

‘Mental Health Crisis, Don’t Shoot!’



New York City, like the nation, often responds to emotionally disturbed persons with police violence. Some places are trying to change that.

Experiencing a mental health crisis in New York City can be a harrowing ordeal, but it shouldn't be a fatal one. Yet when many New Yorkers face a moment of desperate psychological distress, the only "help" available is a police officer wielding a gun.

According to *The City*, a local investigative news site, the number of 911 calls related to "emotionally disturbed persons," or EDPs, nearly doubled from about 97,000 to 179,600 from 2009 to 2018. The city's police force is generally the default first responder, whether or not they involve any actual threat to public safety.

When police arrive and encounter a person in extreme psychiatric distress, perhaps psychosis, it too

often leads to confusion and panic, mixed with latent prejudice and an impulse to reach for a weapon.

There have been about fourteen documented police killings in New York City encounters involving a psychological crisis in the past three years. Advocates say every crisis that has ended needlessly in death is a measure of how far the city falls short in safeguarding its most vulnerable residents.

Carla Rabinowitz, advocacy coordinator with the service organization Community Access, tells *The Progressive* of one client she knows who "saw the officers coming, and so she got ready to fight, because she's afraid of them."

“And I know her,” she says. “She’s a really good soul. She’s getting her life back together. But when she was sick, and you see four, ten officers coming into your apartment, you get afraid. People are afraid.”

After the distress call, hospitals and jails end up absorbing people in crisis as a default mental health care system for those who cannot get proper care. In 2018, about 94,000 911 calls resulted in people going to emergency rooms, the vast majority escorted by the city’s police department.

“She’s a really good soul. She’s getting her life back together. But when she was sick, and you see four, ten officers coming into your apartment, you get afraid.”

Despite an overall drop in the city’s inmate population since the 1980s, people with mental health conditions still make up about 34 percent of the people in its jails. At the same time, New York City suffers from an acute shortage of behavioral health professionals. A study by University of Southern California found that about 30 percent of New Yorkers live in areas with a major shortage of mental health services.

Rabinowitz argues that the city should provide an alternative crisis number for people needing mental health intervention, and put psychologists and trained social workers on the frontlines instead of cops.

Not surprisingly, the tragedies involving people with mental illness have been concentrated in deprived communities where police presence is oppressive and social services are scarce.

One recent casualty was Kawaski Trawick, a thirty-two-year-old black man living in a nonprofit supportive housing project in the Bronx. On April 14, police reportedly responded to an EDP call describing him as acting out and harassing neighbors. Following a series of crossed 911 messages, Trawick had a confrontation with cops while holding a wooden stick and a knife. He was tasered and then fatally shot—all within about two minutes.

Community members and local politicians are demanding to know why additional precautions were not taken with Trawick, who was clearly in distress.

Activists see the intersection of mental illness and police brutality as an illustration of systemic racism in law enforcement.

About a year before Trawick’s death, Saheed Vassell, a young black man with bipolar disorder, was gunned down by cops after the pipe he was wielding was mistaken for a gun. And in 2016, Erickson Brito, a twenty-one-year-old black man with a history of mental illness and drug use, got into a dispute with cops at a Brooklyn housing complex and ended up being shot twice in the head, after he allegedly grabbed an officer’s baton.

In April, the one year anniversary of Vassell’s death, his father, Eric Vassell, told the Brooklyn Eagle: “We are scared, because they are murderers still out there. And just like how my son was killed, other family members are scared also that their loved one can be killed.”

Facing enormous public pressure to overhaul the emergency-response system, New York City Mayor Bill de Blasio’s administration established a Crisis Prevention and Response Task Force in April 2018 to develop “a comprehensive strategy” for reforming both police and the social service system, and “develop multi-agency strategies which will allow better coordination between our health and public safety systems.”

After several years of vowing to fix the system, the administration has fallen short on key benchmarks for training officers in crisis intervention and integrating social services into the emergency-response infrastructure. The mayor’s primary reform to the mental healthcare infrastructure has been Thrive NYC, a broad-based program that focuses on raising public awareness and referring people to treatment—but it is largely disconnected from the emergency response system.

According to advocates, the police shouldn’t even be responding to most of these cases.

“We have tasked the police with a lot of work that doesn’t seem appropriate” given how they are trained, says Ira Burnim, legal director at the Bazelon Center for Mental Health Law. Yet, he notes, “we have a mental-health system that basically has little to no capacity to respond to crises,” leaving police and paramedics to carry the “burden of intervention.”

One suggestion for a more humane crisis-response infrastructure comes from Police Reform Organizing Project (PROP), a grassroots watchdog group that wants to remove police from the emergency response system as much as possible.

“We don’t think this is an appropriate role at all for the police unless there’s a clear and present danger,” says PROP founder Robert Gangi. In his view, the government should redirect funding away from police and toward psychosocial services.

“We have tasked the police with a lot of work that doesn’t seem appropriate.”

Meanwhile, PROP contends in a new report that mental health-related cases should be handled by “professionals whose vocation is to relieve people in stress . . . rather than officers whose training mainly involves how to use force effectively.” Advocates also [recommend](#) that the city establish dedicated urgent care-type centers to provide short-term respite and therapeutic care within the community.

“You don’t send police when someone has diabetes [or when they are] having high cholesterol,” Rabinowitz says. “You don’t send police to go check in on them. You send a nurse, or take them to an urgent care center.”

Rabinowitz acknowledges that police might be needed in some situations—for instance, when an assault is taking place. But the intervention should be handled by “people who are trained to de-escalate.”

“We want the police to normalize mental health, just like the rest of society’s doing,” she adds.

The de Blasio Administration, for its part, had plans to establish improved training protocols for crisis intervention, as well as “Diversion Centers,” where police could drop off people in need of social care. But The City reported in March that the NYPD was lagging behind planned reform benchmarks: The promised diversion centers had not materialized, and most of the force had not undergone enhanced crisis intervention training.

Another plan to expand co-response teams, comprised of mental health professionals and officers, remains in a pilot phase, limited to one district. (The mayor’s office and NYPD declined to comment for this article.)

Cities including Minneapolis, Houston, Boston, and Seattle have revamped their emergency-response systems to include mental-health specialists.

The mobile crisis teams, which roam the area in vans staffed with intervention specialists, respond to about one in five public-safety related calls in the Eugene area, roughly 22,000 calls a year, and also work proactively with local communities through street-based outreach, helping to identify vulnerable people before a crisis starts.

Meanwhile, other cities including Minneapolis, Houston, Boston, and Seattle have revamped their emergency-response systems to include mental-health specialists. These systems typically involve officers and social-service workers being dispatched together, so that a behavioral-health professional can step in to deescalate a situation.

In Eugene, Oregon, the White Bird clinic has run a mobile-response service called CAHOOTS (Crisis Assistance Helping Out On The Streets), in tandem with local police. For the past thirty years, the program has allowed people to connect immediately with services ranging from crisis counseling and first aid, to family conflict resolution and help with housing.

Advocates like Burnim see potential in a model like this. “If you improve the mental health system,” he says, “you could dramatically reduce the number of crises to which the police had to respond.”

Not only would better care prevent crises from occurring in the first place, he adds, but a robust mental health system “would be engaged with people, they’d know them.”

Rabinowitz wants to see the city government proactively partnering with peers like her, people with lived experience with mental health issues, working collaboratively with police and service providers to inform crisis-intervention training programs.

If police aren’t fully educated on how to meet the needs of a person in psychological distress, she says, “when they do respond, [police] are not going to see mental health recipients as regular citizens. And that’s a problem. And we really have to counter the old culture of being anti-mental-health recipient, of seeing us as second-class citizens.”