

SAVING LIVES, REDUCING TRAUMA

REMOVING POLICE FROM NEW YORK CITY'S
MENTAL HEALTH CRISIS RESPONSE

NYLPI

JUSTICE THROUGH
COMMUNITY POWER

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EXECUTIVE SUMMARY

Since 2015, police in New York City have killed at least 18 people experiencing mental health crises,¹ 15 of whom were people of color.² The killings are a microcosm of police violence around the world. Spurred by the deaths of Black Americans at the hands of police, including George Floyd and New Yorker Daniel Prude, millions across the nation and around the world were galvanized to fight against such injustices.³ Intensively resourced training of police officers has not prevented such killings; to the contrary, footage New York Lawyers for the Public Interest (NYLPI) has obtained from body-worn cameras shows police escalating conflict, sometimes with deadly results.⁴

Yet in New York City, police are the longstanding *de facto* first responders to mental health crises, and the repeated violent encounters with people experiencing a crisis, despite decades of attempts at reforms, show again and again that police are ill-equipped to de-escalate and safely address mental health crises.⁵ In 2020, police responded to over 150,000 calls regarding people experiencing a mental health crisis. New Yorkers experiencing mental health crises who do survive their encounters with police routinely report disrespect and deepened trauma. People who lack access to mental health services prior to their crises do not effectively connect to care through police intervention. Earlier this year New York City's most recent pilot project, the Behavioral Health Emergency Assistance Response Division (B-HEARD), began dispatching City EMTs and paramedics teamed with mental health professionals from NYC Health + Hospitals to some Harlem neighborhoods. But the program operates only part-time, the police are still treated as the default response, and the only data released to date covers one month — during which 80 percent of calls regarding mental health crises did not receive any assistance from B-HEARD.

To explore community experiences with mental health crisis response, NYLPI worked with community partners to formulate and distribute a survey about New Yorkers' experiences with governmental responses to mental health crises. NYLPI's analysis of the survey responses, combined with resources from our campaign to transform New York City's mental health crisis response, provide compelling support for shifting New York City's response to mental health crises from police to health professionals and trained peers (those with lived mental health experience).⁶

KEY FINDINGS:

- Respondents who experienced a mental health crisis to which police responded said that they received inadequate care or did not feel safe with the responding officers.
- Respondents stated that even in the absence of a report of a crime or any indication of potential harm to others, 911 routed calls about mental health crises to police, which resulted in increased interactions with the criminal legal system.
- Police response triggered fear, undermined trust in governmental systems providing mental health resources, and deterred New Yorkers from subsequently seeking help or care.

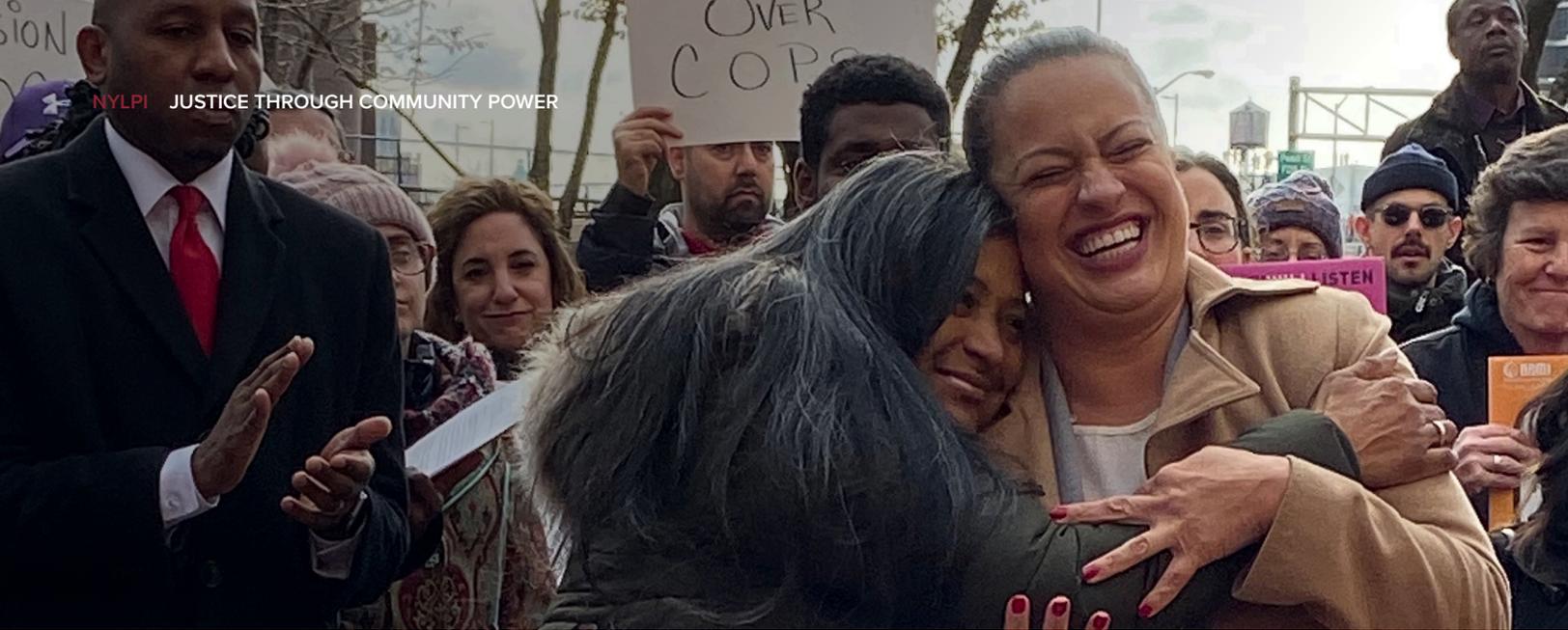
KEY RECOMMENDATIONS:

- Cease referring mental health crises to police, substituting teams of independent EMTs and trained peers.
- Route calls for help addressing mental health crises to a number other than 911.
- Provide system oversight through an advisory board with a majority of peers from low-income Black, Latinx, and other communities of color.
- Expand availability and affordability of mental healthcare services, including therapeutic and psychiatric care.
- Expand and improve outreach and education, including by providing information about available community-based mental health resources.
- Collect and analyze data on short-term and long-term recipient outcomes, to identify any shortcomings and prioritize practices that provide the greatest benefit.

KEY BENEFITS:

A non-police mental health crisis response system will:

- reduce trauma and violence;
- promote connections to mental health support services;
- conserve resources by reducing the burden on psychiatric facilities and the police; and
- save lives.



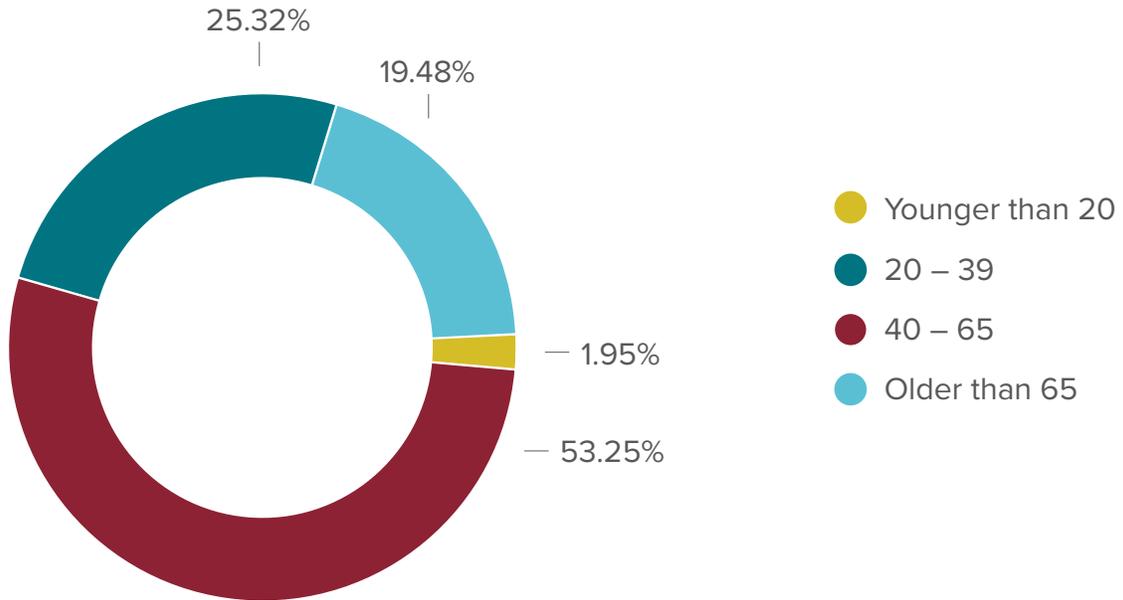
PART I: THE COMMUNITY SURVEYING INITIATIVE

To explore the impact of police responses on people experiencing mental health crises in the metro New York area, NYLPI joined with the National Alliance on Mental Illness — NYC (NAMI-NYC),⁷ Voices of Community Activists and Leaders (VOCAL-NY)⁸ and Correct Crisis Intervention Today — NYC (CCIT-NYC)⁹ to develop and distribute an anonymous survey. From September 2020 to June 2021, we used targeted social media, email, and community outreach to distribute our online form in seven languages: Arabic, Chinese, English, Haitian Creole, Korean, Russian, and Spanish.^{10,11} Community members who participated received a resource guide with information on mental health services in the New York City metro area, know-your-rights information, and ways to remain engaged with efforts to change New York City’s response to mental health crises.¹² Healthcare and legal resources may be difficult to find online; distributing such information was, therefore, important to provide access to mental healthcare to avoid a mental health crisis in the future.

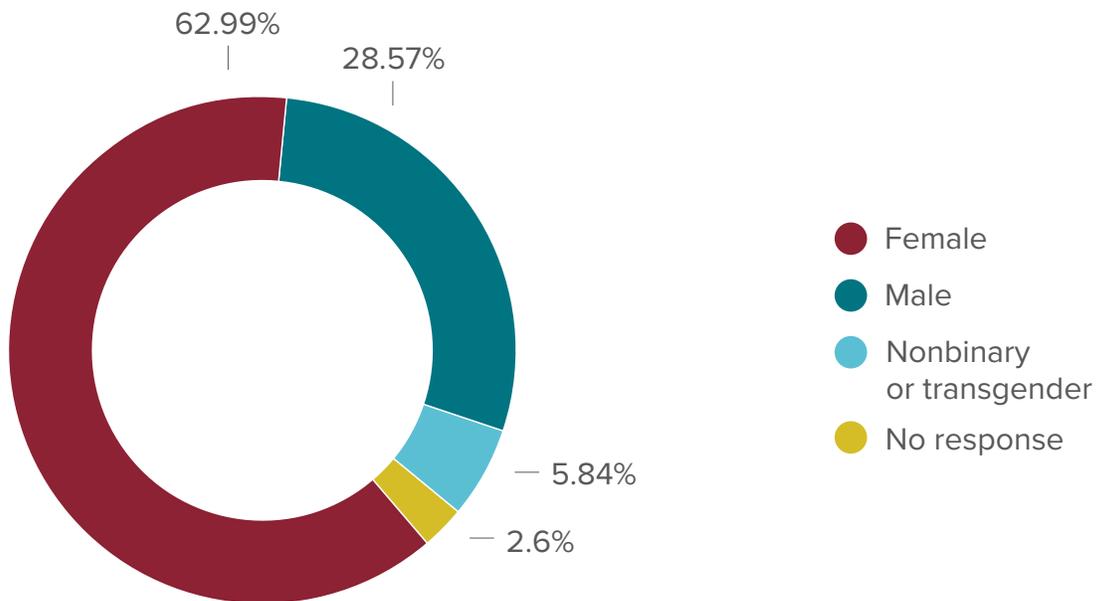
NYLPI analyzed and summarized 154 survey responses.¹³ Some respondents provided information about their own experiences, and others recounted situations they had witnessed affecting family members, friends, or strangers who experienced a mental health crisis.

DEMOGRAPHICS OF RESPONDENTS

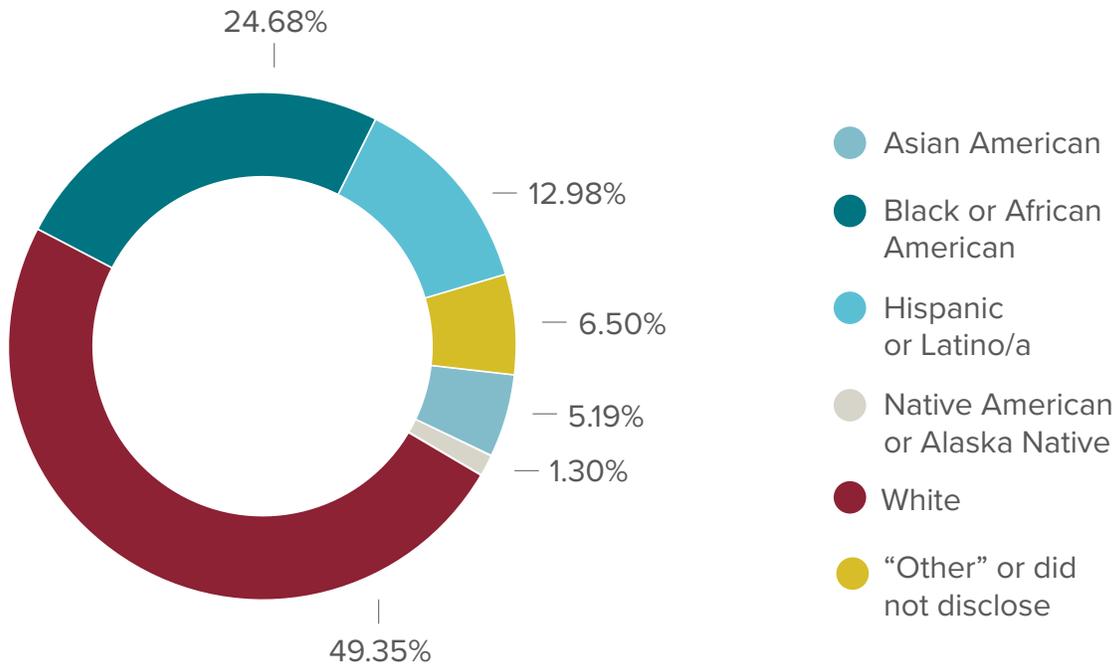
Age



Gender

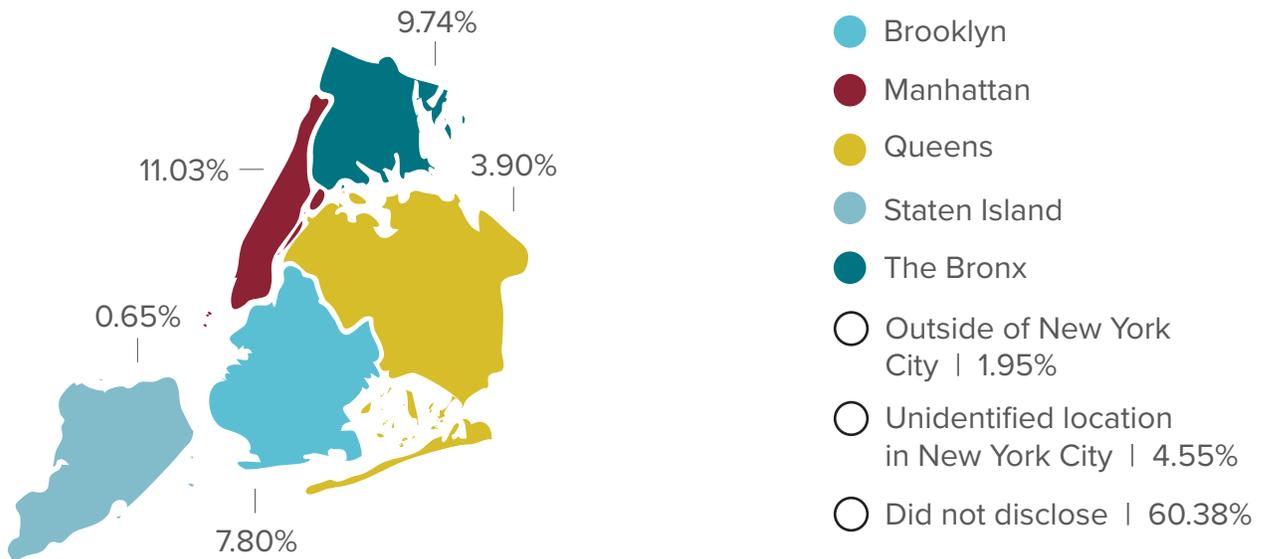


Race/Ethnicity

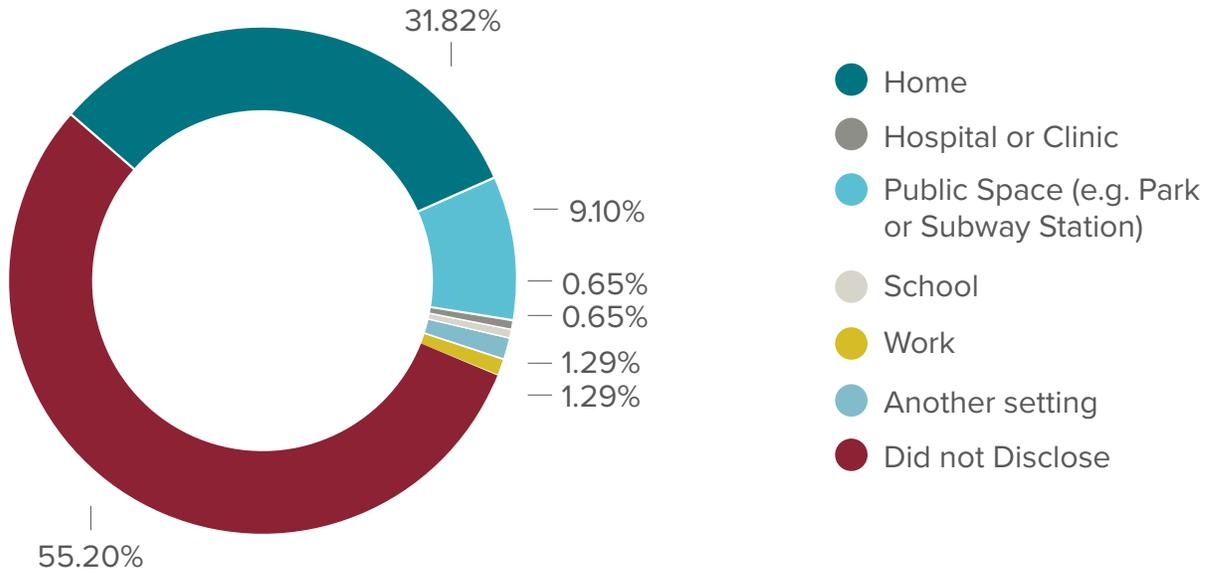


STATISTICAL BREAKDOWN OF CRISIS EXPERIENCES

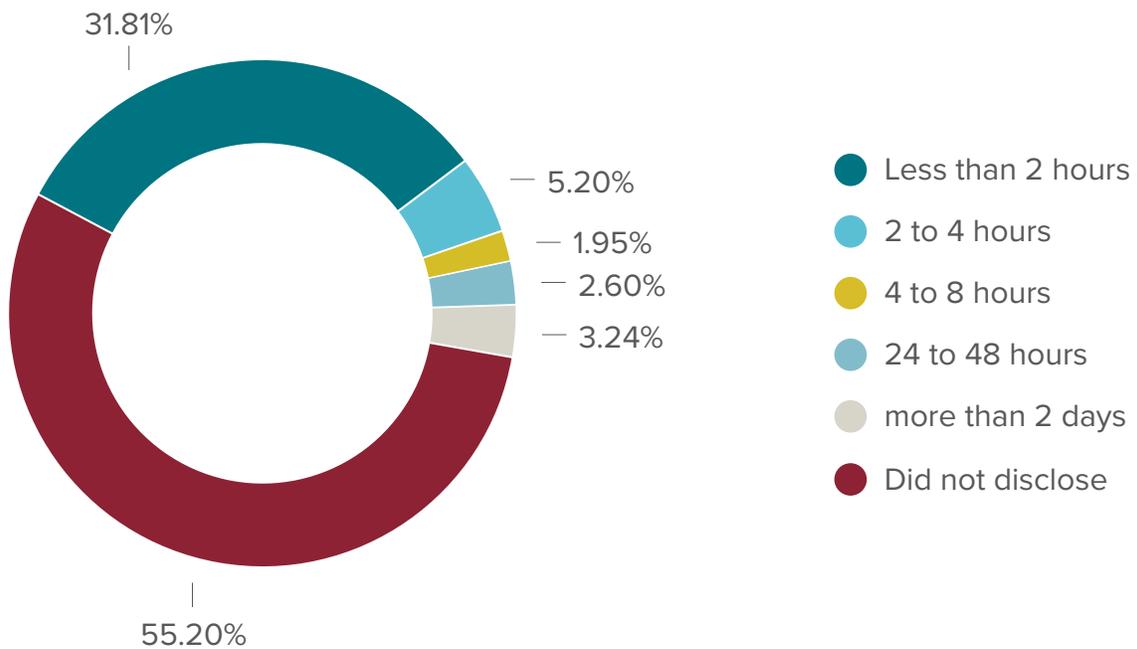
Boroughs and neighborhoods where mental health crises occurred



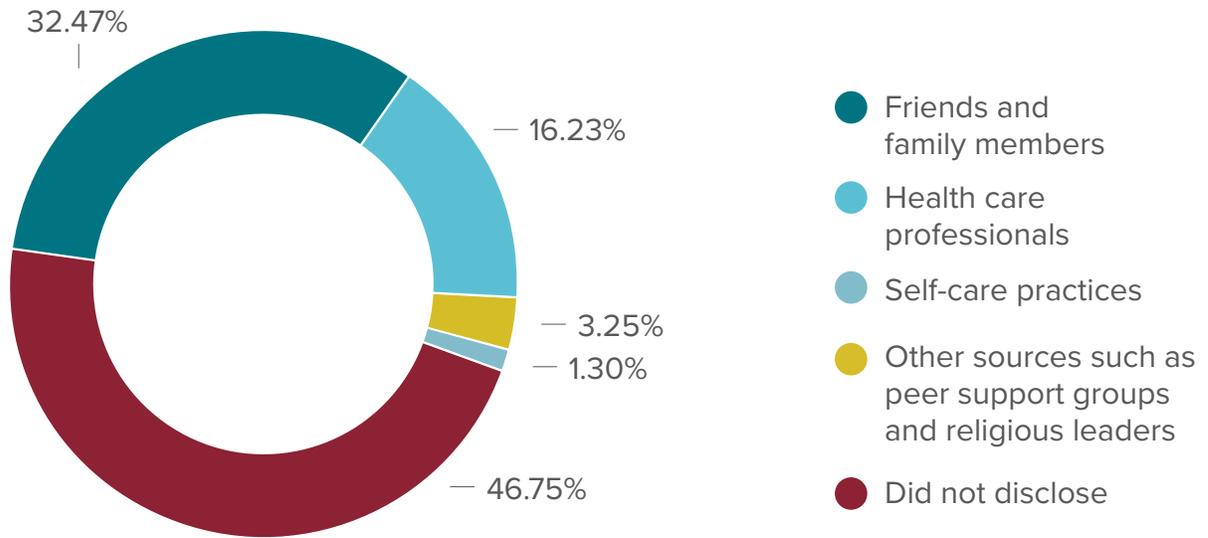
Reported settings where people experienced a mental health crisis



Wait times for crisis response



Sources for respondents' day-to-day mental health support



STATISTICAL BREAKDOWN OF CRISIS RESPONDERS



47.40% reported calls to 911 for assistance with a mental health crisis.¹⁴

Of the respondents who reported calls to 911:



65.75% reported that the New York Police Department (NYPD) — either alone or with New York City’s Emergency Medical Services (EMS) — responded to their calls.



31.51% did not state whether or not NYPD responded with EMS.



2.74% reported that they received a non-police response.



PART II: SURVEY FINDINGS

The survey’s results are powerful examples of the harm caused by a police-based response to mental health crises, and support the need for reform (explained in further detail in Parts III & IV).

INADEQUATE OR DANGEROUS RESPONSES TO MENTAL HEALTH CRISES

Of the twenty survey respondents who shared additional narrative information describing their experiences with 911 responders, 100% described harmful experiences, including inadequate care and treatment, re-traumatization, injuries, unnecessary and inappropriate involvement in the criminal legal system, forced hospitalizations, and elevated fear and mistrust towards law enforcement.¹⁵

Respondents described their experiences:

“The cops were not courteous at all. [T]hey seemed to be annoyed at helping me, instead of trying to make me feel comfortable, it seemed that I was making them feel uncomfortable.... [T]hey were harsh, mean, and did not know how to approach me while I was experiencing an emotional breakdown.... The cops were not trained, had no idea what to do, and were rude.... They ended up shoving me into the car and driving me to the hospital, only to dump me there and not even ask me if I was doing better.”

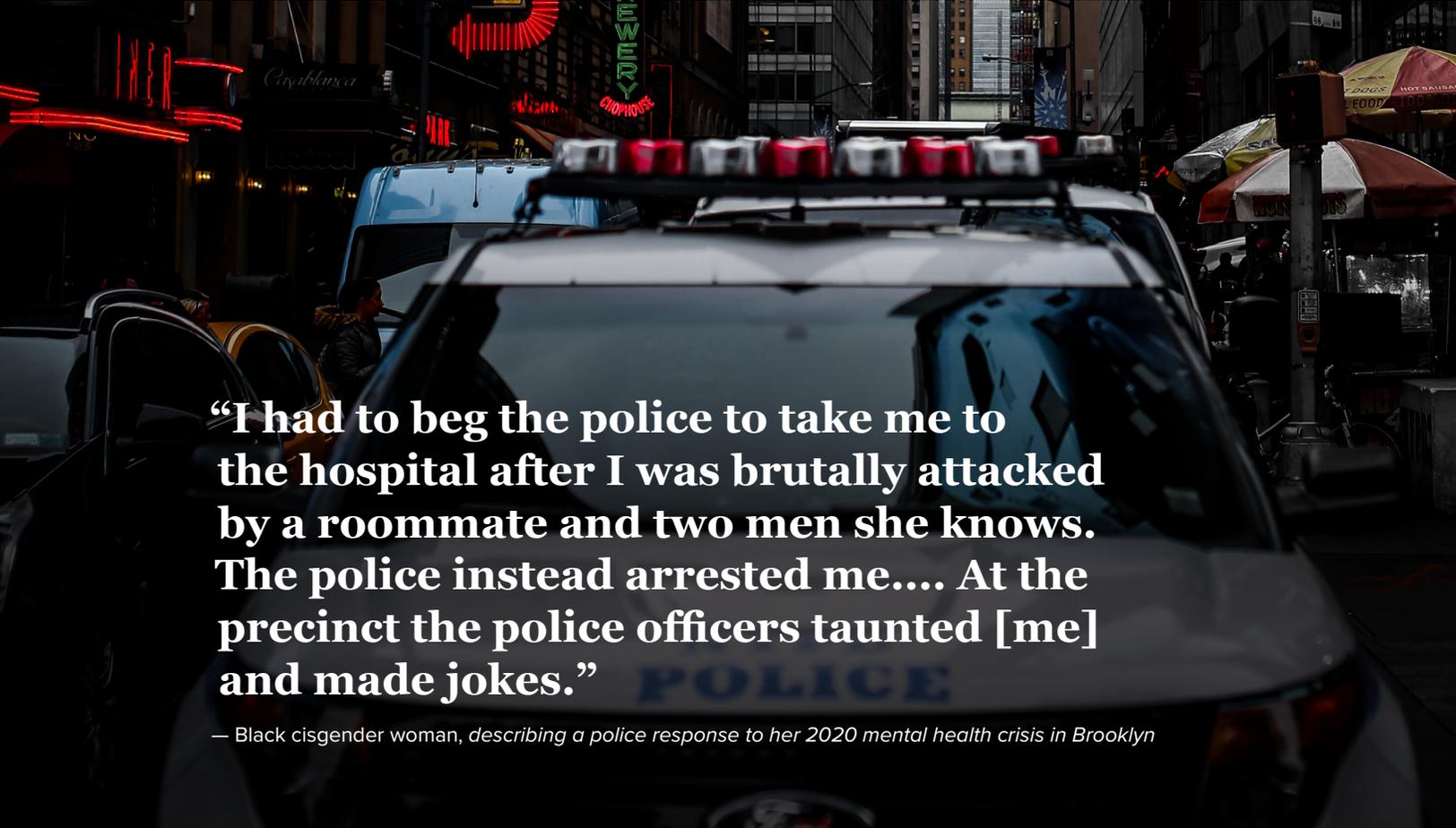
— Black queer man, *describing a police response to their mental health crisis at their Bronx home*

“The police officer who was white was on the edge of pulling his gun out to me. He was not understanding the situation even as my wife was explaining to him and his partner that I suffer from [mental illness]. The police officers did not understand that I was having a mental psychotic episode.... The police did not draw their weapons on me, as my wife explained to them what was happening. The police called for EMS and then the EMS drove me to the hospital.”

— Black cisgender man, *describing a police response to his 2019 mental health crisis at his Brooklyn home*

“They were aggressive, I felt discriminated [against] because I am a poc [person of color]. I was afraid, they did not approach me in a sensitive manner, I felt like an animal... I am an immigrant, living alone in NYC.”

— Black nonbinary person, *describing a police response to their 2020 mental health crisis in their Bronx home*



“I had to beg the police to take me to the hospital after I was brutally attacked by a roommate and two men she knows. The police instead arrested me.... At the precinct the police officers taunted [me] and made jokes.”

— Black cisgender woman, *describing a police response to her 2020 mental health crisis in Brooklyn*

“I had a very traumatic encounter with the NYPD in ... 2014 where I, completely compliant and not at all verbally aggressive, but in a psychotic and manic state, was tackled and pinned to the ground and arrested.... The NYPD officers that cornered me in the hallway of my apartment building and escorted me away in handcuffs in a police car to Centre Street wouldn't let me put on shoes, or even check to see if my apartment door was locked. The handcuffs were unnecessary and entirely too tight, cutting off[f] my circulation. I remained handcuffed for hours with them only being removed to go to the bathroom, once I was in the court building. I didn't get to eat a meal the entire day from the time they cornered me at 9am (I had had no breakfast) to mid-afternoon. I was also very dehydrated. I was treated like a criminal.... Naturally, when... police [later] showed up in my apartment building, I was thoroughly re-traumatized.... ”

— White cisgender woman, describing a police response to her 2014 mental health crisis at her Harlem home

“The cops treated me like an animal, they were not understanding that I was experiencing a mental crisis, they were rude and ruthless. They handcuffed me and shoved me into the cop car. Then they drove me to the hospital and dumped me there. I felt that the doctors were too busy to help me. I felt like I was a nuisance.”

— Black nonbinary person, describing a police response to their 2020 mental health crises at their Bronx home

“I was taken ou[t] of my [apartment] in handcuff[s] kicking and screaming.”

— White cisgender woman, describing a police response to her mental health crisis in her Manhattan home

In sum, survey respondents indicated that police use of force while responding to them during a mental health crisis left them feeling traumatized, disrespected, fearful, and distrustful of law enforcement and other emergency response services.



“Armed police, large build... handcuff[ed] to ch[a]ir... more empathy and compassion, more humane treatment”

— White cisgender woman, describing a police response to her 2014 mental health crisis in her Manhattan home

IMPACT OF MENTAL HEALTH CRISIS RESPONSES ON PEOPLE OF COLOR

Fifty-six percent of respondents who reported calls to 911 for help during a crisis identified as Black, African American, Hispanic or Latino/a, or other people of color, and many of them reported experiencing a violent or unsafe encounter with the police and other responders.

“My mom called 911.... The cops were white, we are from Haiti. My mother speaks broken English and she was trying to explain my condition. The cops refused to listen and put me against the wall and gra[bb]ed my arms and wrists.... They literally threw me into the cop car and left me there until the ambulance came and took me to the hospital.”

— Black cisgender woman, *describing a police response to her 2020 mental health crisis at her Bronx home*

“My friend dialed 911 for help and the police arrived. I am a person of color and the police were forceful. They forced me to turn around, restrained me and bruised my arms and wrists. They then called for EMS services and they took me to the hospital.”

— Black transgender man, *describing a police response to his 2018 mental health crisis at his Brooklyn home*

“My wife called for an ambulance but the cops showed up instead. We were all very scared since we are colored. Knowing [about] recent killings of black folks experiencing a crisis by the police, I was extremely afraid for my life....”

— Black cisgender man, *describing a police response to his 2019 mental health crisis at his Brooklyn home*

“My roommate called 911. She did not ask for mental health support, the cops came. They were aggressive, I felt discriminated [against] because I am a poc [person of color]. I was afraid, they did not approach me in a sensitive manner, I felt like an animal. They made me feel worse than I already felt.... I am an immigrant, living alone in NYC. I do not have anyone and suffer from depression and anxiety. I suffered through a lot of trauma and have been diagnosed with PTSD. I was abused as a child, and during the holiday season, I am at my lowest. I suffered a depression and panic attack coming home from work. Felt alone, felt stuck, I wanted to end the loneliness.”

— Black nonbinary person, *describing a police response to their 2020 mental health crisis at their Bronx home*



The survey's responses align with the statistics that disability is more prevalent in the Black community and other communities of color,¹⁶ align with reports that communities of color experience a high level of aggression from the police that can escalate into violence,¹⁷ and align with the statistics that people who are shot and killed by the police when experiencing mental health crises are disproportionately Black and other people of color.¹⁸

AVOIDING HELP DUE TO FEAR OR MISTRUST

Survey-takers reported that their fear and mistrust of New York City's current police-led response system have deterred them from seeking help or care, even during a mental health crisis.

“I don't trust these folks and they can't help me anyway. I need therapy I can't pay or dedicate the time to. My house is full and my hours are long.”

— Black cisgender woman, *describing her choice not to seek help during her 2020 mental health crisis in Brooklyn*

“I did not want to call the police for fear of possible police brutality.”

— Black cisgender woman, *describing his choice not to seek help during her 2020 mental health crisis at her Brooklyn home*

“I ran away from home instead of seeking help.... [We need] [I]ess involvement of law enforcement and immediate response of mental health crisis workers.”

— White cisgender man, *describing his choice not to seek help during his 2007 mental health crisis in Queens*



PART III: STATE OF MENTAL HEALTH CRISIS RESPONSE IN NEW YORK CITY AND BEYOND

As illustrated by the descriptions of lived mental health experiences above, police responses to mental health crises often begin not with a report of a crime, but with a call from a concerned family member. Almost one in four mental health calls to 911 begins with a family member’s request for assistance, and more than half of mental health calls are attributable to concerns about suicide or self-harm.¹⁹ The crisis calls are the result of the lack of community-based treatment and the shortage of psychiatric care.

The reliance on police as de facto first responders to these mental health crisis calls drives the criminalization of mental illness. According to a Treatment Advocacy Center survey, “[p]eople with mental illness are more likely to be arrested if they live in communities with limited treatment options.”²⁰ Law enforcement officers may be inclined to charge individuals with severe mental illness with a misdemeanor and take them to jail if they believe that no appropriate alternatives are available, a practice sometimes referred to as “mercy booking.”²¹ “[I]n some parts of the country psychiatric treatment is more accessible in jail than in the community.”²² Encounters between police

and individuals experiencing mental health crises predictably contribute to the overrepresentation of people with mental illness in carceral institutions.²³ They are four times more likely to be incarcerated for low-level charges than individuals without mental illness.²⁴

In New York City in 2020, police responded to over 150,000 calls regarding people experiencing a mental health crisis,²⁵ with these calls defined by the New York Police Department (NYPD) as any situation in which a person “appear[s] to be mentally ill or temporarily deranged [sic] and are conducting themselves in a manner that a uniformed member of the service reasonably believes is likely to result in serious injury to themselves or others.”²⁶

Currently, individuals call 911 regarding mental health crises, and without a separate mental health crisis line, calls for assistance placed to 911, are routed to police.²⁷ Individuals with mental illness are disproportionately killed and injured by the police. People with mental illness account for approximately one-quarter of all people shot and killed by police in the United States,²⁸ and New York City is no exception. **Since 2015, the NYPD has killed at least 18 individuals who were experiencing mental health crises, 15 of whom were Black or other people of color.**²⁹ The NYPD’s own data show that in 2020, individuals experiencing mental health crises accounted for at least 23% of all instances of use of force by police, 22% of instances of use of physical force by police, and 29% of Taser discharges by police.³⁰

Despite the severity of this situation, New York City’s new pilot serving parts of Harlem, the Behavioral Health Emergency Assistance Response Division (B-HEARD) program, continues to treat police as the default response in most cases. According to the one month of data released at the time of this report’s publication, the B-HEARD pilot operated for only 16 hours per day, during which 911 routed 25% of the area’s “mental health emergency” calls to the pilot. Furthermore, this limited pilot rejected one in five of all referrals. In other words, for eight hours a day, no callers received a B-HEARD crisis response, and overall, approximately 80% of the crisis calls received no aid from B-HEARD.³¹

In response to the harm done by police-based systems, increasing numbers of communities across the country have turned away from using police as first responders, instead using healthcare providers and peers,³² (those with lived mental health experience), and coordinating with medical and behavioral health services. “Having a peer on the team is essential, as a person with lived

experience, a person who has ‘been there,’ can best relate to the fear of an outsider responding in a moment of crisis and can prove that recovery works.”³³ Peers are trained in cultural competency, de-escalation techniques, and how to problem-solve.³⁴ As Christina Sparrock, a steering committee member of CCIT-NYC has explained, peers “know exactly what a crisis looks like and what recovery looks like. We share personal stories. We create safe spaces and we empower and uplift people.”³⁵ Crisis Intervention Team International — a group consisting primarily of police, which developed crisis intervention team (CIT) training for police 35 years ago — now argues that a healthcare response is the only appropriate response for a mental health crisis, as law enforcement responses often escalate — rather than de-escalate — mental health crises.³⁶ A person experiencing a mental health crisis may have trouble following orders from law enforcement and may become even more distressed due to fear of actions law enforcement may take, including arrest or the use of force.³⁷

On the other hand, the highly successful CAHOOTS (Crisis Assistance Helping Out On The Streets) program has operated in Eugene, Oregon, for more than three decades.³⁸ “The program mobilizes two-person teams consisting of a medic (a nurse, paramedic, or emergency medical technician (EMT)) and a crisis worker”³⁹ that are not members of law enforcement. CAHOOTS has stated that at any given time, upwards of 75% of its staff are peers.⁴⁰ **Importantly, in CAHOOTS’ three decades of service, handling as many as 24,000 calls a year, not a single person — community member or staff — has ever been seriously injured.**⁴¹ Non-police programs inspired by CAHOOTS have emerged in cities across the country, including Aurora, CO;⁴² Austin, TX;⁴³ Denver, CO;⁴⁴ New Haven, CT;⁴⁵ Oakland, CA;⁴⁶ Olympia, WA;⁴⁷ Portland, ME;⁴⁸ Rochester, NY;⁴⁹ and San Francisco, CA;⁵⁰ — and more are on the way. The American Rescue Plan Act also included federal funding for states to establish civilian crisis response programs modeled after CAHOOTS.⁵¹

A non-police mental health crisis response system can also save money. CAHOOTS saves the City of Eugene approximately \$8.5 million per year in public safety spending.⁵² CAHOOTS has a budget of about \$2.1 million per year, in comparison with about \$90 million for police serving the same jurisdiction.⁵³ Scaling this figure to New York City’s 77 police precincts, it would cost roughly \$100 million per year for New York City to implement such a program — as proposed by CCIT-NYC (see Part IV below) — citywide,⁵⁴ which is equivalent to less than 1% of total annual spending on the NYPD (roughly \$11 billion in FY 2020).⁵⁵ Additionally, the proposal will conserve resources by lessening

the burden on inpatient psychiatric facilities, police, and other de facto first responders.

A non-police model will also reduce spending on claims stemming from police encounters with people experiencing mental health crises.⁵⁶ Looking at costs in New York City, and based on available statistics from the Office of the New York City Comptroller, NYLPI estimates that encounters between police and individuals experiencing mental health crises likely account for a significant portion of the City’s over \$95 million yearly payments for personal injuries based on claims of excessive force, false arrest, and other NYPD misconduct.⁵⁷ By diverting mental health crisis responses from law enforcement, the City can avoid the monetary costs associated with NYPD misconduct claims attributable to encounters with people experiencing mental health crises. By reallocating funds from the police (since police would have at most, a minimal role in mental health crisis response), New York City could ensure that people experiencing mental health crises receive appropriate services to de-escalate their crises and obtain access to mental health care — at no additional cost to taxpayers and with vast savings to the public.



PART IV: RECOMMENDATIONS FOR A NON-POLICE MENTAL HEALTH CRISIS RESPONSE SYSTEM

NYLPI’s analysis of the survey responses, as well as New York’s history of killing and traumatizing people who experience a mental health crisis, reinforces New York City’s urgent need for a non-police response to mental health crises.

Survey respondents made the point clearly:

“I would like to see a mental health team sent out for 911 mental health crisis calls; like the CAHOOTS program in Eugene Oregon.”

— White cisgender woman

“Have trained practitioners respond to the call. Not involve NYPD who has no clue about mental health. Provide more money to mental health institutions. Completely recreate mental health services that validate the human experience.”

— White bisexual woman

“New number for crisis assistance — NO NYPD involvement at ALL — ONLY response of Crisis Mobile Team with peers trained in de-escalation and a Licensed Nurse Practitioner; Social Worker and perhaps one other staff/Peer.”

— Hispanic / Latino cisgender man

Experts in crisis intervention, including the police-run Crisis Intervention Team International, warn against the “temptation of trainings” for law enforcement, as that approach alone does not improve safety and mistakenly may be used merely to “train officers to be kinder and gentler as they take people to jail.”⁵⁸ On the other hand, a non-police mental health crisis response system can reduce trauma and violence, promote connections to mental health supports, and prevent unnecessary entanglements with the criminal legal system.⁵⁹ In June 2021, the New York City Council authorized Mayor Bill de Blasio’s proposed \$112 million allocation to fund a city-wide mental health crisis response and to improve community-based care. NYLPI’s work continues, however, as City lawmakers have not yet agreed to implement a non-police, peer-led model for the mental health crisis response system.

NYLPI strongly endorses the CCIT-NYC non-police, peer-led crisis response proposal,⁶⁰ which was developed in consultation with affected communities through two 100+ peer focus groups and modeled on the CAHOOTS program in Eugene, Oregon.⁶¹

The CCIT-NYC proposal includes the following key provisions to develop and create a peer-led, healthcare-based, culturally competent, trauma-informed, and accessible mental health crisis response system:

Remove police as first responders

- Cease referring mental health crises to police.

Use a peer-driven response system

- Create peer-driven healthcare response teams consisting of an independent EMT and a trained peer, which are run by culturally competent community organizations.⁶²

Shorten response times

- Ensure response times are comparable to response times for other emergency services.

Operate 24/7 x 365

- The non-police healthcare teams must operate all day, every day, so that crisis response is always available for those who need it.

Route calls to a number other than 911

- Use an alternative phone number to 911, dedicated to mental health crisis calls — such as 988, which was recently authorized by Congress for nationwide implementation as a mental health crisis and suicide hotline.⁶³

Provide oversight by an advisory board of 51% or more peers from low-income Black, Latinx, and other communities of color

- Monitor the mental health crisis response program using an oversight board whose membership is based on recommendations from peers and includes “independent peers from low-income Black, Latinx and other communities of color who do not have a governmental conflict of interest.”⁶⁴ Non-peer members may include staff from crisis centers, departments of health and homeless services, community boards, and members of the city and state legislatures.⁶⁵

Expand available services

- Greatly increase the availability and affordability of mental healthcare services, including therapeutic and psychiatric care.⁶⁶

Increase outreach

- Expand and improve outreach and education in at-risk communities, including providing information about available community-based mental health resources.

Collect and release quality data for oversight and program evaluation

- Collect and analyze data on short-term and long-term recipient outcomes to identify shortcomings in care and prioritize practices that provide the greatest aid.

By involving peers at all stages of planning and implementation, and emphasizing the need for culturally competent community-based care, the CCIT-NYC proposal presents a comprehensive and evidence-backed approach⁶⁷ for individuals experiencing mental health crises.⁶⁸



PART V: CONCLUSION

NYLPI, along with the broader New York City disability community, demands that New York City provide people who experience mental health crises with an appropriate, non-police response that will de-escalate the crises and ensure their wellbeing. By investing in the CCIT-NYC proposal, and addressing our community members' needs, New York City can improve health, build engagement with mental health services, reduce violence and trauma, conserve governmental resources, and literally save lives.

PART VI: IN MEMORY OF THE LIVES TAKEN BY THE POLICE

The following people were killed by the police while experiencing a mental health crisis in New York City between 2015 and 2020:



David Felix (April 25, 2015)

David Felix, 24, who had been previously homeless and diagnosed with schizophrenia, was shot to death by two veteran NYPD detectives on April 25, 2015, in his home. He was a first-generation immigrant from Haiti, an aspiring fashion student, and according to news reports “charmed everyone he met.”⁶⁹ It’s reported he was loved by his colleagues on the runaway, by the homeless youth community, and by the social and legal service providers who knew him.⁷⁰



Mario Ocasio (June 8, 2015)

Mario Ocasio, 51, was killed by the police on June 8, 2015, after his girlfriend called 911 for help, as Mr. Ocasio appeared to be having an adverse reaction to marijuana. According to a lawsuit filed by Mr. Ocasio’s mother, the police restrained Mr. Ocasio “by beating him with batons, punching and kicking him, macing him, and stomping on his face.”⁷¹ The lawsuit further

alleges that Mr. Ocasio was yelling “I am God” while being hit, and that, because of the officers’ “inadequate training,” they “failed to recognize Mario’s delusional statements for what they were, and instead mistook them as a challenge to their authority.”⁷² The police used a Taser device on Mr. Ocasio, who later went into cardiac arrest and died.⁷³



Anthony Paul, II (July 1, 2015)

Anthony Paul, II, 29, was killed by the police on July 1, 2015 in his home in the Bronx, after the police broke down his door with a power saw and used a Taser on him multiple times. Mr. Paul later died in the hospital of cardiac arrest. The police claimed that Mr. Paul was “whacked out on synthetic marijuana,” but the City’s autopsy report did not find synthetic marijuana in Paul’s body.⁷⁴ According to the attorney for Mr. Paul’s family, “He was not a danger to himself, he was not a danger to others, and yet, he ended up dead because of police misconduct, excessive force.”⁷⁵



Garry Conrad (May 18, 2016)

Garry Conrad, 46, was fatally shot by police on May 18, 2016, in Midtown Manhattan, after he experienced a mental health crisis at a local supermarket. According to news reports, Mr. Conrad had a verbal altercation inside the grocery store, was dragged out by an off-duty police officer, and was then tackled to the ground by a second officer, who fractured Mr. Conrad’s jaw. When Mr. Conrad tried to get up, the NYPD shot him nine times.⁷⁶



Rashaun Lloyd (June 19, 2016)

Rashaun Lloyd, 25, was killed by police on June 19, 2016, outside of his Bronx apartment building. According to his family and friends, Mr. Lloyd had been diagnosed with mental illness and was not taking his medication as prescribed. According to news reports, after police arrived at the scene, “[t]hree cops unloaded a barrage of 31 shots.”⁷⁷

According to the police, Mr. Lloyd had refused to drop his weapon. Mr. Lloyd’s mother stated that the police had “been after my son a long time... I know he was going around doing stuff, he had a record, but they didn’t have to do that.”⁷⁸



Deborah Danner (October 18, 2016)

Deborah Danner, 66, was diagnosed with schizophrenia. On October 18, 2016, her sister called police to her apartment after the two of them had had an argument. When the police arrived, Ms. Danner was holding a pair of scissors, which she dropped, but proceeded to pick up a baseball bat. It is unclear whether Ms. Danner swung the bat at the police, but the officer involved, who had received training from the NYPD on engaging with individuals with disabilities and de-escalating mental health crises, shot her twice and killed her.⁷⁹ At the time of this report’s publication, disciplinary proceedings against the officer involved are still pending.⁸⁰



Ariel Galarza (November 2, 2016)

Ariel Galarza, 49, experienced a mental health crisis on November 2, 2016 in his Bronx home. The police officers who responded to a 911 call from Mr. Galarza’s neighbor, used a Taser device on him twice and Mr. Galarza went into cardiac arrest. Mr. Galarza’s neighbor later said that she “made a mistake calling 911.” The 911 call reported “an emotionally disturbed person brandishing a knife” that turned out to be a bottle. The medical examiner has ruled Mr. Galarza’s death a homicide.⁸¹



James Owens (January 3, 2017)

James Owens, 63, was living with his family in Brooklyn when he was killed by the NYPD on January 3, 2017. Mr. Owens was dehydrated and adjusting to new medication when his sister called 911 to request an ambulance. Mr. Owens became agitated and was allegedly holding a knife when four police officers arrived at his home, and within seconds was fatally shot in the head, neck, and chest.⁸²



Dwayne Jeune (July 31, 2017)

Dwayne Jeune, 32, was killed by the police on July 31, 2017. Mr. Jeune had struggled with mental illness for many years, and his neighbors remembered that he would often spend his time outdoors, listening to music and singing along. On July 31, 2017, Mr. Jeune’s mother called 911 to report that her son was agitated. Four police officers arrived at Mr. Jeune’s Brooklyn apartment and one of the officers fatally shot Mr. Jeune, in front of his mother, when they allegedly saw that he was holding a knife.⁸³



Miguel Richards (September 6, 2017)

Miguel Richards, 31, was a college exchange student from Jamaica and an IT expert who was killed by police on September 6, 2017, in his Bronx apartment after his landlord asked the police to do a “wellness check” because he had not heard from Mr. Richards in a while. After a 15-minute encounter in which Mr. Richards remained motionless and silent, the officers at the scene shot Mr. Richards 16 times.⁸⁴ The killing has been described in news reports as “a textbook example of officers’ escalating a situation that might have disappeared had they closed the door and walked away, or had mental health professionals responded to the call.”⁸⁵ Mr. Richards’ landlord later expressed that he had “many regrets” about calling the police and explained that Mr. Richards “just stood there; I have that picture in my head every day.”⁸⁶



Cornell Lockhart (November 13, 2017)

Cornell Lockhart, 67, was a longtime resident of the Hughes House in the Bronx, a place that provided supportive housing for people who were formerly homeless, veterans, people with mental illness, and others. At the time of his death, Mr. Lockhart was in declining health. According to news reports, he was liked by the staff and fellow residents – people called him “Pops.” Mr. Lockhart had a history of mental illness and had been briefly hospitalized after several mental health crises. On November 13, 2017, Mr. Lockhart stabbed two of the building’s security guards and was subsequently shot dead within a minute of the responding officers’ arriving at the scene.⁸⁷



Dwayne Pritchett (January 28, 2018)

Dwayne Pritchett, 48, died at the hands of the police on January 28, 2018. Mr. Pritchett had been prescribed medication for a psychiatric condition, and his father called 911 for help when his son failed to take his medicine and began exhibiting signs of a mental health crisis. The police arrived at the family’s Bronx apartment and restrained Mr.

Pritchett with handcuffs, a mask, and neck compression. The city’s medical examiner declared that Mr. Pritchett’s death was a homicide, explaining “he died during a physical struggle with police.”⁸⁸ Mr. Pritchett had a 3 year-old son at the time of his death.⁸⁹



Michael Hansford (January 29, 2018)

Michael Hansford, 52, was shot by the police on January 29, 2018 outside of his home in the Bronx. Mr. Hansford was an avid New York City biker and had worked as a bike messenger for years. Those who knew him described him as a hard worker and a “rider of great skill.”⁹⁰ The police were called during an altercation between Mr. Hansford and

his landlord, after his landlord told him he would be evicted in two weeks. Mr. Hansford ran after his landlord with a knife and was shot by the police. He was taken to a local hospital but did not survive.⁹¹ According to Mr. Hansford’s neighbors, “[t]here was no need to open fire,” another said, “[t]here must have been some other way to subdue him.”⁹²



Saheed Vassell (April 4, 2018)

Saheed Vassell, 34, was fatally shot by police on April 4, 2018. According to Mr. Vassell’s father, his son “had bipolar disorder and had been admitted to the hospital multiple times in recent years, sometimes after encounters with the police.”⁹³ The police who arrived on the scene that day fired at him, almost immediately, upon seeing him waive something. Mr. Vassell

did not have a gun, and was holding a metal pipe when he was shot. At the time of his death, Mr. Vassell had a 15-year-old son.⁹⁴



Susan Muller (September 17, 2018)

Susan Muller, 54, was fatally shot by police on September 17, 2018, in her Queens home. Ms. Muller had a history of mental illness, and neighbors noted that she was visibly depressed. On the night of her death, Ms. Muller called 911 about an intruder and then purportedly lunged at responding police officers with a knife. Police officers from Ms. Muller’s neighborhood precinct had previously responded to nine other 911 calls from her home since August 2000, and were familiar with her mental health conditions. The police officers who responded to Ms. Muller’s call in 2018 were from a different precinct, and they opened fire within seconds of their arrival, killing Ms. Muller.⁹⁵



Kawaski Trawick (April 4, 2019)

Kawaski Trawick, 32, was a personal trainer and, according to news reports, dreamed of opening a dance studio in NYC. He had struggled with mental health issues and substance use. The day of his death on April 4, 2019, Mr. Trawick was cooking in his Bronx apartment and got locked out of his unit. Concerned about the risk of fire, Mr. Trawick sought help from his neighbors and called the fire department, who let him back into his home. Mr. Trawick’s building superintendent, however, called the police. Within two minutes of arriving in his apartment, police officers fatally shot Mr. Trawick.⁹⁶



Kwesi Ashun (October 25, 2019)

Kwesi Ashun, 33, was shot by police on October 25, 2019. Mr. Ashun was a t-shirt designer, and according to his sister, creativity had always been important to him. Mr. Ashun was diagnosed with both bipolar disorder and schizophrenia at 19. His family fought for years to get him access to more comprehensive psychiatric care through hospital evaluations and contacting City mental health programs. Mr. Ashun was prescribed medications, but his family felt he needed additional care, including hospitalization. According to news reports, “his family was told there was no way to get him off the streets until he actually committed a violent act... all she could

do was call 911 – the very thing the family was trying desperately to avoid.”⁹⁷ Mr. Ashun’s sister said she was “very scared to call the police to show up to deal with a mentally ill black man.” Mr. Ashun got into a struggle with police officers who were detaining a different man in a Brooklyn nail salon, and the police fatally shot him.⁹⁸



George Zapantis (June 21, 2020)

George Zapantis, 29, was killed by NYPD officers in his home on June 21, 2020. Mr. Zapantis lived with his mother and sister in Queens and took medication for bipolar disorder. The day of his death, Mr. Zapantis had an argument with a neighbor, and a passerby called 911. Police officers responded to the call, long after the argument was over. Even though Mr. Zapantis’ neighbors let the arriving officers know about his mental health condition, the officers proceeded to re-escalate the situation by making Mr. Zapantis come out of his house, forcibly restraining him, and repeatedly using a Taser on him to the point that Mr. Zapantis suffered a fatal heart attack. Police later claimed that Mr. Zapantis had been brandishing a samurai sword, but body worn camera footage revealed that Mr. Zapantis put the sword away after the police asked him to do so.⁹⁹

ABOUT NEW YORK LAWYERS FOR THE PUBLIC INTEREST

For 45 years, New York Lawyers for the Public Interest (NYLPI) has been a leading civil rights advocate for New Yorkers fighting marginalization based on race, poverty, disability, and immigration status. We file lawsuits, organize, seek policy reform, inform and educate the public, create pro bono partnerships, and build the capacity of local nonprofits to strengthen our communities. Our work activates the power of New York communities as they lead the fight to make equal justice a reality. Guided by their priorities, we use every tool available to achieve lived equality and create lasting change. Together, we fight systemic racism and strive to achieve equality of opportunity and self-determination for people with disabilities, create equal access to health care, ensure immigrant opportunity, strengthen local nonprofits, and secure environmental justice for low-income communities of color.

NYLPI's Disability Justice Program works to advance the civil rights of New Yorkers with disabilities. NYLPI disability advocates have represented thousands of individuals and won campaigns improving the lives of hundreds of thousands of New Yorkers. Our landmark victories include integration into the community for people with mental illness, securing the right of those in psychiatric hospitals to the outdoors, and establishing the right to mental health discharge planning when leaving institutions.

NYLPI's Health Justice Program brings a racial equity and immigrant justice focus to health care advocacy. With our community partners, we combat the devastating human rights crisis wrought by the immigration detention machine through individual advocacy, high-impact reports, civil rights litigation, and other advocacy pursuing strategic, systemic solutions. NYLPI's Health Justice team also connects undocumented and uninsured immigrants with serious health conditions to state-funded Medicaid, advocates for healthcare coverage for all New Yorkers, and works to address the social determinants of health. We believe health justice affects all parts of New Yorkers' lives.

NYLPI's Disability and Health Justice Programs work together to prioritize the transformation of New York's response to individuals experiencing mental health crises, including successful litigation to obtain body-worn camera footage from NYPD officers who have shot and killed individuals experiencing mental health crises.

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APPENDIX A

NYLPI'S CAMPAIGN TO TRANSFORM NEW YORK CITY'S MENTAL HEALTH CRISIS RESPONSE

NYLPI seeks to transform the response to mental health crises in New York City by replacing the police with trained peers (those with lived mental health experience) and independent emergency medical technicians. At the foundation of the campaign is the understanding that mental health crises are not criminal matters, that they require a health-centered response to promote safety and wellbeing, and that police response to mental health crises has been repeatedly linked to individual and community trauma and violence, especially in communities of color.

Policy Advocacy

Through meetings with elected officials, testimony before the New York City Council and New York State Legislature, media interviews and public demonstrations, NYLPI has urged both City and State officials to transform the City's system for responding to people experiencing mental health crises.

NYLPI works as a steering committee member with Correct Crisis Intervention Today — NYC (CCIT-NYC), a coalition of more than 80 community mental health advocacy and other organizations, which launched its campaign to transform the City's mental health crisis response system in 2014.

Education

During the COVID-19 pandemic, NYLPI mobilized virtually to raise awareness and provide education on the urgent need to remove police responders from mental health crisis response. NYLPI, [National Association for Rights Protection and Advocacy](#) (NARPA), [the Yale Program for Recovery and Community Health](#), and CCIT-NYC co-coordinated and facilitated a two-part webinar series that NYLPI also moderated. The webinars addressed the problems of police as responders to mental health crises, especially in communities of color, and the proposed solutions.¹⁰⁰ With prominent New York City mental health advocates and partners, NYLPI co-sponsored a [Mental Health Mayoral Candidate Forum](#), viewed live

by nearly 2,000 people, that provided an opportunity for mayoral candidates to share their plans to reform New York City’s public health system and to provide comprehensive, culturally competent recovery services.¹⁰¹

Litigation

NYLPI’s fight for a non-police response to people experiencing mental health crises continues in the courts. After New York’s law mandating body-worn cameras went into effect in 2017, NYLPI brought the first litigation for public access to body-worn camera footage from the New York Police Department. NYLPI’s requests for footage of individuals shot by the police while experiencing a mental health crisis were repeatedly rebuffed, both before and after NYLPI filed actions in state court. NYLPI secured resounding victories, including groundbreaking decisions and access to the unredacted footage of the fatal shootings of Miguel Richards and Susan Muller, both of whom were killed by the police in their own homes.¹⁰² NYLPI also filed actions on behalf of two other individuals shot by the police, similarly arguing that the release of footage is in the public interest to expose the violent consequences of police intervention in mental health crises, and to demonstrate the critical need for a crisis response model which provides people with the medical help and support they need.^{103, 104}

Mobilizing the Community

Community organizing plays a key role in the success of NYLPI’s advocacy efforts. Through social media; call-in, email, and letter campaigns; and in-person rallies and demonstrations, NYLPI seeks to elevate community members’ voices to have their experiences taken into account in the transformation of the City’s response to mental health crises.

In October 2019, NYLPI joined a coalition of advocates, elected officials, and impacted community members in front of One Police Plaza to highlight the importance of re-envisioning the City’s response to mental health crises by adopting a peer-response model.¹⁰⁵ During this public rally, impacted community members such as Peggy Herrera spoke out. Ms. Herrera described how police responded to her call for help when her son experienced a mental health crisis in their home in August 2019. During the crisis Ms. Herrera dialed 911 to seek help for her son. By the time the police arrived at their home, her son’s mental health episode had subsided, but the police forcibly entered their home, nonetheless.

Ms. Herrera, in fear for her son’s safety, attempted to stop the police from entering, and was arrested and charged with obstruction. The charges against her were ultimately dropped,¹⁰⁶ and Ms. Herrera continues to advocate to reform the City’s mental health crisis response system.

More recently, in June 2021, NYLPI coordinated a series of online weeks of action,¹⁰⁷ followed by another in-person rally at One Police Plaza,¹⁰⁸ to encourage community members, partner organizations, and other advocates to demand that the New York City Council authorize Mayor Bill de Blasio’s proposed \$112 million allocation to fund a city-wide mental health crisis response, and ensure that the response would be culturally competent, community-based, non-police, and peer-driven.¹⁰⁹

Subsequently, City lawmakers announced the passage of the City’s 2022 budget, which includes the \$112 million allocation to fund new and existing crisis prevention and response programs and to improve community-based care — a tremendous victory for all New Yorkers.¹¹⁰ However, NYLPI’s work continues, as City lawmakers have not yet agreed to follow the CCIT-NYC proposed model of a non-police mental health crisis response system.¹¹¹

APPENDIX B



CORRECT CRISIS INTERVENTION TODAY

FIGHTING TO TRANSFORM RESPONSES TO MENTAL HEALTH CRISES

PILOTING A PEER-DRIVEN MENTAL HEALTH CRISIS RESPONSE PROGRAM

The need

The New York Police Department (NYPD) began providing Crisis Intervention Team (CIT) training in June 2015. In the four and a half ensuing years, sixteen mental health recipients were fatally shot by the police, and four others were shot and arrested.

Not surprisingly, many mental health recipients, family members, and health providers fear calling 911 because of these and other similar tragedies. This causes many people to delay reaching out for help until circumstances have escalated to a critical stage.

Mental healthcare responses to mental health crises are universally considered the best practice. For example, the leaders of CIT international – a group consisting primarily of police, which created crisis intervention team (CIT) training 35 years ago – now argue that only a mental healthcare response is appropriate for a mental health crisis. In the CIT International’s recent best practice guide, they note that even a co-response model (police and mental health workers) is an inappropriate response because it still involves the police. Other police leaders also say mental health workers should be used in lieu of police.

Although New York City created a taskforce to determine an appropriate mechanism for responding to mental health crises, the initiatives put forth by the taskforce do not systematically address how to best respond to the 180,000 crisis calls per year received by the NYPD. The taskforce failed to recognize that responding to mental health crises is a public health issue, and it continued to view the NYPD as the first responder for the vast majority of crisis calls.

In response to the taskforce’s suggestions, the City proposed adding only five mobile crisis teams to respond to crisis calls. However, the minimal increase in mobile crisis teams does not even come close to serving a city of 9,000,000 people and countless visitors. And critically, the mobile crisis teams cannot respond to 911 emergency calls. Mobile crisis teams also do not have a means to transport people to drop-in centers, hospitals, or other appropriate healthcare resources. If transport is required, mobile crisis team members must call 911.

In addition, mobile crisis teams at best respond to the immediate crisis at hand, and do little to ensure the mental health recipient is connected to longer-term community resources. Mobile crisis teams do not always have a peer — an individual with lived mental health experience — on staff and they utilize the no-longer acceptable “medical model,” which often focuses narrowly on medication rather than a person’s ability to recover and live well. Moreover, mobile crisis teams consist of five staff members and are relatively expensive.

New York also has Health Engagement Assessment Teams (HEAT teams) which consist of one peer and one clinician. But HEAT teams are only used by police for areas of outreach that do not involve any active risk, and, like mobile crisis teams, they cannot be deployed to 911 mental health crisis calls and they cannot transport anyone.

The solution

We propose forming a mental health crisis response team that would embody existing best practices in non-police alternative mental health crisis response. The team would consist of one peer trained as a crisis counselor and one emergency medical technician (EMT).

What is the role of the peers?

During all stages of the pilot (planning, design, implementation, maintenance, evaluation), peers from low-income Black, Latinx and other communities of color within the areas in which the pilot is taking place, who do not have a governmental interest, will be included in the discussions and given the ability to weigh in on key decisions, including the hiring and training of peers, dispatch personnel and other personnel. During the planning for the pilot, multiple forums will be held in the pilot communities, at times that allow working people to attend, in order provide input into the pilot.

Where would the pilot be located?

In order to provide complete coverage to a given geographical area, the pilot will be located in two police precincts with the highest number of “emotional health crisis” calls (formerly derisively referred to as “Emotionally Disturbed Person” or “EDP” calls): Midtown South’s 14th Precinct with 4,356 mental health crisis calls in 2018 and Brooklyn’s 75th Precinct with 5,428 mental health crisis calls in 2018. The selected precincts are among those with the highest number of mental health calls per capita.

What would the peer-driven mental health crisis response teams look like? The new mental health crisis response team would embody existing best practices in non-police alternative mental health crisis response, and consist of one peer trained as a crisis counselor and one emergency medical technician (EMT). Having a peer on the team is essential, as a person with lived experience, a person who has “been there,” can best relate to the fear of an outsider responding in a moment of crisis, and can prove that recovery works. An EMT worker is needed as many crisis calls may involve physical health issues which are masked by the mental health crisis.

The Office of Consumer Affairs in the New York City Department of Health and Mental Hygiene (DOHMH) will contract with non-governmental agencies which will deploy the mental health crisis response teams.

The mental health crisis response teams will consist of peers who have worked with people in crisis, such as those who have worked in crisis respite centers, and also have experience in de-escalating crises. It would be desirable for the peers to either have lived or worked in the areas in which they are hired to serve.

The teams must operate 24/7, 365 days a year, in three consecutive shifts per precinct (8 a.m. to 4 p.m., 4 p.m. to 12 a.m., and 12 a.m. to 8 a.m.), with two teams in place for the day and evening shifts, and one team for the overnight shift. Since each team consists of two people, the staffing need for the pilot requires 38 total FTE’s for the two precincts for all shifts.

In addition, the pilot requires one Project Director, two Supervisors and one Administrator.

The pilot also requires two vans per precinct so that the team can transport individuals to drop in centers, safe havens, the new support and connection centers, urgent care centers, or hospitals.

What type of training will the pilot provide?

The agency with which DOHMH contracts, operating with consensus from peer-driven organizations and peers from low-income Black, Latinx and other communities of color, who do not have a governmental conflict of interest, will be responsible for training all mental health crisis response teams, NYC Well staff involved in the project, as well as all 911 operators who will likely still be responsible for directing some of these calls.

How would people call for the mental health crisis response team?

The pilot will establish a new number dedicated to mental health crisis calls such as “WEL” or 988, which anyone can call. The calls would go to NYC Well’s hotline and will be staffed by NYC Well staff who would automatically send the calls to the mental health crisis response teams. Since NYC Well operators will be dispatching mobile crisis teams in the next few months it will be cost-effective to have NYC Well also dispatch the mental health crisis response teams.

What would the average response time be for the mental health crisis response teams? The average response time for the mental health crisis response teams will be the same as the current average response of police to non-mental health crises — or less time.

How long will the pilot last?

The pilot will last five years, thereby allowing sufficient time for start-up and evaluation.

If after 18 months the data reveal the pilot is having a positive impact based on established metrics, two additional pilots will be funded at that time.

How much will the pilot cost?

The pilot will cost roughly \$3.5 million to \$4.0 million annually for the two proposed precincts. Costs are estimated.

Notably, Eugene, Oregon, which is the size of one New York City police precinct, uses a similar mental health crisis response model which includes two workers and has an annual budget of \$1.9 million.

The pilot requires training and data collection/evaluation (see below), which is not part of the Eugene budget, but is pivotal to determine how the pilot is working and what changes need to be made to it. Additional costs above those in Eugene will also be incurred by the pilot in order to keep salaries commensurate with the cost of living in New York City.

A draft budget is attached.

Which entity will run the pilot?

DOHMH will contract out with a non-governmental agency which will run the pilot.

Who will monitor the pilot?

The pilot will be monitored by an oversight board whose membership will be decided upon after soliciting recommendations from peers from low-income Black, Latinx and other communities of color.

Such a board must include independent peers from low-income Black, Latinx and other communities of color who do not have a governmental conflict of interest. These peers will constitute 51% of the board. Additional board members might include staff of NYC Well, the support and connection centers, the crisis respite centers, DOHMH, the New York State Department of Health (DOH), the New York State Office of Mental Health (OMH), the New York City Department of Homeless Services (DHS), the New York City Human Resources Administration (HRA), the New York City Fire Department (FDNY) and other Emergency Medical Service (EMS) providers, the Office of the Comptroller, the Community Board for the relevant precinct, the Public Advocate, the relevant Borough President, and members of the City Council and the New York State Legislature from the relevant precincts.

The oversight board will be empowered to request and obtain data from law enforcement agencies necessary to carry out this pilot. Law enforcement agencies will not at any point have access to identifying data related to participants in the pilot.

How will the pilot be monitored?

The oversight board will:

- hire an independent evaluation entity which will evaluate the pilot
- review data from the pilot project
- suggest changes to the pilot
- meet at least quarterly
- issue meeting agendas
- publicly list all agendas
- issue minutes of meetings
- publicly list all minutes
- ensure all meetings are open to the public
- pay stipends to those members who are not receiving a salary for participating in oversight board activities

There will be one oversight board for all pilot precincts.

How will data be collected?

Data will be collected and analyzed by an independent evaluation entity every three months once the pilot is operational. The data will be provided to the oversight board which will also have the right to request additional data, as needed.

The data evaluation entity must protect the privacy and autonomy of those receiving services from the mental health crisis teams. Data from this project will not be admissible in criminal cases. Summaries of the data collected, as well as the management and privacy plans, will be made transparent and accessible to the public.

How will the pilot be funded?

Primary funding will come from New York City's budget. New York City should also reach out to New York State for funding, possibly from money allocated statewide for CIT but never used for New York City.

How will the pilot be publicized?

NYC Well and all other City and State agencies which comprise the oversight board will work closely with CCITNYC and other advocates to develop an extensive list of agencies, community organizations, and individuals who will receive direct notice of the pilot. In addition, NYC Well will utilize its best efforts to obtain extensive media coverage of the pilot, and will prominently promote the pilot via social media and other campaigns to raise awareness amongst the public in the identified precincts.

ENDNOTES

1 See Greg B. Smith, *Cops Still Handling Most Mental Health Calls Despite Efforts to Keep Them Away*, The City (Jul. 22, 2021), <https://www.thecity.nyc/2021/7/22/22587983/nypd-cops-still-responding-to-most-911-mental-health-calls>.

2 Julie Tate, Jennifer Jenkins, Steven Rich & John Muyskens, *Fatal Force Database*, Wash. Post, (Mar. 10, 2021), <https://github.com/washingtonpost/data-police-shootings>.

3 See Evan Hill et al., *How George Floyd Was Killed in Police Custody*, N.Y. Times (May 31, 2020 updated Sept. 7, 2021), <https://www.nytimes.com/2020/05/31/us/george-floyd-investigation.html>. Matt Stieb, *Rochester Police Officers Will Not Be Charged in Killing of Daniel Prude*, N.Y. Intelligencer (Feb. 23, 2021), <https://nymag.com/intelligencer/2021/02/rochester-cops-wont-be-charged-in-killing-of-daniel-prude.html>.

4 See Appendix A.

5 By comparison, each crisis worker in Oregon’s Crisis Assistance Helping Out On The Streets (CAHOOTS) program undergoes 500 hours of training in areas including medical care, conflict resolution, and crisis counseling. Anna V. Smith, *There’s Already An Alternative to Calling the Police*, High Country News (June 11, 2020), <https://www.hcn.org/issues/52/7/public-health-theres-already-an-alternative-to-calling-the-police>.

6 A peer is an individual who self-identifies as having lived mental health experience, including any type of mental health concern, whether or not they have a mental health diagnosis.

7 NAMI-NYC, https://www.naminycmetro.org/?qclid=Cj0KCCQjwqKuKBhCxARIsACf4XuGhjHHGjP-eQM0gu6RjIP75iyxwVKetKgqgwXYi6RORlqP6LJp7oDcaAufvEALw_wcB

8 VOCAL-NY, <https://www.vocal-ny.org/>

9 CCIT-NYC, <https://www.ccitnyc.org/>

10 See *Community Surveying Initiative: Mental Health Crisis & Policing Reform Campaign*, NYLPI (2020), <https://www.nylpi.org/our-work/health-justice/community-surveying-initiative-mental-health-crisis-policing-reform-campaign/>.

Please note, that in order to further protect the privacy of survey respondents who desired anonymity, this survey did not require respondents to submit any personally-identifiable information.

11 Due to the coronavirus pandemic, this survey was conducted solely online, which likely limited the reach of this project within communities that lack equitable access to technology.

12 See *Community Surveying Initiative: Mental Health Crisis & Policing Reform Campaign*, NYLPI (2020), <https://www.nylpi.org/our-work/health-justice/community-surveying-initiative-mental-health-crisis-policing-reform-campaign/>.

13 NYLPI received a total of 162 responses and analyzed 154 responses. The remaining 8 responses were disregarded because they were duplicates. Of the 154 total responses, 20.78% did not share a relevant experience; 47.40% indicated that 911 was called during a crisis; 29.87% of respondents did not seek help through 911 during a mental health crisis, and turned to other resources such as healthcare providers, clinics, mental health crisis hotlines like NYC WELL, or sought help from their family or close friends; and 1.95% of respondents did not seek help due to fear or mistrust of police and available services.

14 27% or 20 out of the 73 individuals who reported calls to 911 for assistance, reported an unsafe or violent interaction with responders, and/or received inadequate care/treatment.

15 14 out of these 20 experiences specifically described interactions with the police.

16 See Mayor’s Office for People with Disabilities, *Accessible NYC, Annual Report on the State of People with Disabilities Living in New York City* (2016), https://www1.nyc.gov/assets/mopd/downloads/pdf/accessiblenyc_2016.pdf

According to U.S. Census Bureau’s data from 2014, Black, non-Hispanic respondents had the highest rate of disability (12.9%) of any group in New York City, followed by Hispanic respondents (12.0%). White, non-Hispanic respondents had a disability

rate of 10.9%, Asian and non-Hispanic respondents had a disability rate of 7.4%, while Multiracial and other non-Hispanic respondents in New York City had a disability rate of 9.7%. *Id.*

17 Anna V. Smith, *There's Already An Alternative to Calling the Police*, High Country News (June 11, 2020), <https://www.hcn.org/issues/52.7/public-health-theres-already-an-alternative-to-calling-the-police> (“When police show up, situations can escalate, and the use of force can be disproportionate, especially towards Black people . . .”). See also Gabriel Schwartz, *Mapping fatal police violence across U.S. metropolitan areas: Overall rates and racial/ethnic inequities, 2013-2017*, PLOS ONE (June 2020).

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