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Testimony of
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on behalf of
New York Lawyers for the Public Interest
before the
Council of the City of New York
Committees on Public Safety
March 20, 2023

My name is Marinda van Dalen and I am a Senior Staff Attorney at New York Lawyers for the Public Interest (NYLPI). Thank you for the opportunity to present testimony today regarding public safety. New York Lawyers is gravely concerned about the City's dangerous and illegal practices relating to the involuntary removal of individuals perceived to have mental illness diagnoses for psychiatric evaluation and the City's Involuntary Removal Plan announced by Mayor Eric Adams on November 29, 2022. We also oppose B-HEARD, a deeply flawed City program that diverts resources desperately needed for non-police response to mental health crisis into a program that continues the criminalization of disability.

THE MAYOR MUST IMMEDIATELY RESCIND HIS NEW POLICY OF FORCIBLY REMOVING INDIVIDUALS PERCEIVED TO HAVE A MENTAL ILLNESS DIAGNOSIS AND PERCEIVED TO BE "UNABLE TO CARE FOR THEIR BASIC NEEDS," BUT WHO DO NOT PRESENT A DANGER TO THEMSELVES OR OTHERS

The Mayor's new Involuntary Removal Policy, which he announced on November 29, 2022, allows a police officer to detain an individual by force, and remove the individual to a psychiatric hospital, solely because the officer believes the individual has a mental disability and is unable to meet "basic needs" -- without any indication that the individual is a danger to themself or others.

The Policy is both illegal and immoral.

By failing to mandate that an individual is "conducting himself or herself in a manner which is likely to result in serious harm to the person or others," the Involuntary Removal Policy runs afoul of Section 9.41 of New York's Mental Hygiene Law, as well as myriad other federal and state constitutional and statutory provisions, including the Americans with Disabilities Act, Section 504 of the Rehabilitation Act, and New York City's Human Rights Law.

Details on the Involuntary Removal Policy remain scarce, but Mayor Adams' statements, as well as the City's November 28, 2022 press release, entitled "Mental Health Involuntary Removals," make clear that city agencies have aggressively instituted involuntary removals by police officers who have little to no expertise in dealing with individuals with mental disabilities and who will be

required to determine whether an individual should be forcefully detained against their will. The examples cited by Mayor Adams at his press conference illustrate how difficult it is for police officers to make these sorts of determinations and how likely it is that the rights of New Yorkers will be violated by the Involuntary Removal Policy. Mayor Adams' example of "the shadow boxer on the street corner in Midtown, mumbling to himself as he jabs at an invisible adversary," does not describe someone who is unable to care for their basic needs, let alone describe someone who meets the standard of serious danger to themselves or others. The City's Involuntary Removal Policy also contains no information about how an officer would even go about determining whether such shadow boxers are unable to take care of their basic needs or are merely exercising.

Notably, even the NYPD's union has raised questions about how the police are to implement the Involuntary Removal Policy, noting that the new policy puts a strain on the "understaffed, overworked and underpaid" NYPD officers.[1] In addition, it has been reported that the NYPD was blindsided by the Mayor's announcement and was inadequately prepared to implement it,[2] and that

[1] Corey Kilgannon, *Plan Tests Tense Relationship Between N.Y.P.D. and Mentally Ill People*, N.Y. Times, (December 5, 2022), https://www.nytimes.com/2022/12/05/nyregion/mental-health-plan-nypd.html.

[2] Craig McCarthy, *NYPD was blindsided by Eric Adams' plan to involuntarily commit more mentally ill homeless people*, N.Y. Post (November 30, 2022), https://nypost.com/2022/11/30/nypd-blindsided-by-eric-adams-plan-tocommit-mentally-ill-homeless/.

hospitals have limited capacity to deal with the influx of people brought in under these circumstances.[3] We know of no mechanisms for tracking the City employees' work under the Involuntary Removal Policy, no reference to publicly reporting about the involuntary removals, and no mention of any oversight mechanism for the removals.

The City must rescind the Involuntary Removal Policy to ensure that countless New Yorkers are not subjected to unlawful detention and involuntary hospitalization just for exhibiting behavior perceived by a police officer to be unusual—whether the individual has a mental disability or not and whether the individual is a danger to self or others or not.

THE CITY MUST WHOLLY TRANSFORM ITS RESPONSE TO MENTAL HEALTH CRISES BY ELIMINATING POLICE AND REPLACING THEM WITH A PEER-LED HEALTH RESPONSE

In lieu of the Mayor's wholly wrongheaded policy of stepping up police involvement in dealing with individuals experiencing mental health crises, the City must join other cities across the country – including Los Angeles, San Francisco, Albuquerque, Denver, New Haven and many more – to ***remove*** **police** entirely from the equation, and **ensure that healthcare workers respond to healthcare**

[3] Ethan Geringer-Sameth, Despite State Budget Funding, Little Progress Bringing Psychiatric Beds Back Into Service, Gotham Gazette, November 28, 2022, https://www.gothamgazette.com/state/11696-ny-state-budgetlittle-progress-psychiatric-beds-hochul-adams.

crises.

The City must establish a system whereby individuals who experience a mental health crisis receive appropriate services which will de-escalate the crisis and ensure their wellbeing and the wellbeing of all other New Yorkers. Only those who are trained in de-escalation practices should respond to a mental health crisis, and the most appropriate individuals to receive such training are peers (those with lived mental health experience) and health care providers.[4] Police officers, who are trained to uphold law and order, are not suited to deal with individuals experiencing mental health crises, and New York's history of its police killing 19 individuals who were experiencing crises in the last six years alone, is sad testament to that. Eliminating the police as mental health crisis responders has been shown to result in quicker recovery from crises, greater connections with long-term healthcare services and other community resources, and averting future crises.[5]

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[4] Martha Williams Deane, *et al.*, "Emerging Partnerships between Mental Health and Law Enforcement," Psychiatric Services (1999), http://ps.psychiatryonline.org/doi/abs/10.1176/ps.50.1.99?url_ver=Z39.88-2003&rfr_id=ori%3Arid%3Acrossref.org&rfr_dat=cr_pub%3Dpubmed&#/doi/abs/10.1176/ps.50.1.99?url_ver=Z39.88-2003&rfr_id=ori%3Arid%3Acrossref.org&rfr_dat=cr_pub%3Dpubmed.

[5] Henry J. Steadman, *et al.*, "A Specialized Crisis Response Site as a Core Element of Police-Based Diversion Programs," Psychiatric Services (2001), http://ps.psychiatryonline.org/doi/10.1176/appi.ps.52.2.219?utm_source=TrendMD&utm_medium=cpc& utm_campaign=Psychiatric_Services_TrendMD_0.

The scores of people experiencing mental health crises who have died at the hands of the police over the years is a microcosm of police brutality around the world. Disability is disproportionately prevalent in the Black community and other communities of color,[6] and individuals who are shot or tased and killed by the police when experiencing mental health crises are disproportionately Black and other people of color. Of the 19 individuals killed by police in the last six years, 16 – or greater than 80% -- were Black or other people of color. The City Council simply cannot stand by while the killings continue. Now is the time for major transformations. Now is the time to remove the police as responders to mental health crises – and certainly we must all oppose the Mayor's efforts to increase the role of the police as it relates to people with mental disabilities, including our neighbors who are unhoused. Lives are literally at stake.

Correct Crisis Intervention Today – NYC (CCIT-NYC), which has over 80 organizational members including NYLPI, has developed the needed antidote. Modeled on the CAHOOTS (Crisis Assistance Helping Out On The Streets) program in Oregon, which has successfully operated for over 30 years without *any* major injuries to respondents or responders – let alone deaths -- the CCIT-NYC proposal

[6] Mayor's Office for People with Disabilities, "Accessible NYC" (2016), https://www1.nyc.gov/assets/mopd/downloads/pdf/accessiblenyc_2016.pdf.

is positioned to make non-police responses available to those experiencing mental health crises in New York City. The proposal avoids the enormous pitfalls of the City's B-HEARD pilot, which it inaccurately refers to as a non-police model. Hallmarks of the CCIT-NYC proposal are:

- teams of trained peers and emergency medical technicians who are independent of city government;
- teams run by culturally-competent community organizations;
- response times comparable to those of other emergencies;
- 24/7 operating hours;
- calls routed to 988 rather than the city-operated 911; and
- oversight by an advisory board of 51% or more peers.

The full text of the CCIT-NYC proposal can be found at

https://www.ccitnyc.org/ourproposal

THE CITY MUST ENTIRELY REVAMP THE B-HEARD PILOT AS THE PILOT AUTHORIZES EXTENSIVE POLICE INVOLVEMENT AND IS LIKELY TO CONTINUE OR EVEN INCREASE THE RATE OF VIOLENT RESPONSES BY THE NYPD

The City, via its Mayor's Office of Community Mental Health (Formerly THRIVENYC), introduced a pilot program in 2021 that it contends is responsive to the need to cease the killings at the hands of the police of individuals experiencing mental health crises. Unfortunately, that is simply not the case,

despite the City's glowing description of the program. Among B-HEARD's grim statistics are the following:

- An astronomical **84% of all calls** in B-HEARD precincts continue to be **directed to the NYPD**, even twelve months after its kick-off.
- Even when all kinks are ironed out, the City anticipates continuing to have a nearly-as-astronomical **50% of all calls directed to the NYPD**.
- Moreover, **all calls continue to go through 911,** which is under the NYPD's jurisdiction.
- The entire **program is run by the Fire Department and other City agencies**, with ***NO* role whatsoever for community organizations**. And there is not even any delineation of the lines of authority and communication among the various city agencies.
- **The crisis response teams are composed of emergency medical technicians (EMTs) who are City employees** (from the Fire Department) **who are deeply enmeshed in the current police-led response system**. Peers do not trust these EMTs. The other team members are *licensed clinical* social workers. The licensure and clinical orientation requirements are both unnecessary and preclude a vast array of potential candidates who have excellent skills and a long history of working with people experiencing crises.

- B-HEARD has ***NO* requirement to hire peers**.
- **The training of the teams does *NOT* require a trauma-informed framework, need *NOT* be experiential, and need *NOT* use skilled instructors who are peers or even care providers.**
- The anticipated **response time for crisis calls could be as long as half an hour**, and when last reviewed averaged over **fifteen minutes**, which is not even remotely comparable to the City's response times for other emergencies of 8-11 minutes.
- **The pilot operates only sixteen hours a day.**
- **There are no outcome/effectiveness metrics.**
- **There is no oversight mechanism.**

A comparison of the CCIT-NYC proposal, which is based on the CAHOOTS model with a stellar track record, and the B-HEARD program, which is not aligned with any best practices, is illustrated in the following chart:

Critical Attributes of a Mental Health Crisis Response System	**CCIT-NYC's Proposal**	**NYC's B-HEARD Proposal**
Removal of police responders	**YES**	**NO** (currently, 84% of calls are still responded to by police, and even when all kinks are removed, 50% of calls will still be responded to by police)
Three-digit phone number such as 988, in lieu of 911.	**YES**	**NO**
Response team to consist of an independent EMT and a trained peer who has lived experience of mental health crises and know best how to engage people in need of support	**YES**	**NO** (licensed clinical social worker and EMT employed by the New York City Bureau of Emergency Medical Services)
Crisis response program run by community-based entity/ies which will provide culturally competent care and will more likely have a history with the person in need and can intervene prior to a crisis	**YES**	**NO** (run by New York City Police Department and other City agencies)
Peer involvement in all aspects of planning/implementation/oversight	**YES**	**NO**
Oversight board consisting of 51% peers from low-income communities, especially Black, Latinx, and other communities of color	**YES**	**NO**
Creation/funding of non-coercive mental health services ("safety net"), including respite centers and 24/7 mental health care to minimize crises in the first place and to serve those for whom crisis de-escalation is insufficient	**YES**	**NO**

Response times comparable to those of other emergencies	**YES**	**NO** (Current response time of 15 minutes, 30 seconds -- compared with average response time of 8-11 minutes for non-mental health emergencies)
Response available 24/7	**YES**	**NO** (Response only available 16 hours/day)
Training of the teams to use a trauma-informed framework, be experiential, and use skilled instructors who are peers	**YES**	**NO**

NYLPI therefore urges the Council to ensure that the money previously allocated for a non-police mental health crisis response, be utilized solely for a truly non-police response such as the CCIT-NYC model, and not be utilized for the B-HEARD program in its current iteration.

THE CITY COUNCIL MUST ENSURE THAT NEW YORKERS HAVE ACCESS TO A WIDE RANGE OF VOLUNTARY NON-HOSPITAL, COMMUNITY-BASED MENTAL HEALTH SERVICES THAT PROMOTE RECOVERY AND WELLNESS, AS WELL AS A FULL PANOPLY OF COMMUNITY SERVICES, INCLUDING HOUSING, EMPLOYMENT, AND EDUCATION, BY ALLOCATING FUNDING FOR SUCH PROGRAMS

Since NYLPI was established nearly 50 years ago, we have prioritized advocating on behalf of individuals with mental health conditions, and we have consistently fought to ensure that the rights of individuals with mental health conditions are protected by every aspect of New York's service delivery system.

Core to our work is the principle of self-determination for all individuals with disabilities, along with the right to access a robust healthcare system that is available on a *voluntary, non-coercive* basis.

We have long been on record opposing mandatory outpatient and inpatient treatment -- as insufficiently safeguarding the rights of persons with mental health concerns and failing to offer appropriate healthcare.

Quite simply, there is no place for coercion. Forced "treatment" is not treatment at all, and it has long been rejected by health practitioners -- to say nothing of the disability community – in favor of numerous best practices strategies that offer assistance even to those who have previously resisted offers of care.[7] There are multiple less invasive models of care[8] that New York City must invest in to avoid the tragedy and enormous cost of forced treatment. At the heart of these models are trained peers, who are ideally suited to implement effective harm reduction and de-escalation techniques, especially during crises.

We know how to help those with the most severe mental illness, but we

[7] *See, e.g.,* de Bruijjn-Wezeman, Reina "Ending Coercion in Mental Health: The Need for a Human Rights-Based Approach," Committee on Social Affairs, Health and Sustainable Development, Council of Europe, Parliamentary Assembly, Doc. 14895 (May 22, 2019), https://assembly.coe.int/nw/xml/XRef/Xref-XML2HTML-en.asp?fileid=27701&lang=en.

[8] *See* the attached list of long-term, voluntary programs that have excellent track records.

fail to do so because the services are insufficient or are not held to the highest accountability. We face complete system failure, yet we have done little to correct the failure, and even point our fingers at those most affected by the system failure. We must stop the finger pointing and fix the system. We must invest in innovative, voluntary health programs. And we must invest in supportive housing and not cart people off to a psychiatric ward or to jail.

Any proposal that facilitates the ability to force people into in-patient or out-patient "treatment" must be seen in the context of whom we're entrusting to "remove" these individuals. As we now surely know all too well, the police, who are steeped in law and order, are not well-suited to deal with individuals with mental health concerns. The Mayor's policy includes an outsized role for the police, and the City Council must halt it immediately.

Forced "treatment" must also be seen in the context of existing racial disparities. Of the 19 individuals killed at the hands of New York City police in recent years, 16 were people of color. This systemic racism also underlies the disproportionate prevalence of disability in the Black community and other communities of color.[9] Likewise, racism is at the heart of the similarly vast

[9] Mayor's Office for People with Disabilities, "Accessible NYC" (2016), https://www1.nyc.gov/assets/mopd/downloads/pdf/accessiblenyc_2016.pdf.

disparities of forced treatment, which will only worsen if the Mayor's push for greater enforcement of commitment laws is not halted by City Council. The racial disparities in the application of forced outpatient treatment (also known as Kendra's Law) are vast.

While there is extensive literature supporting voluntary treatment, there is no support for the success of forced evaluation and treatment.

CONCLUSION

NYLPI respectfully requests that the Council:

- Halt the Mayor's policy of forcibly removing individuals perceived to have a mental illness diagnosis and perceived to be "unable to care for their basic needs," but who do not present a danger to themselves or others.
- Enact into legislation and fund the CCIT-NYC proposal to create a non-police, peer-driven mental health crisis response.
- Ensure that New Yorkers have access to a wide range of non-hospital, community-based mental health services that promote recovery and wellness, as well as a full panoply of community services, including housing, employment, and education, by allocating funding for such programs.

Thank you for your consideration. I can be reached at (212) 244-4664 or MvanDalen@NYLPI.org, and I look forward to the opportunity to discuss how best to respond to the needs of individuals experiencing mental health crises in New York City.

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ABOUT NEW YORK LAWYERS FOR THE PUBLIC INTEREST

For nearly 50 years, New York Lawyers for the Public Interest (NYLPI) has been a leading civil rights advocate for New Yorkers marginalized by race, poverty, disability, and immigration status. Through our community lawyering model, we bridge the gap between traditional civil legal services and civil rights, building strength and capacity for both individual solutions and long-term impact. Our work integrates the power of individual representation, impact litigation, and comprehensive organizing and policy campaigns. Guided by the priorities of our communities, we 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. In the past five years alone, 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, access to medical care and government services, and increased accessibility of New York City's public hospitals. Working together with NYLPI's Health Justice Program, we prioritize the reform of New York City's response to individuals experiencing mental health crises. We have successfully litigated to obtain the body-worn camera footage from the NYPD officers who shot and killed individuals experiencing mental health crises. In late 2021, NYLPI and co-counsel filed a class action lawsuit which seeks to halt New York's practice of dispatching police to respond to mental health crises, and in the context of that lawsuit, seeks relief on behalf of individuals affected by the Mayor's Involuntary Removal Policy.

Community Voluntary Long-Term
Innovations for At-Risk Individuals

Residential

Crisis Respite – Intensive Crisis Residential Program: OMH program: "a safe place for the stabilization of psychiatric symptoms and a range of services from support to treatment services for children and adults. are intended to be located in the community and provide a home-like setting." https://omh.ny.gov/omhweb/bho/docs/crisis-residence-program-guidance.pdf.

Crisis Respite (shorter term and less intensive): OMH Program: "Crisis Respite Centers provide an alternative to hospitalization for people experiencing emotional crises. They are warm, safe and supportive home-like places to rest and recover when more support is needed than can be provided at home. The Crisis Respite Centers offer stays for up to one week and provide an open-door setting where people can continue their daily activities. Trained peers and non-peers work with individuals to help them successfully overcome emotional crises. https://www1.nyc.gov/site/doh/health/health-topics/crisis-emergency-services-respite-centers.page.

Peer Crisis Respite programs: OMH funded; Peer operated short-term crisis respites that are home-like alternatives to hospital psychiatric ERs and inpatient units. Guests can stay up to seven nights, and they can come-and-go for appointments, jobs, and other essential needs. Offers a "full, customizable menu of services designed to help them understand what happened that caused their crisis, educate them about skills and resources that can help in times of emotional distress, explore the relationship between their current situation and their overall well-being, resolve the issues that brought them to the house, learn simple and effective ways to feel better, connect with other useful services and supports in the community, and feel comfortable returning home after their stay." https://people-usa.org/program/rose-houses/.

Housing First: a housing approach that prioritizes permanent housing for people experiencing homelessness and frequently serious mental illness and substance use issues. Supportive services including substance use counseling and treatment are part of the model, but abstinence or even engagement in services is not required. https://endhomelessness.org/resource/housing-first/.

Soteria: a Therapeutic Community Residence for the prevention of hospitalization for individuals experiencing a distressing extreme state, commonly referred to as psychosis. We believe that psychosis can be a temporary experience that one works through rather than a chronic mental illness that needs to be managed. We practice the approach of "being with" – this is a process of actively staying present with people and learning about their experiences. https://www.pathwaysvermont.org/what-we-do/our-programs/soteria-house/.

Safe Haven: provides transitional housing for vulnerable street homeless individuals, primarily women. "low-threshold" resources: they have fewer requirements, making them attractive to those who are resistant to emergency shelter. Safe Havens offer intensive case management, along with mental health and substance abuse assistance, with the ultimate goal of moving each client into permanent housing. https://breakingground.org/our-housing/midwood.

Family Crisis Respite: trained and paid community members with extra space in their homes provide respite for individuals who can thereby avoid hospitalization.

Living Room model: a community crisis center that offers people experiencing a mental health crisis an alternative to hospitalization. health crises a calm and safe environment. The community outpatient centers are open 24 hours a day, 7 days a week and people receive care immediately. Services include: crisis intervention, a safe place in which to rest and relax, support from peer counselors; intervention from professional counselors including teaching de-escalation skills and developing safety plans, Linkage with referrals for emergency housing, healthcare, food, and mental health services. https://smiadviser.org/knowledge_post/what-is-the-living-room-model-for-people-experiencing-a-mental-health-crisis.

Crisis Stabilization Centers: 24/7 community crisis response hub where people of all ages can connect immediately with an integrated team of clinical counselors, peer specialists, and behavioral health professionals, as well as to our local community's health & human service providers, to address any mental health, addiction, or social determinant of health needs. People use the Stabilization Center when they're experiencing emotional distress, acute psychiatric symptoms, addiction challenges, intoxication, family issues, and other life stressors. https://people-usa.org/program/crisis-stabilization-center/.

Parachute NYC / Open Dialogue: provides a non-threatening environment where people who are coming undone can take a break from their turbulent lives and think through their problems before they reach a crisis point. Many who shun hospitals and crisis stabilization units will voluntarily seek help at respite centers. Parachute NYC includes mobile treatment units and phone counseling in addition to the four brick-and-mortar respite centers. https://www.nyaprs.org/e-news-bulletins/2015/parachute-nyc-highlights-success-of-peer-crisis-model-impact-of-community-access.

Non-residential

Safe Options Support teams: consisting of direct outreach workers as well as clinicians to help more New Yorkers come off of streets and into shelters and/or housing**.** SOS CTI Teams will be comprised of licensed clinicians, care managers, peers, and registered nurses. Services will be provided for up to 12 months, pre- and post-housing placement, with an intensive initial outreach and engagement period that includes multiple visits per week, each for several hours. Participants will learn self-management skills and master activities of daily living on the road to self-efficacy and recovery. The teams' outreach will facilitate connection to treatment and support services. The SOS CTI Teams will follow the CTI model – a time-limited, evidence-based service that helps vulnerable individuals during periods of transitions. The teams will be serving individuals as they transition from street homelessness to housing. https://omh.ny.gov/omhweb/rfp/2022/sos/sos_cti_rfp.pdf.

Intensive and Sustained Engagement Team (**INSET)**: a model of integrated peer and professional services provides rapid, intensive, flexible and sustained interventions to help individuals who have experienced frequent periods of acute states of distress, frequent

emergency room visits, hospitalizations and criminal justice involvement and for whom prior programs of care and support have been ineffective. MHA has found that participants, previously labeled “non-adherent,” “resistant to treatment” or “in need of a higher level of care” and “mandated services,” become voluntarily engaged and motivated to work toward recovery once offered peer connection, hope and opportunities to collaborate, share in decisions and exercise more control over their lives and their services and supports. their treatment plans. Engaged 80% of people either AOT eligible or AOT involved. https://www.mhawestchester.org/our-services/treatment-support.

NYAPRS Peer Bridger™ program: a peer-run and staffed model providing transitional support for people being discharged from state and local hospitals, with the goal of helping people to live successfully in the community, breaking cycles of frequent relapses and readmissions. The program include inpatient and community based intensive one on one peer support groups, discharge planning, connection to community resources; provides access to emergency housing, wrap around dollars and free cell phones and minutes. https://www.nyaprs.org/peer-bridger.

NYC Mayor’s Office of Community Mental Health Intensive Mobile Treatment teams: provide intensive and continuous support and treatment to individuals right in their communities, where and when they need it. Clients have had recent and frequent contact with the mental health, criminal justice, and homeless services systems, recent behavior that is unsafe and escalating, and who were poorly served by traditional treatment models. IMT teams include mental health, substance use, and peer specialists who provide support and treatment including medication, and facilitate connections to housing and additional supportive services. https://mentalhealth.cityofnewyork.us/program/intensive-mobile-treatment-imt.

Pathway Home™: a community-based care transition/management intervention offering intensive, mobile, time-limited services to individuals transitioning from an institutional setting back to the community. CBC acts as a single point of referral to multidisciplinary teams at ten care management agencies (CMAs) in CBC’s broader IPA network. These teams maintain small caseloads and offer flexible interventions where frequency, duration and intensity is tailored to match the individual’s community needs and have the capacity to respond rapidly to crisis. https://cbcare.org/innovative-programs/pathway-home/.