Mental health programs that address the need for non-police response to mental health issues are popping up all over the country. Among them is B-HEARD (the Behavioral Health Emergency Assistant Response Division), a pilot program that will send EMTs and licensed social workers in lieu of the police to respond to mental health emergencies. The program is set to launch this spring in New York City.

Although B-HEARD is modeled after highly successful programs elsewhere in the country, some community members still have questions about the program’s ongoing ties to the NYPD and the absence of key elements that could be crucial to saving lives.

Created by ThriveNYC, the New York City Mayor’s Office’s hub for mental health-related initiatives, B-HEARD will be piloted in three Harlem precincts that share a single 911 radio dispatch zone. Due to the number of mental health-related calls placed over the past two years, these precincts are recognized as one of the city’s higher need areas. Sean Redding, deputy director of external affairs for ThriveNYC, noted that the program wants to “maximize capacity to respond to calls when most needed, and the volume of calls drops off significantly in the early morning hours.” Teams will respond to calls for 16 hours per day but will not operate during the early morning hours.

The makeup of B-HEARD’s Response Teams is heavily informed by programs being developed in Denver, Chicago, and San Francisco, as well as New York state’s Ulster, Albany, and Orange counties. B-HEARD is especially taking cues from CAHOOTS, the most well-established non-police crisis response program in the nation, which was founded in 1989 and is based in Eugene, Oregon. According to Susan Herman, senior advisor to the
mayor and director of the Office of ThriveNYC, the teams will have expertise in responding to “a range of behavioral health problems such as suicidal ideation, substance misuse, serious mental illness, and physical health problems that can be exacerbated by mental health problems.” Team members will include NYC Health + Hospitals social workers and FDNY EMTs who have experience in de-escalating crisis situations.

New York City’s past attempts to address mental health emergencies include Mobile Crisis Teams and Crisis Intervention Training (CIT), a training program for NYPD officers led by instructors from the police academy and licensed mental health clinicians. Despite garnering initial support from advocates, CIT has since been widely critiqued particularly as police killings of individuals experiencing mental health crises has only risen in the years since the program was founded. In a memo provided to Prism by Community Access, a nonprofit that serves people living with mental health concerns, the group explained that “40 hours of CIT training cannot compete with the hundreds more hours of firearms and tactical training [NYPD officers] receive and the command-and-control of law enforcement.” The Mobile Crisis Teams on the other hand have been reviewed favorably, but despite their name they are not designed to respond to urgent crises.

Both residents and advocates say these existing services are inadequate and allow police to become the default responders when crises occur. Of the 16 New Yorkers killed in police encounters while experiencing a mental health crisis since 2015, 14 were people of color. According to Community Access, most of these deaths were a result of not just shootings but tasering, beatings, and neck compression as well.

Cal Hedigan, CEO of Community Access, says that the tools that the city provides for addressing mental health issues are not applicable to the problem at hand.

“In many instances there is a real mismatch between the perspective of law enforcement officers and the needs of people in crisis, and sometimes that mismatch results in people losing their lives, which is obviously incredibly awful in terms of our system of care and really speaks to the need for urgent and quick change to how we respond to people in crisis within New York City,” Hedigan said.

The idea that police are an inadequate response to mental health emergencies is one shared by a growing portion of the public. A 2020 Data For Progress survey found that 68% of voters nationwide support the development of non-police responses to mental health crises.

While the program seeks to reduce police contact during mental health emergencies, it’s not entirely delinked from the NYPD. Emergency dispatchers will still have the discretion to send police in emergency situations involving a weapon or “imminent risk of harm.” If callers wish to only have mental health response teams deployed even if there is a weapon involved, the Office of ThriveNYC says that police must still be deployed. According to Sean Redding, deputy director of external affairs for the Office of ThriveNYC, police may call for Mental Health Response teams as needed, and the teams can call NYPD dispatch for assistance.

Advocates have concerns about the program’s continued reliance on the NYPD. According to a 2015 report from the Treatment Advocacy Center, the risk of being approached by police is 16 times higher for those with untreated serious mental illness. Conservative estimates find that at least 25% of all police killings involve an individual with some serious mental illness. In New York City where some 200,000 mental health related calls are made every year, fatal police encounters mirror these national trends. Annually New York City spends approximately $250 million on cases involving police misconduct by the NYPD and according to an analysis by the Gotham Gazette, roughly one-third of those cases involve people undergoing a mental health crisis.

While the Office of ThriveNYC estimates that their Response Teams will reach about 70% of mental health related crises while sending the NYPD to 30%, Hedigan believes isn’t enough. Community Access also argues that under the pilot, 911 dispatchers will have wide discretion in defining what poses imminent harm or threatens public safety and thus merits police response. If those definitions are too broad, dispatchers run the risk of just defaulting to “business as usual.” A similar pilot ran out of Staten Island reportedly ended up still relying heavily on police. This
can be particularly troubling as one criterion for deploying police within the program is the presence of a weapon.

“The difference between how nail scissors could be used as a weapon versus garden shears—it’s all in the determination of where there’s real danger,” said Hedigan.

Advocates are also concerned about the lack of peer support in B-HEARD. Dr. Ashwin Vasan, president and CEO of Fountain House, a national nonprofit fighting on behalf of those living with serious mental illness, says that Response Teams within the program must include this key feature. Peers or individuals who have experienced mental health crises themselves provide a level of insight and expertise that no other trained professional can truly acquire and are especially effective at engaging and building trust with others experiencing mental health crises.

“The best models in the country all involve peers and right now, the New York City model doesn’t. But I hope that in the next iteration that it will and based on my understanding, they want to do that,” Vasan said.

Vasan also notes that it is important that New York City takes the vast diversity of its residents into account. In the Harlem region where B-HEARD will begin operations, there were over 9,000 mental health 911 calls in 2019 and over 7,000 between January and November 2020. The region is made up of Community Board 10, which is 62% Black and 22% Latinx, and Community Board 11, which is 31% Black and 52% Latinx. Residents speak a large swath of languages including English, Spanish, French, Creole, and Twi.

“Creating a workforce that represents New York, that’s culturally competent and able to speak multiple languages—that is a challenge,” said Vasan. “You have to create a behavioral health workforce ready to respond, that can engage people in those ways. So that’s a real challenge and something that could be an impediment to the rapid scale of a program.”

Residents in the Harlem areas where B-HEARD will initially cover have mixed feelings about the program but also a deep investment in its success, having seen how police interact with those in their neighborhoods. Corey Smith, an East Harlem resident, views it as a step in the right direction but believes that it must be developed alongside the community. He would love to see it have the same impact as a similar program launched in Denver, which contributed to a decrease in arrest rates, but the true marker of success will be how it impacts Black and brown residents who are most acutely targeted by police.

“Quite frankly, I’m not one of the people that would decide if it works or declare that it works,” said Smith. “I would want to consult with the Black folks in my life, I’d want to go online, I’d want to see what Black media sources are saying, what Black activists are saying.”

“Sonja Jones,” who has asked to use a pseudonym to protect her identity, works for NYC Health + Hospitals and has lived in Central Harlem since 2001. She is pleased to see there is an initiative utilizing a nonviolent approach and would love to see funds shifted from the NYPD to support similar programs. Jones has witnessed gentrification heighten police presence in her community over the decades and says that police are a violent force against Black and lower income residents, not a protective one.

“I think it will be good to have a nonviolent approach to people—especially our people—because that’s usually our experience with these sort of institutions. The cops are violent towards us [and] the hospitals aren’t really friendly. So I think it’s great that people have this resource,” Jones said. “My biggest concern is how will they know when they need to deploy the social worker and EMS as opposed to the cops?”

Jones also expressed concern about whether the teams will be robust enough and adequately culturally competent to address the needs of her community. In addition to feeling that just one social worker responding to calls may not be enough, Jones also noted that the variety of mental health needs and the diversity within the communities served will render a “one size fits all” approach deeply ineffective.

“A lot of people are living with conditions that I think might be more advanced than just one social worker would be able to handle,” Jones said. “I’m concerned about the number
of people, and it would be great if they were culturally competent—people who understood our communities.”

Both Jones and Smith feel that more people in the neighborhood need to be made aware of B-HEARD and what it offers in order for the program to yield the results they hope for. As far as they have seen, there hasn’t been much public outreach throughout their neighborhoods, resulting in a lack of awareness amongst residents that the program even exists.

“If I wasn’t home on Twitter all day, I don’t even know if I would stumble across the information about it,” said Smith. “If it’s something that’s going to be a big change in our community, and potentially a positive one, I definitely think people should know about it a little more openly.”

Despite working for NYC Health + Hospitals, Jones didn’t learn about the program until just this month when she read about it online via social media. She notes how often she’s seen emergency rooms overwhelmed by people who could have otherwise benefited from nonviolent mental health services and support that didn’t involve the police.

“Just understanding the prison industrial complex and [living near] Harlem Hospital, I see how violent people are towards people living with mental conditions or the unhoused,” Jones said. “So after learning about the program, I was curious about why our very own system hasn’t talked about it, which just speaks to the kind of leaders we have in our system.”

The B-HEARD pilot is prepared to launch as soon as hiring is completed and the Office of ThriveNYC plans to monitor it and collect data with the hope to scale it up as rapidly as possible. The city council is also considering two additional pieces of legislation related to mental health: one aims to establish an Office of Community Mental Health within the Department of Health and Mental Hygiene and the other seeks to create a separate three-digit hotline for calls pertaining to mental health crises.

Hedigan says that these initiatives are a promising sign that the city’s leadership is moving in the right direction, noting how even just two years ago, nothing like these programs existed in New York City.

While forward movement is important it rings bittersweet against the backdrop of the lives that have been lost and could have been saved if change had been made sooner. In 2016, Deborah Danner, a 62-year-old New Yorker and Fountain House member, was shot to death in her own apartment by NYPD after a neighbor called 911 to report that Danner was “emotionally disturbed.” NYPD officer Hugh Barry shot Danner twice in her torso after she reportedly charged at him with a baseball bat.

Just four years prior, Danner had penned a moving essay about living with schizophrenia and the myriad ways that stigma around mental health can permeate almost every corner of one’s life and even lead to one’s death. “We are all aware of the all too frequent news stories about the mentally ill who come up against law enforcement instead of mental health professionals and end up dead,” Danner wrote. She ended the piece with the declaration “I smile rarely, but I am surviving.”

In a November 2020 interview with NY1, Jennifer Danner, Deborah’s sister who was with her at her apartment at the time of her death, spoke of being hopeful that the program will actually be successfully implemented and “not just paperwork.”

“Now they are doing this?” said Jennifer Danner. “If they did this a little earlier my sister might still be here.”