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Presented before

New York City Council

Committee on Mental Health, Disabilities, and Addiction

Oversight Hearing on the Mental Health Roadmap

May 4, 2023

My name is Jackie Gosdigian and I am Senior Policy Counsel at Brooklyn Defender Services. I have been a public defender for 15 years. I want to thank the Committee on Mental Health, Disabilities and Addiction, and in particular Chair Linda Lee, for holding this important hearing today on the City Council's Mental Health Roadmap.

BDS is a public defense office whose mission is to provide outstanding representation and advocacy free of cost to people facing loss of freedom, family separation and other serious legal harms by the government. We provide multi-disciplinary and client-centered criminal defense, family defense, immigration, civil legal services, social work support and advocacy in nearly 22,000 cases involving Brooklyn residents every year.

BDS' interdisciplinary, wraparound model allows us to provide support to people who may have avoided court involvement if they had access to services sooner. We help the people we represent apply for benefits and supportive housing, connect to mental health and substance use treatment, and locate beds in respite centers and safe havens. BDS is proud of having played an important role in the creation of the Brooklyn Mental Health Court in 2002. The Brooklyn Mental Health Court works with people accused of crimes who have serious and persistent mental illnesses, linking them to long-term treatment as an alternative to incarceration. BDS continues to

collaborate with this court to advocate for its expansion to meet the needs of more people, including people with intellectual disabilities and people who have previous criminal legal system involvement.

Earlier this year, we appeared before this committee to express our grave concern about the mayor's plan to expand the forced hospitalization of people experiencing housing instability and living with mental illness. We urged the council to consider why it takes an arrest, investigation, or court involvement for a New Yorker to access meaningful assistance and humane support. We are grateful to this Council for naming the harm of criminal legal system involvement for people experiencing mental health concerns and presenting a roadmap to mental health care that emphasizes non-coercive and non-carceral pathways to treatment.

Intersection of Mental Health and the Criminal Legal System

It is nearly impossible to divorce conversations about mental health from the criminal legal system. The media and public discourse have conflated the two–creating a false narrative which links mental illness to increased rates of violence.[1] This damaging and unfounded messaging exacerbates social stigma and reduces public support of policies that create alternatives to incarceration.[2] New York relies largely on policing and incarceration to address issues related to mental health and substance use. The rollout of non-police responses to mental health crises across New York City has been slow.[3] Police, rather than medical providers, are most likely to respond to people experiencing a mental health crisis.[4] Instances where the police respond to mental health crises often end in abuse or even death.[5]

I. Reporting on the Mayor's Involuntary Removal Program - In. 1018-2023 (Lee)

Mayor Adam's plan to increase involuntary removals of people deemed a risk to themselves or others relies on a short-term emergency response which will not meet the short- *or* long-term needs of people living with mental illness. Forcibly removing people perceived to be mentally ill from

[1] Heather Stuart, Violence and mental illness: an overview, World Psychiatry, June 2003, Available online at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1525086/

[2] *Id.*

[3] Greg Smith, Cops Still Handling Most 911 Mental Health Calls Despite Efforts to Keep them Away, The City, July 22, 2021, Available online at https://www.thecity.nyc/2021/7/22/22587983/nypd-cops-still-responding-to-most-911- mental-health-calls

[4] National Alliance on Mental Illness, Jailing people with mental illness, 2019, Available online at https://www.nami.org/Learn-More/Mental-Health-Public-Policy/Jailing-People-with-Mental-Illness.

[5] Eric Umansky, It wasn't the first time the NYPD killed someone in crisis, *Propublica*, December 4, 2020, Available online at https://www.propublica.org/article/it-wasnt-the-first-time-the-nypd-killed-someone-in-crisis-for-kawaski -trawick-it-only-took-112-seconds

the street to the most restrictive setting is not only inhumane, it is also ineffective in facilitating the goal of engaging people in mental health treatment.

Forcible removals by the police entail a risk of danger to the person who is experiencing a mental health crisis and does little to increase public safety long-term. When police respond to calls related to mental health crises, they are frequently not trained nor prepared, which is why these calls commonly result in harmful, if not fatal, outcomes. These interactions with police do not result in obtaining proper care for the person in crisis—but rather, the opposite happens. These interactions routinely result in handcuffs and incarceration. "It's why some U.S. jails hold more people with serious mental health conditions than any treatment facility in the country."[6] These interactions also make people vulnerable to police violence; in 2021, at least 104 people across the country were killed after police responded to someone "behaving erratically or having a mental health crisis." [7]

Even when police are properly trained, the simple presence of an armed police officer can escalate tension and trigger anxiety and distress for those who are living with mental illness or behavioral health conditions. As public defenders, we have seen firsthand how police interactions play out all too often. Our most recent cases confirm that an increase in police encounters with those living with mental illness are not resulting in removal to a hospital or care facility, but are instead resulting in arrest, incarceration, and further decompensation.

BDS supports the spirit of Int. 1018 and we encourage the Council to go further to include broader reporting, including:

- Whether an arrest was made,
- Whether a person was transferred to a hospital and not admitted to the hospital, including the average length of stay in the emergency department or Comprehensive Psychiatric Emergency Services Program (CPEP),
- Whether a person was transferred to a crisis respite center, stabilization center, or support connection center, and the average length of stay.

As the Council works to create, fund, and scale-up programs to meet the needs of people with serious mental illness, it is critical to understand if and how these programs are being used by emergency responders.

II. Expanded Access to Intensive Mobile and Community-Based Treatment

We recognize a need for high quality, trauma informed therapy and psychiatry services for adults with serious mental illness (SMI). Inadequate community-based mental health and substance use treatment funnels people struggling with mental illness into handcuffs, jails, and prisons. For people living with SMI, time in city jails frequently exacerbates preexisting mental illness, as

[6] *Id.*
[7] Nicholas Turner, We Need to Think Beyond Police in Mental health Crises, Vera institute, April 2022, Available at https://www.vera.org/news/we-need-to-think-beyond-police-in-mental-health-crises

behavioral health needs are all too often met with violence and isolation rather than appropriate care. After serving time in jail or prison, people return to their communities frequently lacking adequate healthcare infrastructure and access to affordable and supportive resources. These inadequacies lead too often to tragic results–either irreversible sickness and death or the churning cycle of incarceration, lapses in treatment, homelessness, and rearrest.[8]

The Mental Health Roadmap calls for meaningful investment in community care. To ensure that every New Yorker is able to access the care they need, we ask that the city expand evidenced-based treatments available to people with serious mental illness before they are engaged in the criminal legal system. This includes expanding access to Assertive Community Treatment (ACT) and Forensic Assertive Community Treatment (FACT) teams, investing in community based mental health treatment programs in low-income communities, and training frontline workers on available mental health care options for New Yorkers with serious mental illness.

BDS also strongly supports the expansion of access to Intensive Mobile Treatment (IMT) teams and programs using the community first model. The city must ensure that these programs are sufficiently staffed and that providers receive appropriate compensation. IMT teams and peer based support systems have been imperative, on the ground support for the people we serve. Providers must earn a living wage and the city must work to retain seasoned providers.

III. Expand Access to Affordable and Supportive Housing

As public defenders, we have seen how critical permanent, affordable housing is for the people we serve who are living with SMI. With a safe and stable home, people can engage in treatment more effectively. When their basic needs are met, people can choose to access medication, healthcare, counseling, and services. People with serious mental health concerns are disproportionately homeless or housing insecure, which creates additional barriers for them to access the treatment they need. People experiencing homelessness may have difficulties connecting to providers, affording treatment or medication, or accessing transportation to appointments. We urge the Council to work with the mayor to ensure funding for supportive housing, Justice Involved Supportive Housing (JISH), scattered site housing, crisis respite, and affordable, permanent housing are included in the FY24 budget.

One critical program, the MOCJ Emergency Reentry Housing Program—which has been a lifeline to people leaving the city jails—is scheduled to close at the end of the fiscal year. In April 2020, the City of New York partnered with direct service providers to establish the emergency reentry

[8] The National Commission on Correctional Healthcare has recognized these dangers. See Nat'l Comm. On Corr. Healthcare, About Us, https://www.ncchc.org/about (recognizing that improving the quality of care in jails and prisons not only "improve[s] the health of their inmates," but also "the communities to which they return").

housing program to provide immediate, low barrier to people transitioning out of incarceration. With co-located wrap-around services including medical care, case management, and housing and vocational support, people returning to the community had a safe, stable place to stay and receive care. The current emergency hotel program is scheduled to close on June 30, 2023, with the 530 current residents being moved into transitional housing. This plan, however, fails to serve the goal of using transitional housing to decarcerate Rikers Island. As of February 2023, there were over 375 people on a waitlist for a bed in the emergency hotel program–many of whom are incarcerated only because they do not have stable housing. The Council has a moral imperative to continue to fund this critical program as a step in a continuum of reentry housing.

IV. Crisis Respite

Many of the people we serve would likely not have become court involved if they had safe housing, access to medications, and the support of mental health professionals while addressing a short-term crisis or mediating a concern with a family member or caretaker. While crisis respite centers are available, restrictive policies often prevent people who are court involved, suicidal, or deemed to be acting erratically from accessing beds.

When NYPD responds to a mental health emergency the person in crisis is handcuffed and transported to a hospital for evaluation or a police precinct. Mental health teams, on the other hand, have begun to move away from this practice by providing care in the community, outpatient referrals, and bringing people to crisis respite centers.[9]

The city should continue to fund these critical centers to ensure they are ready to meet the needs of people who choose to access care in crisis, are ready to engage in treatment and need help to stabilize, as well as individuals who are transported by a mental health response team or NYPD. We believe these spaces should be accessible in areas with the highest rates of emergency mental health calls and operated by trusted, community-based organizations, so people in crisis can remain in their own neighborhoods near their support systems while receiving care.

V. Non-Police Response to Mental Health Crisis

For years, BDS has called for the removal of NYPD from all mental health responses, including mental health emergencies, and the expansion of mobile crisis teams. The city has attempted to change the response to serious mental illness (SMI) through piecemeal legislation and pilot programs. As we feared, in the neighborhoods where mental health teams are being piloted, NYPD

[9] B-Heard, Transforming NYC's Response to Mental health Crisis, *Mayor's Office of Community Mental Health,* July 2021, Available at https://mentalhealth.cityofnewyork.us/wp-content/uploads/2021/07/B-HEARD-First-Month-Data.pdf

officers are still responding to mental health emergencies in most cases.[10] Now Mayor Adams is encouraging officers to engage further with people they believe are experiencing mental illness. Allowing the NYPD to continue responding to these calls—even with additional training—does not address the real danger that police pose to people experiencing mental health crises. This plan criminalizes mental illness. Police are not mental health experts or medical professionals, and they should not be tasked with filling this role.

BDS echos the Council's call to fully fund mental health crisis response teams to ensure mental health emergency calls are addressed by medical professionals, clinicians, and peers who are trained in de-escalation methods.

VI. Treatment Not Jails - Res. 156-2022

Over the past few years, the New York State Legislature has championed and won historic legislative change in the criminal legal system. BDS fully supports Res. 156-2022 (Rivera), which calls on the legislature to pass and the governor to sign the Treatment Not Jail Act (S2881B - Ramos/A8524A - Forrest).

As previously stated, New York's current treatment court model has many restrictions on who is able to participate in a diversion program, based on their changes, diagnoses, or personal history. The Treatment Not Jail Act (TNJ) will substantially expand access to judicial diversion and create tangible steps toward ending the criminalization of mental health and cognitive impairments in New York. TNJ will create parity in the court system for vulnerable populations who need support and opportunity, and promote public safety by opening avenues of appropriate, individualized treatment where currently the default is incarceration. TNJ will:

- Create equitable access to judicial diversion by making the current judicial diversion law inclusive of people with mental health challenges and neurological, intellectual, and other disabilities.
- Allow New Yorkers to access treatment regardless of where they live. Currently, some counties will not allow people to participate in treatment court unless they are a county resident. TNJ will enable people to engage in treatment court within their county of residence, regardless of where the offense with which they are charged took place.
- Provide due process protection by ensuring that judicial diversion participants are not jailed without due process by requiring there be some substantiation of violations of judicial diversion conditions.

[10] Greg Smith, Cops Still Handling Most 911 Mental Health Calls Despite Efforts to Keep them Away, The City, July 22, 2021, Available online at https://www.thecity.nyc/2021/7/22/22587983/nypd-cops-still-responding-to-most-911-mental-health-calls

- End automatic exclusions based on level of charge. Currently, some people are excluded from participating in judicial diversion because of the section of the Penal Law with which they are charged regardless of their personal circumstances and background. TNJ will expand access to judicial diversion to people accused of any criminal offense. Research shows that diversion programs promote public safety, and that the nature of the charge does not impact treatment outcomes. TNJ will provide judges with the discretion to give people appearing before them individual consideration.
- Increase likelihood of success by embracing a clinical rather than punitive approach. TNJ will allow individuals to participate in treatment court without requiring them to plead guilty to access treatment. Judges will be trained in the best practices for mental health treatment within the judicial system. These practices will be grounded in providing support for participants and guided by treatment providers' individualized recommendations rather than over relying on punitive sanctions. TNJ will promote collaboration between participants and treatment providers, offering participants the best chance of achieving their treatment goals.

The number of people living with or having experienced mental health issues is at an all-time high, and jails and prisons have become the de facto mental health facilities across New York State. Treatment Not Jail seeks to put an end to this untenable condition and to redirect people out of jails and the criminal legal system and into evidence-based treatment programs that can offer the medical care and support they need.

VII. Strengthen Discharge Planning and Community-Based Mental Health Treatment

We recognize a need for high quality, trauma informed therapy and psychiatry services for adults with SMI. Many of the people we represent have tried for years to access mental health treatment, but face barriers to accessing mental health care in their neighborhoods, in their language, or with providers who are culturally competent. If untreated symptoms lead to a crisis situation, people with SMI may be hospitalized but are discharged and met with a lack of appropriate resources in the community. People seeking care remain on waitlists for months or years for ACT teams, supportive housing, psychiatric visits or other care they require. People we represent are routinely discharged from psychiatric hospitalization or CPEP stay with a referral to first-come-first-serve walk in mental health care and a list of congregate shelters. Others are denied services for requiring a "higher level of care" or having a co-occurring substance use disorder. With no information on where to turn next, they are often met with police, are arrested, and incarcerated.

New York City has invested over one billion dollars[11] in mental health education, outreach, and resources–but low-income New Yorkers still struggle to access care. New York State and federal legislation require insurance providers to offer comparable coverage for mental illness as they do for physical illnesses.[12] Yet many low-income people struggle to find high quality providers who accept Medicaid or Marketplace insurances, and are unable to cover copays for private insurance provided through an employer.

Current mental health paradigms rely upon the highest level of care – Assisted Outpatient Treatment (AOT) and Kendra's Law. While many of our clients have thrived with ACT and FACT teams, this level of intervention is not needed for many people living with SMI. To ensure that every New Yorker is able to access the care they need, we ask that the City expand evidenced-based treatments available to people with serious mental illness before they become involved in the criminal legal system. This must include comprehensive discharge planning from inpatient hospitalization or CPEP visits; expanding access to the previously mentioned IMT teams; investing in community based mental health treatment programs in low-income communities; expanding access to Article 31 and Article 32 clinics; and educating frontline workers on available mental health care options for New Yorkers with SMI. Linkages to appropriate care and warm handoffs to outpatient services must be prioritized. Free, voluntary mental health care must be made available in communities with the highest rates of mental health calls to 911 and must be expanded to include longer hours to reduce instances where people are turned away when seeking help.

Conclusion

The Council's proposed Mental Health Roadmap calls for greater investment in community care. To ensure that every New Yorker is able to access the care they need, we ask that this Council to support funding for the expansion of evidenced-based treatments available to people with serious mental illness before they are engaged in the criminal legal system.

BDS is grateful to the Committee on Mental Health, Disabilities, and Addiction for hosting this important hearing on the Mental Health Roadmap. We thank the Council for its continued support of people living with serious mental illness and acknowledge the critical role the Council plays in safeguarding this community and all New Yorkers. Thank you for your time and consideration of my comments. If you have any questions, please feel free to reach out to me at jgosdigian@bds.org.

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[11] See for example, Amanda Eisenberg, With opaque budget and elusive metrics, $850M ThriveNYC program attempts a reset, *Politico*, 2019, Available at 2https://www.politico.com/states/new-york/city-hall/story/2019/02/27/with-opaque-budget-and-elusive-metrics-850m-thrivenyc-program-attempts-a-reset-873945

[12] https://omh.ny.gov/omhweb/bho/parity.html