Testimony of

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At a New York City Council Oversight Hearing:

<u>"Examining the Roles of the NYPD and the Department of Health and Mental Hygiene in Responding to Calls to the Police Involving Emotionally Disturbed People"</u>

<u>"Resolution 1249 by Council Members Dickens and Vann – Resolution calling on the Mayor, the NYPD and DOHMH to continually reevaluate their protocols and response to field incidents concerning the apprehension of, restraint of, and use of lethal force against emotionally disturbed persons."</u>

The Committee on Mental Health, Mental Retardation,
Alcoholism, Drug Abuse and Disability Services
Hon. G. Oliver Koppell, Chair

The Committee on Public Safety
Hon. Peter Vallone, Jr., Chair

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INTRODUCTION

Chairman Koppell, Chairman Vallone, distinguished members of the respective Committees, thank you for inviting us to testify before you today on the topic of the dual roles of the New York City Police Department (NYPD) and the Department of Health and Mental Hygiene (DOHMH) in responding to the needs of New Yorkers who are experiencing a psychiatric crisis. My name is Michael Polenberg, and I am the Director of Policy & Advocacy for the Coalition of Behavioral Health Agencies, the umbrella advocacy organization of New York's behavioral health community, representing over 100 non-profit community-based mental health and substance abuse agencies in New York City and surrounding areas. Our members constitute a broad cross section of service providers – all sizes from very small to very large; treatment and rehabilitation-oriented; outpatient and residential; focused on linguistically and culturally specific populations and on many special-needs – serving more than 350,000 individuals in the five boroughs of New York City and its environs.

Before we begin our formal testimony, we'd like to offer our profound sympathies to the family, friends and colleagues of Kathryn Faughey, the psychologist who was tragically killed in her Manhattan office earlier in the month. The terrible murder of one of our fellow New Yorkers deeply affects us all, and we share in the grief that accompanies this kind of senseless killing.

It is important, too, to keep in mind the following: this morning, tens of thousands of New Yorkers living with schizophrenia, bi-polar disorder, major depression, and other

mental health disorders woke up, got dressed, went to school, went to work, attended day programs, sought comfort from family and friends, took medication, pursued wellness through exercise, proper diet and smoking cessation, and made plans to see a movie, join with friends and family, have dinner, or read a book. In other words, the overwhelming majority of New Yorkers living with mental illness, including major illness such as schizophrenia and bipolar disorder, do not require the kinds of emergency services which are the subject of today's hearing. Make no mistake: each of these tens of thousands of people represents a profound victory for the strength of the community mental health system, the advances in pharmacology, the adoption of the principles of rehabilitation and recovery, the commitment of government at all levels to helping those in need and the personal resilience of these individuals. In respect to the ordinariness of their days, they are very much like all of us.

We are supportive of the in-depth look that the Council is taking at how the NYPD and DOHMH respond to New Yorkers in crisis, and is calling for periodic re-examinations of training protocols related to this issue. Since the police are often the first to respond in these cases, it is critically important that they are properly trained and equipped to relate to and deal with someone with a mental illness who is potentially posing a danger to him or herself or others. It is just as important that sufficient numbers of mobile crisis teams are readily available for those instances where specialized psychiatric expertise is required. Moreover, the State should consider funding additional Assertive Community Treatment (ACT) Teams to provide the appropriate level of care to certain consumers discharged from psychiatric

hospitalization. Protocols should be developed for these teams in dealing with resistant clients and in potentially threatening situations.

One issue that the Coalition is working on with colleagues from around the State has to do with the gaps in the continuity of mental health care for some New Yorkers. The transition, for example, from inpatient to outpatient care, is not always seamless. There is tremendous pressure on hospitals to empty beds for consumers once their symptoms have subsided and the insurance will no longer pay for their inpatient stay. Depending on their level of functioning, consumers are generally referred to some form of aftercare, including intensive or supportive case management and Assertive Community Treatment (ACT) teams. In most cases, the process consists of a phone call and submission of paperwork from the hospital to a centralized referral bank (the Single Point of Access, or SPOA), which in turn refers the consumer's file to a provider who has the capacity and expertise to offer the appropriate level of care (case management or ACT team) in the neighborhood where the consumer lives. By the time the provider receives the case file, however, the consumer has likely been discharged from the hospital and is now somewhere – anywhere -- in the five boroughs of New York. An inordinate amount of time is spent by case management teams trying first to locate the consumer before even the most rudimentary elements of aftercare can be provided. This hardly strikes us as the most efficient way to deliver services. The problem is further compounded when the case managers have no central number to call to find out, for example, if the consumer has been re-admitted into any of the city's public or private hospitals.

Another problem has to do with the level of aftercare assigned to New Yorkers with serious mental illnesses. In general, patients who are preparing to be discharged from hospitalization are referred to the level of care that most appropriately meets their needs. ACT teams, which are referred to as "clinics on wheels", offer the most service-rich options for these consumers and include psychiatrists and psychiatric nurse practitioners who are authorized to call for an involuntary hospitalization if a danger exists. The next levels, Intensive Case Management (ICM) and Supportive Case Management (SCM), utilize social workers to help connect consumers to services (benefits, housing, medical care, treatment, etc.).

But the referral process depends to a certain extent on the availability of the proper aftercare slot. If a consumer requires the services of an ACT team based on his or her assessed ability to function in the community, and willingness (or unwillingness in this case) to access traditional clinic or day treatment services, but no ACT slot is available in that particular catchment area, the consumer will instead be referred to the next and lower level of care – an Intensive Case Management slot. Theoretically, that consumer will be shifted out of ICM and into an ACT slot if and when one opens up. In practice, this is not always the case. Providers report that consumers with very serious impairments are in levels of care that cannot offer the kind of services they require. We would encourage the State to consider funding additional ACT teams to ensure an appropriate level of care for those consumers whose needs are the greatest. As mentioned earlier, ACT teams can also authorize involuntary hospitalizations if a consumer presents with thoughts or actions that indicate a danger to themselves or others.

We would also like to see a level of “step-down” care for persons who are no longer in need of hospitalization but who require some level of care beyond that which can be offered in most outpatient settings. This setting could also serve as a “safe space” for persons who are acting erratically but do not necessarily meet all of the conditions that would require involuntary hospitalization.

Finally, we would like to encourage training for police officers which includes shadowing a mobile crisis unit with the goal of gaining a more comprehensive understanding of the psychiatric side of working with persons in crisis. Perhaps a cohort of these officers, could be identified as being “on call” to assist with emergencies of this nature, given that the police are more likely to be the first responder.

These are fraught and extremely complex matters and we do not pretend to have all the answers or even all the questions. We do think that the best minds in the City and State, from government, the provider world, the NYPD and a full range of healthcare professionals should be convened to examine and consider models of success and to work to develop urban-sensitive and culturally sensitive responses and modalities in New York City to better prepare us and help us avoid the preventable tragedy of the future.

Thank you again for the opportunity to testify, and I’d be happy to take any questions you might have.