyed NYC Well users who contacted NYC Well for themselves reported that they would have considered calling 911 or going to an emergency room if not for NYC Well. They knew they had another option.

To continue this positive momentum, in November 2020, the Mayor announced that for the first time in our history, health professionals will be the default response to 911 mental health crisis calls.

This new health-centered approach – called B-HEARD (the Behavioral Health Emergency Assistance Response Division) – will be a critical step forward in the City's commitment to treat mental health crises as public health problems, not public safety issues. Currently, NYPD officers and FDNY/EMS Emergency Medical Technicians (EMTs) respond to all mental health crisis calls to 911. This is regardless of the severity of the mental health need, or whether a crime is involved, or whether there is an imminent risk of violence—all 911 mental health calls get this joint response. Beginning in Spring 2021 in Northern Manhattan (specifically, the 25, 28, and 32 precincts in East and Central Harlem), the new Mental Health Response Teams of Health and Hospitals social workers and FDNY EMTs will be the new primary response to mental health emergencies. In emergency situations involving a weapon or imminent risk of harm, NYPD officers and EMTs will continue to respond as before.

Mental Health Response Teams will have the experience and expertise to de-escalate crisis situations and respond to a range of behavioral health problems, such as suicidal ideation, substance misuse, and serious mental illness, as well as physical health problems, which can be exacerbated by, or mask, mental health problems.

This pilot has been shaped by a steering committee that includes FDNY, NYC Health + Hospitals, the Department of Health and Mental Hygiene, NYPD and the Mayor's Office of ThriveNYC. We have been intentional about its design. We have consulted cities across the country that are undertaking similar work and have met with members of the Crisis Prevention and Response Task Force, advocates from Correct Crisis Intervention Today (CCIT-NYC), and elected officials to hear their thoughts.

First, we think it makes good sense to build on the tremendous capacity and decades of experience within FDNY's Emergency Medical Services, which currently responds to over 150,000 mental health emergencies every year. EMTs will be able to arrive on the scene within minutes and have expertise to assess and treat many health issues.

Second, Health and Hospitals, the largest public hospital system in the country, is the City's behavioral health safety net, operating psychiatric emergency departments, as well as inpatient and outpatient behavioral healthcare. H+H also manages several Mobile Crisis Teams and assertive community treatment teams or ACT teams that offer ongoing mobile treatment to people with serious mental illness in their communities.

EMS and H+H both have deep experience running emergency operations. These are the right partners to create the right teams of experienced EMTs and social workers. And they are the right partners to provide the appropriate training and supervision for these teams.

Third, in introducing this entirely new service to NYC, we have ensured that we are integrating lessons learned in other jurisdictions. Our model builds on the most established program in the country: CAHOOTS (Crisis Assistance Helping Out On The Streets) in Eugene, Oregon. CAHOOTS, a program of a community-based clinic, handles cases sent by their 911 system. Designed to address a wide array of physical and mental health problems in non-violent situations, CAHOOTS teams of paramedics and social workers responded to approximately 24,000 calls last year.

New York City will be the largest city to rollout this kind of an approach. To inform our pilot, we have also spoken to large cities such as Denver, Chicago, and San Francisco that are just beginning this work, as well as nearby Ulster, Albany, and Orange counties. All of these programs are dispatched out of 911. There are many similarities with our model: Every model is using a social worker or clinician and an emergency medical responder (an EMT or a paramedic). No team exceeds three people. No team is directly providing medical transports to hospitals; each is calling ambulances to provide transport where needed.

Denver and San Francisco are basing their teams within the emergency medical services function of their fire departments, as we are, and contracting out for social workers to add to their teams. Chicago is pursuing a hybrid model: they plan to hire some mental health professionals directly through their health department and contract with community partners to hire others. They want to test both approaches. None of these team will respond to 911 calls that involve violence. While there is some variation in how cities define "violence," the presence of a weapon automatically excludes these new teams from responding in every city we have spoken to -- including the CAHOOTS model in Oregon.

The design of New York City's pilot differs from models elsewhere in several key ways. Some cities are integrating pre-existing mobile crisis teams into their 911 system. In New York City, Mobile Crisis Teams respond to urgent situations, not emergencies. In some cities, peers are part of the crisis response team in addition to mental health clinicians. Denver and San Francisco's models are overseen by their local public health authorities; however, in both of these cities, their health authority includes the entire public hospital system. In New York City, our public hospital system is a separate entity – Health + Hospitals. There are also some limitations on the kinds of situations teams respond to – for instance, in San Francisco, teams are only dispatched to public locations.

In big cities nationwide – health-centered approaches to mental health emergencies – are new. Denver's began in June 2020, San Francisco's in November 2020, and Chicago is aiming to begin in summer 2021. There are few established best practices yet in large cities; we are all designing these initial pilots carefully and learning from one another.

Fourth, we wanted to ensure that the teams in the pilot phase are based in communities with sufficient operational infrastructure to support rapid implementation and a range of community mental healthcare options. We needed to select a single 911 radio dispatch zone – usually two or three contiguous precincts – where everyone is on the same radio frequency, making dispatch

easier. We chose zone 7 – which includes the 25, 28, and 32 precincts or East Harlem, and parts of north and central Harlem because of the high volume of mental health calls. Zone 7 had 9,058 mental health 911 calls in 2019; and 7,446 calls between January and November 2020, the most in the City. H+H has hospitals, clinics, and a psychiatric emergency program in this zone, and the new East Harlem Support and Connection Center, which offers short-term stabilization services, is there as well. Furthermore, EMS has facilities nearby that could be quickly adapted to serve as a base for operations.

We have been hard at work – operational protocols are nearly finalized, the training is designed, and hiring is underway. We will launch as soon as everyone is hired and trained. Once we launch, we will monitor this pilot to ensure we can scale as quickly as possible. Specifically, we will gather detailed data on metrics such as: the percentage of mental health 911 calls selected for the new teams; the number of times the new teams are dispatched; the time from dispatch to arrival on scene; the kinds of locations to which the teams are dispatched; and how calls are resolved.

This pilot represents an important change in how New York City responds to mental health crises, and it is imperative that we get it right. We want to make sure the protocols are correct, the training is sufficient, and the staffing levels are right – before we expand.

Given the work currently underway, the City shares a commitment to the spirit of Intro. No. 2210, which would create an office of community mental health and a citywide mental health emergency response protocol. However, we think it is premature to mandate citywide implementation of a different model. There is too much to learn from the pilot to decide now to use a very different approach.

The City also has concerns with Int. No. 2222, which would create a three-digit mental health emergency hotline. As I mentioned earlier, a recent independent evaluation of NYC Well made clear, many New Yorkers are already turning to this helpline instead of calling 911 or going to an emergency room. Staffed by trained counselors and peers, NYC Well can provide immediate crisis counseling and suicide prevention as well as dispatch Mobile Crisis Teams to provide in-person assessments for people experiencing a behavioral health crisis. The City has invested in capacity at NYC Well, refined its services, and conducted significant outreach to New Yorkers to encourage them to contact this helpline.

In addition, last summer the FCC enacted rules to establish 988 as the 3-digit phone number to connect people in crisis with suicide prevention and mental health crisis counselors. By July 2022, all phone service providers will connect 988 calls to the existing National Suicide Prevention Hotline. In NYC, NYC Well answers National Suicide Prevention Hotline calls. As such, we believe existing infrastructure already accomplishes many of the aims contemplated in Int. No. 2222.

We have not found an alternative three-digit number in any jurisdiction in the country that dispatches emergency responses. We teach our children from a very young age to call 911 in any

kind of emergency – whether it is a safety problem, a fire, or a health crisis. You shouldn't have to think hard about who to call in an emergency. If it's an emergency, call 911.

I thank this Committee for your ongoing partnership and commitment to continuing to strengthen mental health crisis prevention and response in our city. We are happy to answer any questions you have.