Daniel's Law Task Force
New York State
Behavioral Health Crisis Response
Report

Table of Contents

Executive Summary

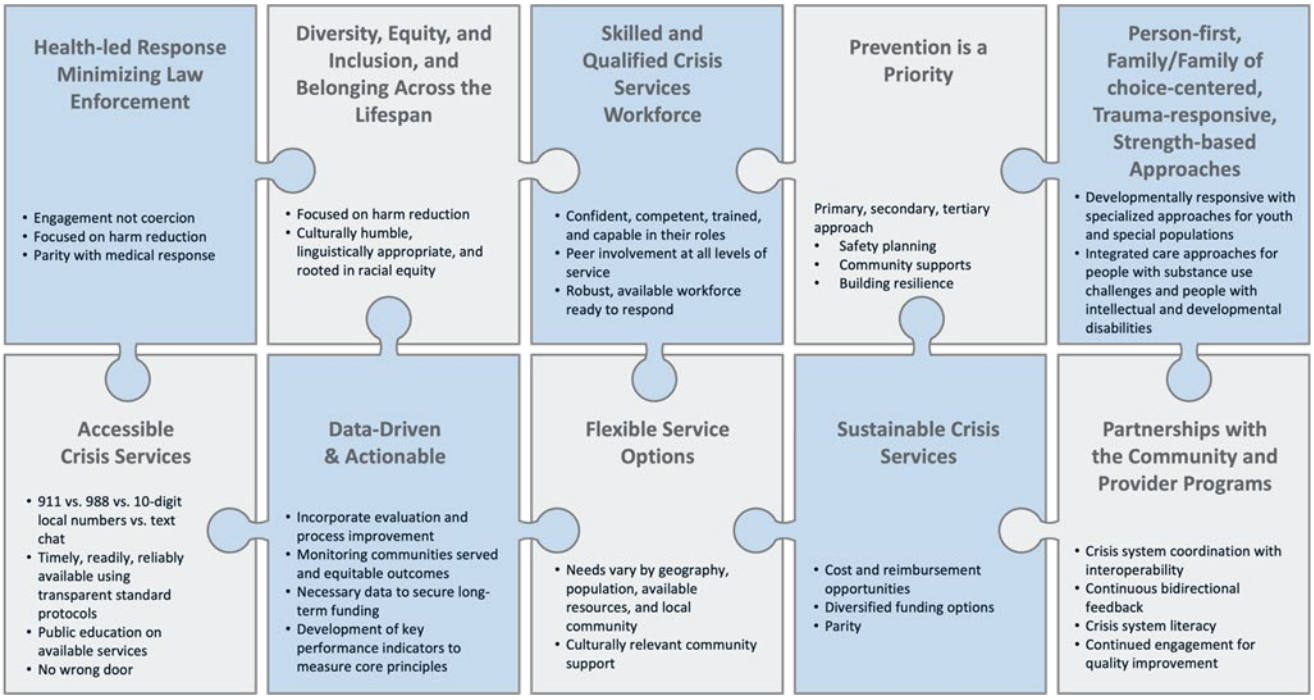
The Daniel's Law Task Force was established under **Chapter 57 of the New York State laws of 2023** to examine behavioral health crisis response in the State and across the country with specific attention to the goal of supporting trauma-informed, community and public health-based crisis response and diversion. New York State is currently developing and expanding its comprehensive crisis system which makes for the timely inclusion of this work.

Named for Daniel Prude, a young man who experienced a behavioral health crisis in March 2020 and tragically lost his life following an interaction with law enforcement, the Task Force has approached its charge by invoking the memory of victims of violence at each gathering and working collectively to explore opportunities to improve the system.

The current state of crisis response often includes law enforcement due to several factors including 911 dispatch protocols, lack of mobile mental health crisis capacity, and the absence of a coordinated behavioral health response system. By examining the current system in conjunction with the initiatives being launched in jurisdictions across the State, country, and Canada, as well as gathering input from stakeholders across New York State, the Task Force was able to make significant progress throughout the past year in understanding systems that provide an effective health-led response while reducing the reliance on law enforcement to situations when violence is threatened or present.

The Task Force is comprised of a diverse group of ten individuals with expertise in trauma-informed, community-led crisis response and diversion for mental health, alcohol use, and substance use crises. Charged with ensuring a comprehensive understanding of the current crisis response landscape and identifying critical areas for improvement, the task force reviewed best practices and conducted extensive outreach to engage a range of stakeholders including representatives overseeing behavioral health crisis response programs within NYS and outside the state. This collaborative effort facilitated a broad perspective and significantly informed the Task Force's recommendations. Additionally, potential funding sources were identified to support the enhancement and expansion of these crisis response and diversion services for individuals facing mental health, alcohol use, or substance use crises.

To further guide the vision described in the Daniel's Law Task Force charge, the Task Force developed ten core principles that reflect both their collective expertise, and their review of the insights gathered through stakeholder engagement and national best practices. These principles serve as the foundation for understanding the essential elements of a responsive and effective crisis response system and include a focus on incorporating the values of health equity, diversity, and inclusion, and the expertise of peers with lived experience. The interest in moving toward a health-led response is not unique to NYS, there is an international movement to reform the behavioral health crisis system to reduce reliance on law enforcement and increase mental health and substance use community-based response. There is overwhelming agreement across behavioral health crisis response organizations that shifting towards community, health, and person-first care is crucial to mitigating the negative impacts on marginalized communities.



In developing recommendations, the Task Force took into consideration that behavioral health crisis response in NYS varies widely across and within regions, counties, and municipalities. Local factors that impact or influence the diversity of community needs may include geography, public awareness of available resources, and the cultural diversity of the community itself.

Bearing these factors in mind, the Task Force proceeded with its goal of developing recommendations to support a health-led response to behavioral health crisis through the design of standardized protocols, that can be adapted and implemented in the diverse communities of New York, with the aim of ensuring a system that responds to individuals in crisis when and where it is needed with a person/family-centered, culturally appropriate, health-led response that would only include law enforcement when the situation poses a significant threat or risk of violence.

The Task Force developed two overarching recommendations and additionally identified the criteria that members believe is required for the successful implementation of each. The recommendations and implementation considerations are more thoroughly defined in the body of the full report.

Recommendation # 1.

That New York State establish a defined response protocol for a behavioral health crisis to include the following criteria:

- A call regarding mental health or substance use should receive a behavioral health response.
- Behavioral health response teams should respond to calls received by either 988 or 911.
- Law enforcement should only be deployed with the threat of violence.

- The Crisis response is designed with the principles of diversity, equity, inclusion, and belonging.
- A health-led response team should be comprised of a mental health professional and mental health workers (to include peers) and/or an EMS team with mental health workers (to include peers).
- The availability of training for dispatchers, crisis responders, and law enforcement that follows recommended developed protocols.
- Behavioral health wellness checks should be incorporated into the triage system so that wellness checks utilize a health-led response.
- Implementation of the behavioral health response teams described here could involve the establishment of several pilots across New York State in large, medium, small cities and rural areas, focused on developing sustainable models for expansion statewide.
- During implementation of the health response teams, communities should develop partnerships including individuals with lived experience – to participate in the design, implementation, and review of the system of care.
- During implementation, communities would assess the availability of mental health resources in communities, especially rural communities, to prevent people from experiencing a behavioral health crisis.
- During implementation, communities would assess the accessibility of adequate follow up care and connections to be made after crisis intervention and work to develop a network of quality accessible services.

Recommendation # 2

That New York State establish a Behavioral Health Crisis Technical Assistance Center (BHC TAC) to include the following elements:

- Collaborate with stakeholders including NYS Division of Homeland Security and Emergency Services (DHSES), The NYS Emergency Medical Services Council (SEMSCO), local communities, and 988 Crisis Contact centers to develop standardized protocols for a health-led response to behavioral health crisis.
- Provide training and assist local communities in implementing best practice protocols and monitoring their effectiveness
- Pursue the interoperability of 911 and 988 with local communities and statewide systems.
- Maintain a repository of innovative strategies for all crisis work including best practices for 911/988 interoperability, behavioral health crisis response work, systems processes, and community involvement – and be available for technical assistance throughout statewide implementation.
- Collect and analyze required data and serve as a quality monitor for implemented response teams.

- Provide information to communities for evaluation purposes and feedback from all stakeholders.
- Establish an Advisory Council of key stakeholders including a diverse majority of people with lived experience of the crisis response system to advise and review the work of the center.
- The TAC could be housed in the Office of Mental Health.

The Daniel's Law Task Force believes that implementing the recommendations listed above is a first step towards improving behavioral health crisis response and ensuring that individuals receive a health-led response when and where they need it. The work of the Task Force could not have been completed successfully without the participation of the many stakeholders who shared their experiences, insights, and thoughts as well as the many behavioral health crisis providers across NYS, the United States, and Canada who shared their innovative programming.

The Daniel's Law Task Force report is a focused document that outlines the process undertaken by the Task Force, the need for a standardized crisis response system that minimizes law enforcement response, and recommendations to begin that process of implementation. In addition to the report itself, it contains **a number of appendices** that outline all of the research on crisis response, existing programs, stakeholder engagement, and funding options that led to the report recommendations.

Task Force Charge, Composition, and Process

To achieve the shared NYS vision for behavioral health crisis response, the Daniel's Law Task Force was established under **Chapter 57 of the laws of 2023**. The Office of Mental Health (OMH) in collaboration with the Office of Addiction Services and Supports (OASAS), was given the responsibility for establishing the Task Force comprised of individuals with expertise in trauma-informed, community-led health-led crisis response and diversion for mental health, alcohol use, and substance use crises, as well as individuals affected by police responses to behavioral health crises.

Named for Daniel Prude, a man whose tragic death occurred following an interaction with law enforcement responding to a behavioral health crisis in 2020, the Daniel's Law Task Force was given the following charge.

Daniel's Law Task Force Charge

The Daniel's Law Task Force was charged with examining the current crisis response landscape and identifying critical areas for improvement. The full text of the Daniel's Law Task Force statute is in **Appendix A**. To fulfill this charge, extensive outreach was conducted to engage a diverse range of stakeholders, including healthcare professionals specializing in mental health and substance use disorder services, individuals with lived experience and their primary caregivers, personnel within the mental health and addiction fields, crisis response call center staff, first responders including law enforcement, and representatives from not-for-profit organizations with expertise in supporting individuals in crisis. This collaborative effort facilitated a broad perspective and significantly informed the Task Force's recommendations.

The primary focus was to identify the operational and financial needs necessary to support trauma-informed, community-based, health-led crisis response and diversion strategies. The Task Force reviewed and evaluated state and national programs and systems that could serve as effective models for crisis and emergency response services. Additionally, potential funding sources were identified to support the enhancement and expansion of these crisis response and diversion services for individuals facing mental health, alcohol use, or substance use crises.

This report by the Task Force summarizes the findings, opinions, and recommendations. It includes an inventory of existing crisis response and diversion services, as well as an evaluation of their effectiveness. It offers detailed recommendations for expanding these services to ensure that individuals experiencing mental health, alcohol use, or substance use crises receive appropriate treatment during a crisis while reducing the risk of arrest or incarceration.

Composition - Task Force Membership

Ann Sullivan, MD, Chair
Commissioner of the NYS Office of Mental Health

Chinazo Cunningham, MD
Commissioner of the NYS Office of Addiction Services and Supports

Rossana Rosado
Commissioner of the NYS Division of Criminal Justice Services

Chacku Mathai
Appointed by the Temporary President of the Senate, Member of Daniel's Law Coalition, and person with lived experience of mental health and substance use conditions

Mark Deavers, MBA
Representative with expertise in crisis response through the State Emergency Medical Services Council, Director of Emergency Medical Services at St. Lawrence Health, and Chair of the New York State Emergency Medical Services Council (SEMSCO) Systems Committee

Jonathan McLean, LCSW
Representative working as a licensed mental health professional, Chief Executive Officer at Center for Alternative Sentencing and Employment Services (CASES)

Rachel Morrison, MAMHC
Representative who is employed as a crisis response call center personnel or crisis intervention personnel, Program Director of 24-hour Crisis Hotline at Crisis Services, Buffalo

Christina Sparrock, CPA
Representative with lived experience mental health, Member of Daniel's Law Coalition, behavioral health advocate and educator

Michael Orth, MSW
Representative of the New York Conference of Local Mental Hygiene Directors, Commissioner of the Westchester County Department of Community Mental Health (appointed May 2024 to replace Darcie Miller)

Darcie Miller, LCSW-R
Representative of the New York Conference of Local Mental Hygiene Directors, Commissioner of the Orange County Departments of Mental Health and Social Services
(appointed August 2023, resigned due to retirement May 2024)

Rohsennase Dalton LaBarge, MD
Appointed by the Speaker of the Assembly *(resigned July 2024)*

Task Force Process

The Daniel's Law Task Force convened its first meeting August 30, 2023, and held nine subsequent meetings both in person and virtually. The Task Force heard presentations from innovative programs both within and outside of New York State and at each of the first eight meetings, the Task Force invited the public to make comment. Additionally, five Listening Sessions were convened – two of which were conducted virtually – the remaining three were held in person in Long Island, New York City, and Rochester where Task Force members listened to statements made by the public and engaged them in conversation about strategies to improve the behavioral health crisis system. Lastly, the Office of Mental Health created a dedicated **Daniel's Law Task Force webpage** to provide history and context and post recordings and transcripts of the livestream sessions. A link on the webpage continues to provide an **opportunity for the public to submit comments** and questions.

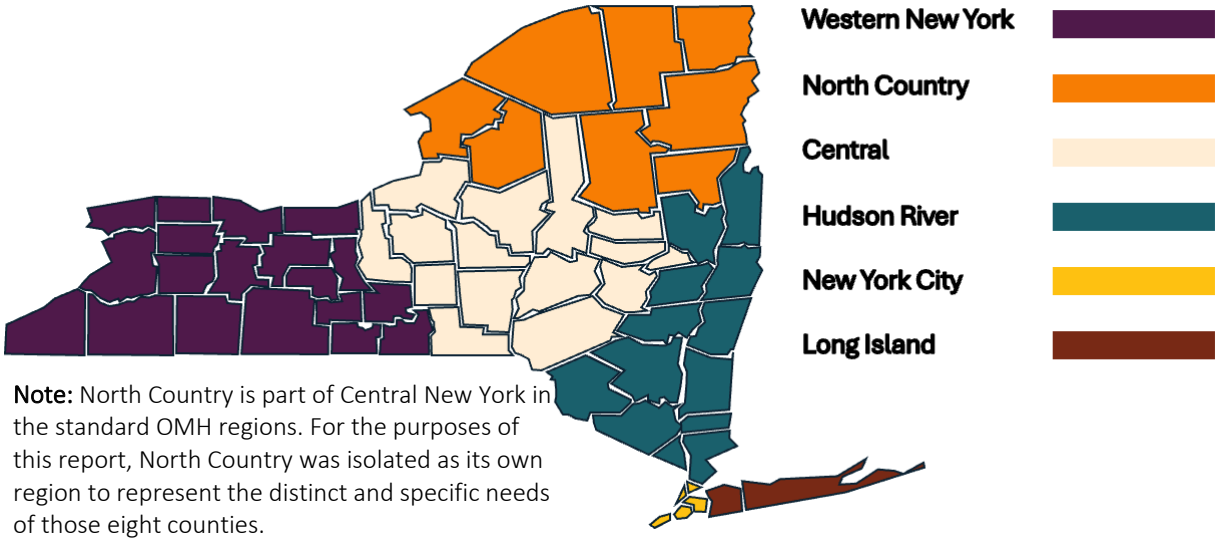
The Task Force contracted with the New York State Technology Enterprise Corporation (NYSTEC) to conduct research, convene wider stakeholder engagement opportunities, and prepare a summary of findings (**the complete NYSTEC Summary of Findings is located in Appendix D**).

The findings from stakeholder engagement and the literature review were compiled and analyzed for opportunities to bridge the gaps between where NYS crisis services are currently and where the Task Force is charged to steer crisis services in the future. Opportunity areas were identified with a strong emphasis on racial equity and by examining behavioral health crisis services from both person-centered and programmatic perspectives, focusing on prevention, access, community partnerships, technological infrastructure, and funding. The Task Force gave close and thoughtful attention to programs that had limited law enforcement involvement except in dangerous situations, and those that utilized peers for successful engagement. A large component of the stakeholder outreach and literature review was conducted to compare select crisis response models in New York with those in other cities and states to offer potential solutions. **Within the appendix of this report** is a detailed analysis of various models, funding options, and proposed strategic, technical, and financial opportunities for continued improvements in crisis services.

National models and best practices were reviewed to identify potential changes to policies and procedures. Insights were gathered through stakeholder engagement efforts that were conducted through several methods, including surveys, interviews, focus groups, and public comments. Stakeholders represented the following categories to ensure a broad and inclusive representation of voices: (1) public safety officials, (2) NYS agencies invested in crisis services delivery outcomes, (3) local crisis service providers, (4) people with lived experience and their social supports, (5) crisis service providers in other cities and states, and (5) leading advocacy, professional, and community organizations. The list of stakeholders who participated in this research are found in the **Appendix B**.

NYS local crisis services were reviewed separately and regionally to assess opportunities for collaboration to leverage and enhance existing services. Counties were categorized using the OMH definition of regions (**see Figure 1**) for crisis services with the addition of a North Country carveout.

FIGURE 1 OMH REGIONS



Note: North Country is part of Central New York in the standard OMH regions. For the purposes of this report, North Country was isolated as its own region to represent the distinct and specific needs of those eight counties.

Qualitative data was reviewed to identify trends and themes, while quantitative survey response data was analyzed and visualized to highlight key findings, impacts, and gaps.

Need for a Statewide Health-led Crisis Response

The interest in moving toward a health-led response is not unique to NYS, there is an international movement to reform the behavioral health crisis system to reduce reliance on law enforcement and increase mental health and substance use community-based response. There is overwhelming agreement across behavioral health crisis response organizations that shifting towards community, health, and person-first care is crucial to mitigating the negative impacts on marginalized communities.

The Task Force identified a critical need in NYS for trauma-informed, community-based crisis response approaches that prioritize racial equity, cultural humility, and harm reduction for New Yorkers across their lifespans. Current NYS behavioral health crisis response approaches often involve law enforcement with or without mental health involvement rather than a health-led response that engages and minimizes risk for the individual in crisis. A primarily health-led response to a behavioral health crisis is the standard being proposed nationwide, with law enforcement collaboration in situations threatening violence.

Behavioral health experts and advocacy organizations are responding to the public call for research, guidance, and standards for crisis response. According to the Substance Abuse and Mental Health Services Administration **(SAMHSA) Best Practices Toolkit**, emergency behavioral health response should follow three core tenets:

1. **Timely Intervention**
    - Rapid response during a crisis can prevent escalation and reduce harm.

- Immediate access to mental health professionals, crisis hotlines, or mobile crisis teams is essential. A primary mental health response.
- Involvement of trained peer support service staff, when possible, as first line engagement and intervention.

2. **Collaboration and Coordination**
    - Federal, state, and local agencies must work together to create a seamless continuum of care for those in crisis.
    - Coordinated efforts ensure that individuals receive optimal services, including crisis stabilization and follow-up care.
3. **Community-Based Solutions**
    - Community resources, such as crisis centers, peer supports, and crisis intervention training support prevention, assist crisis de-escalation, and enhance emergency response.
    - Involving families, or chosen families, and social services helps to reduce harm and address the complex needs of individuals in crisis.
    - Involving individuals with lived experience of crisis services to provide feedback on what is helpful and needed.

Current Status of Behavioral Health Crisis Response in New York State

Behavioral health crisis response in NYS varies widely across and within regions, counties, and municipalities. Local factors that impact or influence the diversity of community needs may include geography, public awareness of available resources, and the culture of the community itself.

On a statewide level, the following factors influence crisis service delivery:

- **State and local legislation, policy, and budget appropriations:** Within each level of government, statutes, formal agreements, and budget allocations are determined and upheld. These may include considerations such as collective bargaining agreements, ballot propositions, and local budgets.
- **Workforce, technology, and other infrastructure needs:** Systems, structures, and capacity levels vary across the state, including infrastructure challenges like broadband, facilities, equipment, and staff.
- **Diverse populations and geography:** The state's diverse geography, government structure, economy, and demographics all contribute to its unique identity. With a population of 19.6 million people, New York is a melting pot of cultures, races, and traditions across a vast landscape spanning more than 54,000 square miles.

- **Varying methods for data collection, evaluation, and reporting:** As illustrated by the phased rollout of 988, readiness varies across the state in terms of technologies and practices for data collection and performance evaluation.
- **Home rule state authority:** Home rule state authority grants local governments the power to autonomously set up their own system of self-government without receiving a charter from the state.
- **Current local processes for crisis response:** NYS Mental Hygiene Law (§ 41.16) requires the Office of Addiction Services and Supports (OASAS), the Office of Mental Health (OMH), and the Office for People With Developmental Disabilities (OPWDD) to collaboratively guide and facilitate the local planning process for Local Governmental Units (LGUs) in NYS. Each LGU represents one county except for Warren and Washington Counties combined into one LGU and New York City is one LGU representing five counties (Bronx, Kings, New York, Queens, and Richmond). LGUs work with provider programs in each community to represent the human service needs of towns and cities. This collaborative effort ensures effective planning and coordination of behavioral health services across NYS.

There is a great deal of coordination that happens at the state and local level. Oversight agencies in NYS have published guidance documents defining and outlining standards for the delivery and reimbursement of crisis services. For example, OASAS and OMH provide clear guidance for crisis response services, steering programs to meet requirements around staffing, community engagement, and specific program elements.

Highlighted Behavioral Health Crisis Services Programs

Highlighted in this section are the following NYS programs whose approaches represent the work already underway to move behavioral health crisis services toward the goals of the Daniel's Law Task Force: (1) Dutchess County Crisis Services, (2) Orange County Crisis Services, and (3) Westchester County Project Alliance. The description of these models showcases how programs are tailored to local infrastructure, needs, and challenges, yet may still need to reduce the involvement of law enforcement to further align with the goals of the Daniel's Law Taskforce.

Representatives from crisis services programs in other cities and states were interviewed to gather information on elements of their programs that could be emulated in NYS to minimize reliance on law enforcement and further align with the Daniel's Law Task Force charge. In addition to their program strengths, representatives shared their challenges to offer their lessons learned and obstacles that could be avoided in NYS. Two exemplary programs reviewed, which significantly reduced reliance on law enforcement, are highlighted in this section: (1) Crisis Assistance Helping Out On The Streets (CAHOOTS) in Eugene, Oregon and (2) Gerstein Centre – Toronto Community Crisis Service (TCCS) in Toronto, Ontario, Canada.

Dutchess County Crisis Services

Dutchess County 911 has a **HELPLINE** diversion procedure and script for 911 call takers. If the caller meets certain criteria, the call is transferred to the helpline crisis call center via a warm hand off. The county Department of Emergency Response provides training to first responders to learn essential mental health resources for themselves and the people they serve. Additionally, all police agencies in Dutchess County are offered Crisis Intervention Training (CIT). One of the highlights in Dutchess County is the use of the ECHO (Enhancing Community Health thru Outreach) program which is geared towards community outreach and prevention. Behavioral Health Specialists (Specialists) employed by MHA Dutchess are embedded within the local police department to provide insight and expertise when going out on calls within the community. Police and Specialists work together with the community towards a common goal. ECHO focuses on intervention and prevention, supporting the community as holistically as possible, and helping individuals in mental health distress reduce the chance of escalation or violence.

Orange County Crisis Services

The **Orange County Crisis Mobile Response Team** (MRT) is co-located with the Emergency Operations Center for 911. MRT always has at least one licensed clinician on the responding team. Operating in teams of two with three teams during the day and two teams at night, MRT aims to respond in 30 to 45 minutes across the county. MRT clinicians, counselors, and/or peers assess clients and provide stabilization, safety planning, and referrals to services with the goals of promoting community stabilization and avoiding unnecessary police interactions and hospitalizations. Coordination occurs between the **Crisis Call Center** and 911 where there is an assessment of whether the call requires a behavioral health response or poses imminent risk. If a caller is deemed to be at imminent risk, then the call will be transferred to 911. The 311/988 call-taker may stay on the line to assist the 911 call-taker, provide emotional support to the caller, and/or dispatch MRT along with police, the fire department, or EMS. Relationships between county agencies, law enforcement, mobile response, and peer support services have facilitated interoperability.

Westchester County Project Alliance

Project Alliance involves a 5-prong approach including mobile crisis response. **Five agencies operate eight mobile crisis response teams** (MCRT). When deployed, these calls for services will be a co-response *until the local police agency establishes scene safety* at which time the team will be provided with further guidance and direction by the supervisor and/or primary officer on scene to engage the person in crisis. It is recommended that police departments will provide a Community Resource Officer (CRO) with CIT training, or a CIT-trained officer as a law enforcement liaison for MCRT to coordinate services. MCRT offers support to individuals in crisis to provide brief intervention and facilitate access to other crisis/behavioral health services. Dispatched and deployed through the police department, MCRT provides appropriate care and support to help individual experiencing a behavioral health crisis avoid unnecessary emergency department use and hospitalization. MCRT offers an assessment of behavioral health symptoms and crisis-related needs, development of a safety plan or crisis prevention plan, therapeutic communication, referral, and linkage to appropriate community services, and more.

Crisis Assistance Helping Out On The Streets (CAHOOTS) in Eugene, Oregon

Crisis Assistance Helping Out On The Streets (CAHOOTS) is a mobile crisis intervention program staffed by **White Bird Clinic** mental-health-trained personnel using City of Eugene vehicles. This relationship has been in place for nearly 30 years and is well embedded in the community. The crisis workers who respond with EMT should have lived experiences with behavioral health needs in addition to previous experience working in social services with a focus on mental health, homelessness/poverty, or substance use. CAHOOTS-trained personnel often provide initial contact and transport for people who are intoxicated, mentally ill, or disoriented, as well as transport for necessary non-emergency medical care. CAHOOTS teams deliver voluntary, person-centered interventions and make referrals to behavioral health supports and services without the uniforms, sirens, and handcuffs that can exacerbate feelings of distress for people in crisis. They reduce unnecessary police contact and allow police to spend more time on crime-related matters. Dispatchers consider the safety of the responder, the presence of weapons, criminal activity, and the needs of the person requesting assistance when deciding whether to have police respond. Sometimes, police will decide that CAHOOTS support is needed after their arrival to a scene and vice versa. Participation in city planning meetings, maintaining an open and responsive working relationship between the clinic and police department, and partnering with dozens of community organizations is required.

Gerstein Centre – Toronto Community Crisis Service (TCCS) in Toronto, Ontario, Canada

The overall approach of the **Gerstein Crisis Centre** is to be an accessible source of support to give people an opportunity to use their own strengths and resources, as well as connect them to resources needed to assist in their recovery. TCCS can provide up to three months of follow-up crisis support and assistance connecting to community providers. The Gerstein Crisis Centre provides 24-hour crisis lines, mobile crisis teams, crisis follow-up and short-term crisis beds for any Toronto resident experiencing a mental health or substance use crisis. Gerstein also has co-located crisis workers at the 911 call center to respond to callers diverted from 911 directly. The Gerstein Centre will involve law enforcement only when a person is at immediate risk of harming themselves or others. Response teams are comprised of mental health staff, harm reduction workers, people trained in de-escalation, and peers with lived experience. The Gerstein Crisis Centre aims to employ people with lived experience at all levels from support workers to leadership.

Themes from Stakeholder Engagement

Daniel's Law Task Force Listening Sessions Themes and Highlights

To ensure that recommendations are grounded in real-world experiences, the **Daniel's Law Task Force conducted a series of listening sessions** with a diverse group of stakeholders. These sessions provided a platform for gathering insights on current challenges and opportunities within the crisis response

landscape. Stakeholders included individuals with lived experience, healthcare professionals, law enforcement, crisis response teams, and representatives from community organizations.

Representatives from the Task Force attended each session, actively engaging with participants to capture their feedback. Task Force members who were not present reviewed the session recordings to ensure a thorough understanding of public input. Through these sessions, the Task Force identified recurring themes and key issues that inform the recommendations presented in this report. This input from various perspectives highlighted both successes and barriers within existing crisis response systems. Included here are themes and highlights from each listening session.

November 20, 2023 – Virtual

- Focus on community and provider engagement
- Focus on preventing crises
    - Need for a robust, person-centered system of care
    - Increase investment in programs like Community Oriented Recovery and Empowerment (CORE). (These are person-centered, recovery-oriented mobile behavioral health supports. They build skills and assist in community participation and independence)
- Utilize collaborative community responders instead of Law Enforcement for crisis response
    - Use Peers as responders who will be culturally sensitive and trauma-informed using lived experience
    - Minimize police response using models like **CAHOOTS**
    - Suggestions to utilize a clinician/peer team
- Need for racial justice to stop negative impact on BIPOC communities
- Need for accurate data to examine areas of the system that may be failing
- Need for redesign of crisis services overall to focus on the above suggestions

January 11, 2024 – hosted by the State University of New York at Stony Brook in Long Island

- Need for crisis response that is peer led, designed to decrease contact with police, and centered on engagement and access to the highest quality of care
- Focus on improving marketing for 988 to raise community awareness
- Improve community-police engagement to reduce fear – improve law enforcement approach to a mental health crisis
- Improve use of mobile crisis teams and increase capacity (number of teams) to ensure coverage for the large geographic area of Long Island
- Consider the use of Lifespan Peers with a crisis specific credential on crisis teams
- Focus on community building and infrastructure of a crisis response system

January 18, 2024 – hosted by the City University of New York: John Jay College of Criminal Justice in New York City

- Need to utilize peers in crisis response and ensure ways to make it sustainable
- Emphasis on Peers as first responders instead of law enforcement
    - Support expressed for the use of Emergency Medical Technician's as a substitute for a peer response if not available

  - Support for community organizations as first responders as well
  - Police are okay as a backup, but should not be the first response
- Emphasis on how the initial response during a crisis impacts the overall trajectory of an individual's recovery
- Need to move away from a criminal justice approach to mental illness and crisis and move away from equating mental illness with violence
- Law enforcement response to behavioral health impacts BIPOC people disproportionately
- Need to humanize the response to mental health crisis and mental illness in general
- Support expressed for the **CAHOOTS Model**
- Need for better cross systems collaboration in developing crisis response
- Need for more local resources/coordination and involvement of local government in crisis response systems

April 16, 2024 – Virtual

- The religious community is willing to assist in crisis intervention development and implementation
- Need for peers and trained mental health professionals as first responders
- Need for response to cover lifespan of people in crisis, including a special focus on children
- Participants expressed fear and concern about the death of people with mental health conditions by law enforcement
- Desire for a community response and a local response that does not involve law enforcement
  - Feelings expressed that Law enforcement may lack empathy/understanding when dealing with individuals having a mental health crisis
  - The presence and interaction with law enforcement may cause trauma for people in crisis

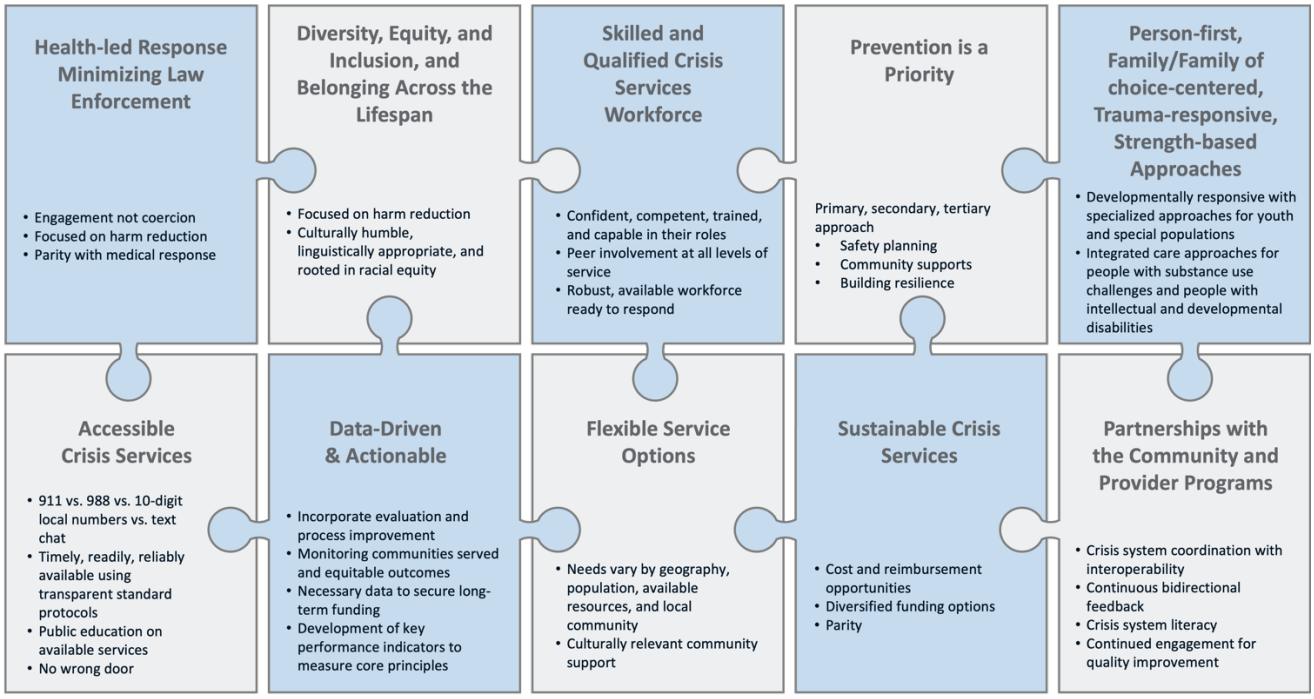
May 8, 2024 – hosted by Central Library of Rochester and Monroe County in Rochester

- Mental Health Professionals should be used in lieu of law enforcement
- There is a lack of helpful, reliable, and appropriate treatment for the community. The system is often not helpful and needs change
- People are often unaware of services
- Emergency services environments are not therapeutic or compassionate
- There is a need for sustainability and support for behavioral health and peer workers to continue to do the work and be available for this initiative
- Full support for peers and mental health professionals on crisis response teams instead of law enforcement
- Emphasis on need for law enforcement training to move towards a more appropriate behavioral health response
- Negative aspects of the current system disproportionally impact the BIPOC community/Individuals with disabilities
- Participants shared experiences of individuals in the BIPOC community who were in mental health distress and were seriously harmed during a law enforcement response.

Appendix B contains summaries of stakeholder feedback and complete information on how stakeholders were engaged as well as transcripts from some of those interactions can be found in the Summary of Findings located in **Appendix D**.

Vision for NYS Behavioral Health Crisis Response

To clarify the vision of the Task Force, the following core principles were developed that reflect both the collective expertise of members, and the review of insights gathered through stakeholder engagement and national best practices. These principles serve as the foundation for understanding the essential elements of a responsive and effective crisis system and were used to inform the recommendations.



Health-led Response Minimizing Law Enforcement which emphasizes engagement, harm reduction, and parity with emergency medical response.

Diversity, Equity, Inclusion, and Belonging Across the Lifespan focusing on services that are culturally humble, linguistically appropriate, rooted in racial equity, and focused on harm reduction.

Skilled and Qualified Crisis Services Workforce, which is robust, available, and ready to respond, confident, competent, and trained. The workforce should include peer involvement at all levels of service.

Prevention is a Priority which includes a primary, secondary, and tertiary approach focused on safety planning, community supports, and building resilience.

Person-first, Family/Family of Choice-Centered, Trauma-responsive, Strength-based Approaches which are developmentally responsive including specified approaches for youth and special populations. These should include integrated care approaches for people with substance use challenges and people with intellectual and developmental disabilities.

Accessible Crisis Services that are timely, readily, and reliably available regardless of whether a caller utilizes 988, 911, or other crisis line. There should be transparent and standard protocols that reinforce a "no wrong door" philosophy. This would include public education efforts on available services.

Data-driven and Actionable incorporating evaluation and process improvement in system planning. This includes the development of key performance indicators to measure core principles.

Flexible Service Options that address the varied needs of local communities based on geography, population, available resources, and culturally relevant community supports.

Sustainable Crisis Services that take into consideration cost and available reimbursement opportunities, diversified funding options, as well as parity.

Partnerships with the Community and Provider Programs that includes building crisis system literacy, continuous bi-directional feedback, and continued engagement to ensure quality improvement.

Daniel's Law Task Force Recommendations

The goal of the Task Force is to develop recommendations to support a health-led response to behavioral health crisis through the design of standardized protocols–which may need to be modified due to geographic limitations in rural New York–with the aim of ensuring a system that responds to individuals in crisis when and where it is needed with a person/family-centered, culturally appropriate, clinical response that would only include law enforcement when the situation poses a risk of violence.

Bearing in mind the factors influencing local crisis services and the role NYS has in supporting local municipalities, the Task Force created two overarching recommendations:

1. **Establish a Defined Response Protocol for Behavioral Health Crisis**
2. **Establish a Statewide Technical Assistance Center**

Within these two recommendations are a list of approaches and methods for how that recommendation may be accomplished.

Recommendation #1: Establish a Defined Response Protocol for A Behavioral Health Crisis

Each community should have a defined protocol to respond to a behavioral health crisis that incorporates the following elements.

- **A call regarding a mental health or substance use crisis should receive a behavioral health response.**

  The comprehensive behavioral health crisis response system envisioned is aligned with **national standards** and is summarized as a behavioral health response that provides "someone to call," "someone to come," and "somewhere to go."

  Crisis systems across the nation are following best practices developed by **SAMSHA** to ensure the best care possible for individuals and families in crisis. These practices describe answering a call for help from someone in a behavioral crisis to be screened and triaged by a trained responder who can determine the level of intervention needed. Following the initial contact, trained behavioral health responders are made available to engage the individual in crisis and provide needed support, intervention and follow up if necessary. Community crisis systems are coordinated and linked to the wider service delivery system in the community. Calls can be made to 911, 988 or local crisis lines.

  Several models of implemented behavioral health-led response teams including the CAHOOTS (Eugene, Oregon) model and the Gerstein Center (Toronto, Canada) are included in the **survey findings and appendices of this report**. Also, some emerging models in New York State are included such as Westchester and Dutchess Counties.

- **Behavioral health response teams should respond to calls received by either 988 or 911.**

  As noted in this report's **Summary of Findings**, behavioral crisis calls are still most frequently made to 911, the emergency call system, and to 988 - the behavioral health crisis and suicide line, as well as local crisis lines. It is critical that the crisis call systems be coordinated and interoperable so that behavioral health crisis calls made to any crisis or emergency line receive a behavioral health response. Communities need to plan with all first responder agencies to develop a smooth and effective system for triaging calls and implementing the best response to a crisis. This may be best accomplished by the development of an advisory group of key stakeholders such as DHSES, counties, local 911 dispatch, 988 and local crisis lines to consult on developing interoperability among all crisis call lines.

- **Law enforcement should only be deployed with the threat of violence.**

  As noted in this report's **Summary of Findings**, researched best practices and recommendations from various academic sources and SAMSHA recommend the use of law enforcement in the crisis response to be limited as much as possible. This frees law enforcement to pursue their public safety mission while trained behavioral health professionals deal with mental health crises. Law enforcement stakeholders across NY emphasize and align with the need for trained responders in a behavioral health crisis and view their role as one of assisting in dangerous situations. They support training for law enforcement and collaboration to decrease law enforcement involvement. While a co-response team of a mental health practitioner and law enforcement is the practice currently in some communities in New York, it is recommended that these teams transition to a health-led response over time.

A law enforcement response, when needed, due to a threat of violence should include officers who have received specialized behavioral health training and/or include co-response with a trained behavioral health professional. However, special attention should be paid to rural communities that have limited resources and may need to modify this specific response model. Technology should be used to the extent possible to connect with a behavioral health professional when a behavioral health led response is not available.

NYS should ensure that there are standard protocols for assessing whether a crisis response should include law enforcement as well as continuous monitoring and data collection of that utilization.

- **The Crisis response is designed with the principles of diversity, equity, inclusion, and belonging.**

  The golden thread of the Daniel's Law Task Force objectives is to seek out solutions that are trauma-informed, culturally, and linguistically appropriate, and rooted in racial equity.

  New York behavioral health crisis services programs and advisory committees should seek to build connection with underserved communities through meaningful engagement and relationship-building with trusted community leaders, and the reduced use of law enforcement in crisis response.[5] Additional ways to help address disparities is through a more representative and culturally sensitive workforce, through organizational priorities, and contract language modifications that support equity. A strong example of incorporating community engagement and diversity, equity, inclusion, and belonging (DEIB) practices into county-wide policies can be found in **Orange County**.

  One nationally recognized approach is the **National Culturally and Linguistically Appropriate Services (CLAS) Standards**. These standards are intended to advance health equity, improve quality, and help eliminate health care disparities by creating a blueprint for health care organizations. One critical **CLAS component** is to "recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area." It is recommended to move toward the common goal of a more diverse behavioral health workforce and the provision of culturally and linguistically appropriate services.

- **A health-led response team should be comprised of a mental health professional and mental health workers (to include peers) and/or an EMS team with mental health workers (to include peers) who are trained in crisis response.**

  Individuals working in crisis response should represent the population they serve whenever possible.

  Teams need to be thoughtfully staffed. Peers should be included routinely on response teams. Teams are highly effective when they reflect the communities they serve racially, ethnically, and culturally. Some teams also utilize EMS or other medically trained personnel.

  It is also recommended that teams participate in standardized trainings recommended by the technical assistance center described in task force recommendation #2 that includes crisis intervention, trauma-informed care, racial and cultural humility, and bias awareness training. It is

critical that behavioral health crisis teams meet established standards including training expectations. Localities may want to consider differential pay for individuals who are employed for crisis response.

- **The availability of training for dispatchers, crisis responders, and law enforcement that follows recommended developed protocols; to include wellness checks.**

  Standardized trainings and protocols approved and or developed by the technical assistance center described in task force recommendation #2 are critical to ensuring that the triage and referral to mobile services or other interventions follow the guidelines that limit law enforcement involvement to dangerous situations and ensure a comprehensive and quality response to a behavioral health crisis.

  Behavioral health wellness checks should be incorporated into the triage system so that wellness checks utilize a health-led response.

- **Implementation of the behavioral health response teams described in the above recommendations could involve the establishment of several pilots across New York State in large, medium, small cities and rural areas, focused on developing sustainable models for expansion statewide.**

  The goal of expansion statewide for these models would involve an evaluation of the barriers and facilitators of their effectiveness in providing quality health response to a behavioral health crisis.

  In this report's **appendix on funding strategies for implementation**, a framework for financing and implementing a series of pilots is described in detail as well as a plan for ongoing sustainability. It is recommended to begin with 6-8 pilots distributed in different size communities across the state that would be designed around the Task Force recommendations but consider local needs.

- **During implementation of the health response teams, communities should develop partnerships including a diverse majority of individuals with lived experience – to participate in the design, implementation, and review of the system of care.**

  Community partners should be involved in educating the community about the importance of early intervention and will receive data to review the effectiveness of the crisis response system, including the reduction of behavioral health crisis response by law enforcement. Diversity, Equity, and Inclusion should be an integral part of staffing, training, and community representation in design and implementation.

- **During implementation communities would assess the availability of mental health resources in communities, especially rural communities, to prevent people from experiencing a behavioral health crisis.**

  As noted in this report's **Summary of Findings**, communities across NY state vary in their continuum of available resources and ability to provide all the services to prevent a behavioral health crisis. Governor Hochul's historic investment in mental health is making significant inroads into providing those preventive services and it is important for all communities to prioritize educating the public

about the importance of prevention, availability of services, and further identifying gaps that need to be addressed.

- **During implementation communities would assess the accessibility of adequate follow up care and connections to be made after crisis intervention and work to develop a network of quality accessible services.**

  As noted in this report's **Summary of Findings**, communities across NY State vary in their crisis continuum of services as well as follow up services after the crisis intervention. Governor Hochul's historic investment in mental health crisis and community services is having a significant impact. However, each community will need to review its services and identify gaps that will need to be addressed. Mapping of services available and those needed could be conducted by counties and regions to include local input. It is also important to ensure that the available network of care includes culturally responsive community-based organizations. This is an ongoing process and will need to involve the ongoing planning, collaboration, and communication among providers, community members, and those with lived experience.

Recommendation #2: Establish a Statewide Technical Assistance Center to Implement a Health Based Crisis Response

The Technical Assistance Center (TAC) would engage as follows:

- **Collaborate with and assist appropriate agencies, the New York State Emergency Medical Services Council (SEMSCO), DHSES and local community response systems in developing standardized protocols for a health-led response to a behavioral health crisis.**

  This can include standardized protocols for triaging crisis calls across systems, protocols for response, for follow up, and for law enforcement involvement when there's a threat of violence.

- **Provide training and assist local communities in implementing best practice protocols and monitoring their effectiveness.**

  Work with local communities to ensure that the response systems meet local needs, especially in rural communities. Provide recommended standard trainings for crisis responders that meet the criteria described in recommendation #1 for a health-led response team. Provide crisis training for law enforcement when they need to respond and or collaborate.

- **Identify and/or develop specific protocols for assessing whether a crisis response requires law enforcement due to a severe threat of violence.**

  Dispatchers will require assessment tools to best determine whether law enforcement should be included in a crisis response. Protocols should also include the possibility of a re-assessment once responders are at the scene of a crisis. There should also be the development of a continuous process for monitoring and collecting data on the appropriateness of the response and use of law enforcement.

- **Pursue the interoperability of 911 and 988 with local communities and statewide systems.**

  Ultimately all behavioral health crisis calls to whatever call system need a health-led response. The interoperability of 911 and 988 is critical to this goal. The TAC should work to find innovative solutions to accomplish this goal so all crisis call systems are interconnected and provide the best health-led response.

- **Maintain a repository of innovative strategies for all crisis work including best practices for 911/988 interoperability, behavioral health crisis response work, systems processes, and community involvement and be available for technical assistance throughout statewide implementation.**

  The TAC will become an ongoing source of best practice and innovation throughout the implementation of a statewide behavioral crisis response system. It will provide ongoing consultation and assistance in implementation considering the needs and resources of the varied communities across the state.

- **Collect and analyze required data and serve as a quality monitor for implemented response teams.**

  The TAC will ensure a commitment to quality assurance, quality control, and quality improvement by regularly soliciting and incorporating feedback that reflects the racial, ethnic, gender, cultural and religious needs of people with lived experience, their families and communities being served. A specific focus on data collection measures towards reducing the reliance on law enforcement involvement in behavioral health crisis response.

- **Provide information to communities for evaluation purposes and feedback from all stakeholders.**

  Ongoing and effective feedback and review of measures on implementation directly to communities is crucial for successful implementation. The TAC can collect and provide this information to communities as they implement a health-led response.

- **Establish an Advisory Council of key stakeholders, a majority of which should be individuals with lived experience, to advise and review the work of the center.**

  The Advisory Council will be composed of stakeholders throughout the state including individuals and families with lived experience, providers, community organizations, advocacy groups and others invested in developing an excellent crisis response system. A majority of those members should be individuals with lived experience of mental health and/or substance use challenges.

- **The Technical Assistance Center could be housed in the Office of Mental Health.**

  The Office of Mental Health is well positioned to house the Technical Assistance Center and oversee its establishment and ensure it provides the necessary services required to implement a successful health-led response system for NY State.

Implementation Considerations

The recommendations are based on a review of best practices across the nation, key stakeholder input across New York State, and models that have already begun implementation in NYS with a focus on

minimizing law enforcement involvement in mental health crises and freeing up law enforcement for their other critical work.

The review of models across the nation demonstrates the complexity of developing a truly excellent state-wide response and suggests that a phased in response with pilots focused on specific communities to inform the statewide implementation may be a practical and effective approach.

- Response teams should be designed locally following the response protocols and requirements and community partnerships and participation described in this plan. Current resources for a behavioral crisis response vary by county and region and need to be considered in developing the health-focused response team.
- These health-focused response teams could be phased in across the state, with the Technical Assistance Center gathering useful information to assist in ongoing implementation. It is important to recognize the complexity of implementing 988/911 interoperability and of scaling response time and availability depending upon status of services. Phasing in pilots in different communities that will inform successful approaches would be a practical approach.
- The initial phase could enlist multiple localities for voluntary implementation and learning, eventually providing a guidebook for statewide required implementation.
- State financial support may be needed and models for possible support are included in the funding strategy section of this report. Insurance payments from all insurers should be required.
- There would be a need in some communities to expand state-wide mobile crisis response depending upon local need as the pilots are implemented.
- The Technical Assistance Center and training needs would need state support.
- Diversity, Equity, and Inclusion would be an integral part of staffing, training, quality improvement, and community representation in design and implementation.

Conclusion

The Daniel's Law Task Force approached the examination of behavioral health crisis response with the goal of identifying strategies to improve the system in New York State. Implementing the recommendations listed above is a first step towards creating a crisis continuum in which individuals receive a health-led response when and where they need it. The work of the Task Force could not have been completed successfully without the participation of the many stakeholders who shared their experiences, insights, and thoughts as well as the many behavioral health crisis providers across NYS, the United States, and Canada who shared their innovative programming. The following appendices outline all of the research conducted on behavioral health crisis response, existing programs, stakeholder engagement, and funding options that led to these recommendations.

Appendix

Appendix A: Daniel's Law Task Force Charge - Chapter 57 of the Laws of 2023 Part OO

Section 1. Subject to available appropriation, the office of mental health, in collaboration with the office of addiction services and supports, shall establish the Daniel's Law task force, consisting of individuals with expertise in trauma-informed, community-led responses and diversions for mental health, alcohol use or substance use crises, as well as individuals affected by police responses to mental health, alcohol use or substance use crises.

(a) The Daniel's Law task force shall consist of the following ten members: (1) the commissioner of mental health, or their designee, who shall serve as chair; (2) the commissioner of addiction services and supports, or their designee; (3) the commissioner of the division of criminal justice services, or their designee; (4) one member appointed by the temporary president of the senate; (5) one member appointed by the speaker of the assembly; the commissioner of mental health, in consultation with the commissioner of addiction services and supports, shall appoint the following individuals: (6) one individual with experience in crisis response through the State Emergency Medical Services Council; (7) one individual working as a licensed mental health professional; (8) one individual who is employed as a crisis response call center personnel or crisis intervention personnel; (9) one representative of the New York Conference of Local Mental Hygiene Directors; and (10) an individual with lived experience mental health and/or alcohol use or substance use disorder.

The task force shall conduct outreach and engage stakeholders, including but not limited to healthcare professionals with experience providing mental health and/or alcohol use or substance use disorder services; individuals or the primary caregiver for individuals with lived experience with mental health and/or alcohol use or substance use disorder; individuals employed in the mental health or addiction field; crisis response call center personnel, first responders; and individuals employed by not-for-profits with experience in working with individuals experiencing mental health, alcohol use or substance use crises.

(b) The Daniel's Law task force's focus shall include, but not be limited to: identifying potential operational and financial needs to support trauma-informed, community and public health-based crisis response and diversion for anyone in the state experiencing a mental health, alcohol use, or substance use crisis; reviewing and recommending programs and systems operating within the state or nationally that could be deployed as a model crisis and emergency services system; and identifying potential funding sources for expanding mental health, alcohol use and substance use crisis response and diversion services.

(c) The Daniel's Law task force shall convene no later than one hundred twenty days following the effective date of this section and meet as frequently as its business may require, but it shall host at least three statewide town halls. A link to information regarding the task force and their activities shall be made available on the office of mental health's website.

(d) The Daniel's Law task force members shall receive no compensation for their participation but task force members shall be reimbursed for expenses actually and necessarily incurred in the performance of their duties pursuant to this act.

(e) Assistance from state and local agencies. All departments and agencies of the state or subdivision thereof, and local governments of this state shall, at the request of the chair to the maximum extent possible, provide the task force such facilities, assistance, and data to enable the task force to carry out its duties pursuant to this act. Any confidential data, when received by the task force, shall be kept confidential and shall be used solely to carry out the purposes set forth in this act.

(f) The office of mental health shall: prepare a written report summarizing opinions and recommendations from the Daniel's Law task force which includes a list of existing, publicly accessible mental health, alcohol use, and substance use crisis response and diversion services. The report shall examine the effectiveness of programs established in the state to provide crisis responses and diversion services for mental health, alcohol use, and substance abuse crises and make recommendations for the expansion of programs and services for individuals experiencing mental health, alcohol use, or substance abuse crises to receive treatment while limiting arrest or incarceration.

(g) This report shall be submitted to the governor, speaker of the assembly and temporary president of the senate no later than December 31, 2025 and shall be posted on the office of mental health's website.

§ 2. This act shall take effect immediately; provided, however, that the provisions of section one of this act shall expire and be deemed repealed April 1, 2026.

Appendix B: Themes from Stakeholder Engagement

The New York State Technology Enterprise Corporation (NYSTEC) was hired to support fulfilling **sections (a), (b), and (e) of Chapter 57 of the laws of 2023** which instructs the Task Force to "conduct outreach and engage stakeholders." These efforts focused on identifying key insights and best practices that could support New York's vision for a trauma-informed, community-based crisis response system. The summarized findings provide an overview of both the current landscape and the potential paths forward to help guide the Task Force as it developed recommendations aimed at transforming crisis services in NYS, ensuring they are responsive, equitable, and scalable.

In the NYSTEC Summary of Findings document, stakeholder engagement is described as close to verbatim as possible to eliminate potential bias, however, there were instances where stakeholders were promised that their feedback would be shared with the Task Force in a manner that preserves their anonymity through deidentified quotes and/or aggregated summaries of their stakeholder group's feedback. When feedback is offered as an aggregated summary, due diligence was conducted to provide the stakeholder group an opportunity to review and edit their input to ensure the group was represented accurately.

For the purposes of this report, the most common trends and themes shared through stakeholder engagement are summarized according to their stakeholder category.

Daniel's Law Task Force Listening Sessions Themes and Highlights

To ensure that recommendations are grounded in real-world experiences, the Daniel's Law Task Force conducted a series of listening sessions with a diverse group of stakeholders. These sessions provided a platform for gathering insights on current challenges and opportunities within the crisis response landscape. Stakeholders included individuals with lived experience, healthcare professionals, law enforcement, crisis response teams, and representatives from community organizations.

Representatives from the Task Force attended each session, actively engaging with participants to capture their feedback. Task Force members who were not present reviewed the session recordings to ensure a thorough understanding of public input. Through these sessions, the Task Force identified recurring themes and key issues that inform the recommendations presented in this report. This input from various perspectives highlighted both successes and barriers within existing crisis response systems. Included here are themes and highlights from each listening session.

November 20, 2023 – Virtual

- Focus on community and provider engagement
- Focus on preventing crises
    - Need for a robust, person-centered system of care
    - Increase investment in programs like Community Oriented Recovery and Empowerment (CORE). (These are person-centered, recovery-oriented mobile behavioral health supports. They build skills and assist in community participation and independence)
- Utilize collaborative community responders instead of Law Enforcement for crisis response

  - Use Peers as responders who will be culturally sensitive and trauma-informed using lived experience
  - Minimize police response using models like **CAHOOTS**
  - Suggestions to utilize a clinician/peer team
- Need for racial justice to stop negative impact on BIPOC communities
- Need for accurate data to examine areas of the system that may be failing
- Need for redesign of crisis services overall to focus on the above suggestions

January 11, 2024 – hosted by the State University of New York at Stony Brook in Long Island

- Need for crisis response that is peer led, designed to decrease contact with police, and centered on engagement and access to the highest quality of care
- Focus on improving marketing for 988 to raise community awareness.
- Improve community-police engagement to reduce fear – improve law enforcement approach to a mental health crisis
- Improve use of mobile crisis teams and increase capacity (number of teams) to ensure coverage for the large geographic area of Long Island
- Consider the use of Lifespan Peers with a crisis specific credential on crisis teams
- Focus on community building and infrastructure of a crisis response system

January 18, 2024 – hosted by the City University of New York: John Jay College of Criminal Justice in New York City

- Need to utilize peers in crisis response and ensure ways to make it sustainable
- Emphasis on Peers as first responders instead of law enforcement
  - Support expressed for the use of Emergency Medical Technician's as a substitute for a peer response if not available
  - Support for community organizations as first responders as well
  - Police are okay as a backup, but should not be the first response
- Emphasis on how the initial response during a crisis impacts the overall trajectory of an individual's recovery
- Need to move away from a criminal justice approach to mental illness and crisis and move away from equating mental illness with violence
- Law enforcement response to behavioral health impacts BIPOC people disproportionately
- Need to humanize the response to mental health crisis and mental illness in general
- Support expressed for the **CAHOOTS Model**
- Need for better cross systems collaboration in developing crisis response
- Need for more local resources/coordination and involvement of local government in crisis response systems

April 16, 2024 – Virtual

- The religious community is willing to assist in crisis intervention development and implementation
- Need for peers and trained mental health professionals as first responders
- Need for response to cover lifespan of people in crisis, including a special focus on children

- Participants expressed fear and concern about the death of people with mental health conditions by law enforcement
- Desire for a community response and a local response that does not involve law enforcement
    - Feelings expressed that Law enforcement may lack empathy/understanding when dealing with individuals having a mental health crisis
    - The presence and interaction with law enforcement may cause trauma for people in crisis

May 8, 2024 – hosted by Central Library of Rochester and Monroe County in Rochester

- Mental Health Professionals should be used in lieu of law enforcement
- There is a lack of helpful, reliable, and appropriate treatment for the community. The system is often not helpful and needs change
- People are often unaware of services
- Emergency services environments are not therapeutic or compassionate
- There is a need for sustainability and support for behavioral health and peer workers to continue to do the work and be available for this initiative
- Full support for peers and mental health professionals on crisis response teams instead of law enforcement
- Emphasis on need for law enforcement training to move towards a more appropriate behavioral health response
- Negative aspects of the current system disproportionally impact the BIPOC community/Individuals with disabilities
- Participants shared experiences of individuals in the BIPOC community who were in mental health distress and were seriously harmed during a law enforcement response.

People with Lived Experience

Opportunities were offered to individuals with experience receiving behavioral health crisis services or supporting someone who has received such services to share feedback through survey responses and qualitative interviews. The Office of Mental Health (OMH) Office of Advocacy and Peer Support Services (OAPSS), the Office of Diversity and Inclusion (OMH DEI), and the Nathan Kline Institute (NKI) Department of Social Solutions and Services Research partnered with NYSTEC to develop and administer surveys and interviews. Input sought from this group was collected with the intent of identifying potential ways for improving crisis services delivery from a person-centered perspective. Overall, the insights and ideas shared by participants focused on the following:

- Reducing the role of law enforcement and carceral approaches in crisis response and recognizing the roles that power, authority, and coercion can play in exacerbating risk in a given situation
- Desiring for peers to be the first point of contact in crisis and post-crisis follow-up
- Prioritizing the mental health and safety of the crisis response workforce to avoid burnout and harm while encouraging continuity of care

- Providing increased, higher quality, and standardized trainings, including but not limited to trauma, de-escalation, cultural humility, sensitivity, and communication
- Improving crisis response coordination, especially as it relates to the timing of responses, responding across different regions, and responses involving interdisciplinary teams
- Closing the gaps in the continuum of care, as well as emphasizing the importance of community supports, individualized treatment plans, preventative and follow-up care, and patient advocacy throughout that continuum
- Increasing accessibility to care by decreasing barriers throughout the continuum including, but not limited to, lowering costs, exploring geospatial differences, retaining a workforce from the community they serve, and providing patient education and support throughout their treatment plan

Peers Focus Group

Family and youth peer advocates from Families Together in New York State, Inc. participated in a focus group to discuss their ideas for integrating peer supports in the NYS crisis continuum of care. The discussion included feedback related to policy and workforce considerations that offer nuanced details to inform the development of actionable recommendations. Highlights from the discussion include:

Recruitment and Retention

- Peer Advocates will not choose this career without a living wage. The work is tough, conditions can be challenging, and passion alone is not enough. Inadequate pay and burnout lead to high turnover, negatively affecting youth and families in crisis who need reliable support.
- Peer advocates are being assigned to work in crisis intervention roles. Crisis intervention is outside their scope of practice, and they feel unprepared due to lack of training. If they are to provide these services, just like any other discipline, they need proper training, compensation, and support.

Policy

- When it comes to systems and services, "The crisis is the wait list." Crisis often takes place, in the interim weeks/months that families are seeking and waiting for services. The State lacks a community-based system, which is part of the fundamental problem.
- Addressing systemic issues requires acknowledging the need for workforce stability, which is undermined by inadequate compensation that doesn't reflect peers' value. The current reimbursement rates need to be improved and should account for uncompensated time worked.

Practice

- Lived experience are a key component of advocacy. A Peer Advocate's knowledge of what a family is going through can supersede having advanced degrees.
- It is important for youth in crisis to see that someone with lived experience got through the struggle. It empowers them and demonstrates a model of success.

- Advocates have relationships with the service providers. They assist with navigating the system and function as a liaison between service providers and families. Often times, advocacy is about physically "Getting people to the door."
- Advocates are not only connecting families to resources, sometimes they are educating families on being resourceful when the resources are not there, and the child is on a waiting list.

Innovative Ideas

- Having funding to support full-time employees rather than per-diem work would help stabilize the workforce.
- Successful programs to explore: **Family Ties of Westchester** and **AspireHope NY Inc.**

Public Safety Officials

Public safety officials provided insights into the integration of 911 and 988 systems and the evolving role of law enforcement in behavioral health crises. Engagement efforts included surveys, discussions with organizations such as the Law Enforcement Action Partnership (LEAP) and Vibrant Emotional Health, and meetings with public safety technology vendors like Carbyne. Key findings emphasized the need for improved infrastructure to support 911/988 call diversion, reduced law enforcement involvement in crisis response through alternative models, and the use of advanced technologies to enhance interoperability. Observations from the Municipal Police Training Council (MPTC) highlighted opportunities to strengthen police training and set benchmarks for effective crisis response. These findings underscore the importance of collaboration, technology integration, and consistent training to optimize public safety officials' contributions to behavioral health crisis response efforts statewide.

NYS Local Government Partners

Local government stakeholders, including city and county representatives, highlighted critical gaps and opportunities in crisis response systems across New York State. Key areas of need include increased funding for crisis response teams, sustainable staffing, and technology upgrades to improve service delivery and coordination. Stakeholders emphasized the importance of local planning to address unique community needs, particularly in rural areas where geographic challenges and limited resources hinder timely responses. Coordination between 911, 988, and local crisis services was identified as a barrier, with many regions reporting partial integration or insufficient collaboration. Workforce shortages, low salaries, and limited training opportunities were repeatedly cited as obstacles to expanding services. Additionally, stakeholders stressed the need for community-based preventive measures, greater access to peer support, and investment in early intervention to reduce reliance on emergency responses. These insights underscore the urgency of state-level support to address disparities, improve system integration, and enhance the sustainability of local behavioral health crisis response systems.

Provider Network

Input from providers was sought through a survey to gain clarification on how and when they use crisis services and to garner their feedback on where there are opportunities to improve crisis services. A key survey question was, "From your perspective, what changes do you believe would improve crisis stabilization services in your area?" Responses from providers gave a range of ideas with the following overall themes:

- Recruit and retain more staff through higher pay and overall compensation that fairly compensates the workforce for the high intensity of crisis services and having to respond to unpredictable circumstances.
- Revise staffing policies to recruit individuals who are not licensed to mitigate the difficulty recruiting licensed professionals who are willing to work in the community.
- Provide training to all mobile crisis workers that includes cultural sensitivity, trauma-informed care, safety protocols, and administering Narcan.
- Improved communication and collaboration between providers throughout the crisis continuum of care.
- Better communication and care between providers and social supports.
- Reduce hospitalizations and arrests by providing a co-response model between law enforcement and social services agencies.
- Extend the length of time that someone can utilize crisis stabilization services.
- Provide higher level of care services to prevent chronic crisis.
- Expand access to services including mobile response teams, ambulances, transportation to stabilization centers, wraparound services, home visits, youth services, and respite housing.

Advocacy, Legal, and Community Organizations

The advocacy, legal, and community organizations stakeholder group are organizations that represent communities most impacted by the implementation of the Daniel's Law Task Force recommendations. Many of the organizations within this stakeholder group provided public comments at Task Force meetings. To round out what was shared at the Task Force meetings, a survey was distributed to these groups as a means to gather their feedback on considerations for developing recommendations.

Respondents were asked to provide three recommendations to the Task Force on behalf of their organization. Summarized highlights from their recommendations included:

Funding and Infrastructure Support Recommendations

- Ensure adequate funding and technical support is made available to localities who submit plans to create crisis response teams.
- Make sure there are adequate amounts of crisis respite centers and stabilization centers in every region to support individuals in need.
- Ensure resources are provided to expand the behavioral health workforce and provide funding for healthcare professionals to intervene in crisis situations.

- Increase funding for 988 to continue to scale the 988 system and its workforce.
- Launch pilot programs to expand peer supports across NYS.
- Increase base rates of reimbursement to allow not-for-profit agencies providing mental health services to attract qualified professionals with reasonable salaries commiserate to their qualifications and experience.
- Implementation must include expansion and funding of culturally responsive care through a continuum of services in each community.

Policy and Procedure Recommendations

- Support the inclusion of peers throughout the crisis care continuum including prevention services, crisis response, and follow-up care. Center the crisis care continuum on consensual, community-informed care, and de-escalation.
- Prioritize having peers lead crisis response services and minimize the presence of law enforcement and eliminate the inclusion of law enforcement whenever possible.
- Establish a Peer Oversight Board composed of people living with serious mental illness to provide guidance and accountability for the mental health crisis response system and its implementation.
- Develop an oversight structure that holds all mobile crisis teams to a uniform and transparent standard of quality, including minimizing the use of police and hospitalization, cultural humility, community representation, use of force, and quality of services provided.
- Educate and train law enforcement personnel and other first responders on all aspects of behavioral health including cultural humility, trauma-informed care, mental health disorders, substance use disorders, and individuals with intellectual and developmental disabilities.
- Address the silos separating people with disabilities and co-existing behavioral or mental health conditions preventing cross-agency service access.
- Provide affordable professional development and education options to encourage individuals to pursue a career as a mental health provider and subsequently bolster the crisis services workforce. Develop a workforce pipeline so community members with diverse backgrounds can more easily be trained to become mental health providers.
- Make mental health care accessible to crisis services responders to reduce burnout and workforce turnover.
- Transition behavioral health crisis calls out of the 911 system and use 988 as a 24/7 triage system for calls.
- Give real-time resolution and/or support when there is a discrepancy between the response team and the dispatching 988 contact center.
- Integrate 988 with the social service system to connect callers to programs and services that are accessible and community-based to address root cause stressors, such as, housing insecurity, poverty, and systemic barriers to accessing care.
- Develop uniform eligibility criteria that be adjusted due to the unique needs related to region, race, available services, financial circumstances, and historical experiences with service providers.
- Better support transitional services, crisis stabilization centers, and follow-up care that are provided by community-based organizations.
- Distribute surveys on an ongoing basis to collect data for program evaluation and accountability.

- Ensure that crisis services are equitable to the community served. If a community has been successful implementing crisis intervention trainings to law enforcement, then that success must continue. There cannot be a one-size fits all approach statewide.
- Members of the community must be involved in recommending what type of crisis services are needed in their area.

Crisis Services Subject Matter Experts

Similar to the Peers Focus Group, crisis services subject matter experts participated in a focus group to discuss best practices for the crisis continuum of care and to offer ideas around prioritization for Task Force recommendations. Highlights from the key takeaways from subject matter experts included the following:

Sustainable Funding Innovative Practice and Solutions

- Different crises are funded in different ways, depending on who is paying or whether police involvement or CCBHC involvement. "The funding drives the model."
- Look at Maine and Arizona for examples of sustainable funding. Maine has clear oversight, by the state, who could create the crisis system they wanted through RFPs and specific funding. Arizona is successful with braided funding, so there is access to everyone.
- Prospective payment system allows flexibility/innovation. Important to build specific program into cost report and justify a need for it.
- Sustainable funding not just about the right funding mechanism, it's also about the culture within the agency systems. Providers have been deficit funded for so long, they may not see the need to get into Medicaid and insurance during a crisis. Need to teach agencies about billing in new way and change a substantial cultural with agencies.
- The state may fund the "fire station model" of people not being busy. Passive services that take place and being able to cover that overhead is important, not just the billable parts.

Workforce Innovative Practice and Solutions

- Develop a robust crisis workforce with focus on traits and training over formal education credentials.
- Build and consider the infrastructure necessary for support. Create Centers of Excellence/Capacity Building Centers to develop creative training curriculum, offer coaching and support to providers, understanding competencies.
- Data-driven approach is needed in creating, retaining, and supporting a quality workforce. Utilize data to assess skills, ensure fidelity/alignment to a specific model selected, design targeted training and support to target gaps in skills and ensure workforce competency development. Survey the workforce, themselves, regarding needed support, beyond basic competencies.
- Strengthen pipelines by improving recruiting, retention, and career pathways. Diversify this field, making it more attractive to potential workforce. Partner with educational institutions for field placements and work-study opportunities and promote technical school programs for behavioral health (i.e., Oregon) early on, engaging people beyond traditionally clinical paths.

- Consider workforce from a children and family perspective. Peers to include people with lived experience. Integrate youth peers/near-age peers and parent support/family caregivers' peers with lived experience in children and family services.
- Need professional recognition for peers. Acknowledge peers as professionals, providing appropriate support and compensation. Their qualification should be equal to a professional qualification.

Collaboration with Law Enforcement Innovative Practice and Solutions

- Interoperability between 911 and 988 is needed. Need good relationship between mental health and law enforcement (i.e., Harris Center in Texas). 911 gets embedded under law enforcement and behavioral health crises needs to be separated out.
- Need a consistent approach to assessing risk to public around immediate danger and talking about weapons. Opportunity for standardized, consistent way of identifying immediate danger as a result of violence or weapons in play.
- Encourage specificity when assessing safety and dangerousness. Ensure understanding of first responder partners' lingo (i.e., "weapon in possession" vs. "gun on site").
- Exhaust efforts to avoid law enforcement functioning as the lead responder.

Appendix C: Funding Strategy Roadmap - Transforming New York State Crisis Response

The Funding Strategy Roadmap outlines a proposed phased approach to implementing a funding and governance framework in support of the Daniel's Law Task Force's objectives to enhance and expand community crisis response services across New York State. It is intended as high-level guidance and would require further development to operationalize.

The Funding Strategy Roadmap is available on the Task Force website:
https://omh.ny.gov/omhweb/daniels-law-task-force/

Appendix D: Transforming New York State Crisis Response - NYSTEC Summary of Findings

A summary of research findings to fulfill sections (a), (b), and (e) of the Daniel's Law Task Force charge. This summary serves as the foundation for the final Recommendations Report by detailing considerations for the Task Force to review based on stakeholder feedback and research findings.

The NYSTEC Summary of Findings document is available on the Task Force website:
https://omh.ny.gov/omhweb/daniels-law-task-force/

Appendix E: NYS and Landscape Programs Comparison Tool

The NYS and Landscape Programs Comparison Tool provides a matrix to support comparing the approaches outlined in the New York State and Landscape Program Profiles that were highlighted in the

NYSTEC Summary of Findings. The high-level, program overview information is organized into a grid to more easily identify similarities and differences between programs, with the ability to filter by a range of features. For the more comprehensive program overview, reference the full program profiles in the NYSTEC Summary of Findings.

The NYS and Landscape Programs Comparison Tool is available on the Task Force website: **https://omh.ny.gov/omhweb/daniels-law-task-force/**

Appendix F: Publicly Accessible Behavioral Health Crisis Response and Diversion Services

To fulfill **section (f) of Chapter 57 of the laws of 2023**, a list of currently existing, publicly accessible behavioral health crisis response and diversion services are available at the following links:

- **Find a Mental Health Program** – website hosted by OMH that provides a directory of mental health programs by county and program category or subcategory using the **Advanced Search** option. To locate crisis service providers, select "Crisis" from the program subcategory dropdown menu.
- **OASAS Provider and Program Search** – website hosted by OASAS that provides a directory of substance use treatment services. To find crisis services providers, under the Program Name/Type section, select "Crisis Services" from the dropdown menu.