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**Testimony of  
Sakeena Trice, Senior Staff Attorney  
on behalf of the Disability Justice Program at New York Lawyers for the Public Interest  
before the Council of the City of New York  
Committee on Health and Committee on Mental Health, Disabilities, and Addiction**

**March 21, 2024**

My name is Sakeena Trice, and I am a Senior Staff Attorney with the Disability Justice Program at New York Lawyers for the Public Interest (“NYLPI”). Thank you for the opportunity to present testimony today on behalf of NYLPI. NYLPI is deeply concerned about the City’s practices relating to the involuntary removal of individuals perceived to have mental illness diagnoses for psychiatric evaluation. Additionally, NYLPI urges the City Council to mandate significant changes in the Behavioral Health Emergency Assistance Response Division Program (B-HEARD), as it is a deeply flawed pilot which merely purports to be a non-police response to people experiencing mental health crises – but in fact is part of the long tradition of policing, criminalizing, and under- and mis-serving people with mental disabilities. Funding B-HEARD in its current guise diverts money from what we need – a true non- police crisis response system that dispatches teams of peers (those with lived mental health experience) and emergency medical technicians who are not City employees, 24/7 operating hours, calls routed through 988, and above all, prioritizes the self-determination of people with mental disabilities.

**THE MAYOR MUST IMMEDIATELY RESCIND HIS 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 Involuntary Removal Policy launched in November 2022, allows police officers to detain an individual by force, and transport 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 themselves or others.

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 a myriad of other federal and state constitutional and statutory provisions, including the Americans with Disabilities Act, Section 504 of the Rehabilitation Act, and New York City Human Rights Law.

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.

Even though the City touted the success of the policy one year after its launch, the City offered no data on its implementation, including whether people of color are being disproportionately targeted.

The City must rescind the Involuntary Removal Policy to ensure that 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.

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

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 crises**. According to NYLPI and Human Rights Watch’s [joint-research](#), there are at least 160+ emergency response programs nationwide that engage in crisis response activities without police as the initial responders or as automatic co-responders.

Closer to home, New York State is already taking action. The state legislators are working to pass a bill known as Daniel’s Law (Senate Bill [S2398](#)/Assembly Bill [A2210](#)), which would establish a statewide emergency and crisis response system where police are no longer the default first responders to health emergencies. Under Daniel’s Law, the state will only fund emergency response plans where mental health experts and peers control the response to a health emergency, and the role of police would be strictly limited to situations involving imminent risk of serious physical harm to the public. The bill currently has 33 sponsors in the Assembly and 17 sponsors in the Senate.

Likewise, the City must establish a system whereby individuals who experience a mental health crisis receive appropriate services which will de-escalate the crisis and which will 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 and health care providers.<sup>1</sup> 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 eight 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.<sup>2</sup>

The scores of people experiencing mental health crises who have died at the hands of the police over the years is a microcosm of the police brutality around the world. Disability is disproportionately prevalent in the Black community and other communities of color,<sup>3</sup> and individuals who are shot 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 to remove the police as responders to mental health crises – and certainly we must all oppose the Mayor’s efforts to increase the role and funding of the NYPD as it relates to people with mental disabilities. Lives are literally at stake.

[Correct Crisis Intervention Today – NYC](#) has developed the needed antidote. Modeled on the [CAHOOTS](#) program in Oregon, which has successfully operated for over 30 years without *any* major

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<sup>1</sup> 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&rft\\_id=ori%3Arid%3Aacrossref.org&rft\\_dat=cr\\_pub%3Dpubmed&#/doi/abs/10.1176/ps.50.1.99?url\\_ver=Z39.88-2003&rft\\_id=ori%3Arid%3Aacrossref.org&rft\\_dat=cr\\_pub%3Dpubmed](http://ps.psychiatryonline.org/doi/abs/10.1176/ps.50.1.99?url_ver=Z39.88-2003&rft_id=ori%3Arid%3Aacrossref.org&rft_dat=cr_pub%3Dpubmed&#/doi/abs/10.1176/ps.50.1.99?url_ver=Z39.88-2003&rft_id=ori%3Arid%3Aacrossref.org&rft_dat=cr_pub%3Dpubmed).

<sup>2</sup> 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](http://ps.psychiatryonline.org/doi/10.1176/appi.ps.52.2.219?utm_source=TrendMD&utm_medium=cpc&utm_campaign=Psychiatric_Services_TrendMD_0).

<sup>3</sup> Mayor’s Office for People with Disabilities, “Accessible NYC” (2016), [https://www1.nyc.gov/assets/mopd/downloads/pdf/accessiblenyc\\_2016.pdf](https://www1.nyc.gov/assets/mopd/downloads/pdf/accessiblenyc_2016.pdf).

injuries to respondents or responders – let alone deaths -- the CCIT-NYC proposal 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 the City 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:

- In Fiscal Year 2023 (July 2022 through June 2023), about **79% of all mental health calls** in B-HEARD precincts were still **directed to the NYPD**, and B-Heard responded to only about **21% of total mental health calls** in the pilot area.

- Even when all kinks are ironed out, the City anticipates continuing to have about **50% of all mental health calls directed to the NYPD.**
- Moreover, **all mental health 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 unnecessary, and they also 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 reported averaged over **fifteen minutes**<sup>4</sup>, which is not even remotely comparable to the City's response times for other emergencies of 8 to 11 minutes.
- **The pilot operates only sixteen hours a day.**
- **There are no outcome/effectiveness metrics.**
- **There is no oversight mechanism.**

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<sup>4</sup> This information was not even collected for the last reporting period.

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:

<b>Critical Attributes of a Mental Health Crisis Response System</b>	<b>CCIT-NYC's Proposal</b>	<b>NYC's B-HEARD Proposal</b>
Removal of police responders	<b>YES</b>	<b>NO</b> (currently, around 79% 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.	<b>YES</b>	<b>NO</b>
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	<b>YES</b>	<b>NO</b> (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	<b>YES</b>	<b>NO</b> (run by New York City Police Department and other City agencies)
Peer involvement in all aspects of planning/implementation/oversight	<b>YES</b>	<b>NO</b>
Oversight board consisting of 51% peers from low-income communities, especially Black, Latinx, and other communities of color	<b>YES</b>	<b>NO</b>
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	<b>YES</b>	<b>NO</b>



Response times comparable to those of other emergencies	<b>YES</b>	<b>NO</b> (Most recently reported response time of over 15 minutes -- compared with average response time of 8 to 11 minutes for non-mental health emergencies)
Response available 24/7	<b>YES</b>	<b>NO</b> (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	<b>YES</b>	<b>NO</b>

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, mandating substantial modifications to the B-HEARD by including the critical components of the CCIT-NYC proposal.

**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 for 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.<sup>5</sup> There are multiple less invasive models of care 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 fail to do so, instead providing services that are insufficient or 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

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<sup>5</sup> See, e.g., de Bruijn-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>.

other communities of color.<sup>6</sup> The racial disparities in the application of forced outpatient treatment (also known as Kendra’s Law) are also 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.
- Mandate changes to the B-HEARD program to align it with the truly non-police, peer-led CCIT-NYC model and authorize its full funding.
- 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) 336-9321 or Strice@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

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<sup>6</sup> Mayor’s Office for People with Disabilities, “Accessible NYC” (2016), [https://www1.nyc.gov/assets/mopd/downloads/pdf/accessiblenyc\\_2016.pdf](https://www1.nyc.gov/assets/mopd/downloads/pdf/accessiblenyc_2016.pdf).

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.