TESTIMONY OF:

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Presented before New York City Council

Committee on Mental Health, Disabilities and Addiction

Oversight Hearing on the City's Mental Health Response to Community Violence

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My name is Joyce Kendrick and I am the Attorney-in-Charge of the Mental Health Representation Team of the Criminal Defense Practice at Brooklyn Defender Services (BDS). BDS provides multi-disciplinary and client-centered criminal, family, and immigration defense, as well as civil legal services, social work support and advocacy in nearly 30,000 cases in Brooklyn every year. I want to thank the Committee on Mental Health, Disabilities and Addiction, and in particular Chair Diana Ayala, for holding this important hearing on the City's mental health response to community violence.

BDS' Mental Health Representation Team works to support people living with serious mental illness who have been accused of a crime in Brooklyn so that they may receive the most favorable outcome for their criminal case and receive adequate care and treatment during the pendency of their case and an opportunity to be connected to services that will enable them to gain and maintain stability. Our specialized attorneys represent clients at competency evaluations, hearings and other court appearances during the pendency of their case. In addition, these specialized attorneys regularly consult with others in the criminal defense practice to

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advise on mental health concerns in their cases and provide internal expertise to all of BDS' criminal defense attorneys. We are also very 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 defendants 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.

Mental Health, Community Trauma, and COVID-19

The global health emergency due to the COVID-19 pandemic has impacted every aspect of life in New York City. Across the City, people are dealing with economic insecurity, the looming threat of eviction, and dealing with individual and collective illness, loss, and grief. This chronic period of uncertainty has been linked to increased mental health concerns and stress for many people.[1] Black and Latinx communities have been disproportionately impacted by the COVID-19. These communities, too, are at increased risk for mental health concerns due to inequities in healthcare access, systemic racism, and disproportionate rates of poverty.[2]

New York City has seen two decades of decreasing crime rates and is considered one of the safest cities in the United States.[3] While crime rates continue to decline across the City, gun violence continues to be a concern.[4] The same communities that have been most heavily impacted by COVID-19 are also dealing with community violence. For these reasons, we commend the New York City Council for holding this timely hearing on the ways our City can address the mental health impact of community violence and trauma.

Intro 1890-2020

We have worked with many clients who have experienced serious trauma that was the result of direct or indirect community violence. For these reasons, we share the NYC Council's concern that the City dispatch mental health resources directly into communities after a violent incident has occurred.

BDS supports the spirit of Intro 1890-2020, which would require the New York Police Department (NYPD) to contact the Department of Health and Mental Hygiene (DOHMH) to provide mental health outreach following violent or traumatic events in a community. However, we believe there are important components to this outreach that are missing from this bill. We respectfully offer the following recommendations to support meaningful implementation:

Involve community leaders and credible messengers in planning and outreach

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[1] Centers for Disease Control and Prevention, Coronavirus Disease 2019 (COVID-19): Coping with Stress, June 2020, https://www.cdc.gov/coronavirus/2019-ncov/daily-life-coping/managing-stress-anxiety.html.
[2] American Psychological Association, Health Disparities and Stress, 2012, Available online at https://www.apa.org/topics/health-disparities/stress.pdf.
[3] James P. O'Neill, Crime and Enforcement Activity in New York City, https://www1.nyc.gov/assets/nypd/downloads/pdf/analysis_and_planning/year-end-2018-enforcement-report.pdf
[4] Police Department of the City of New York, CompStat Report Covering 10/26/2020 Through 11/1/2020, Available at https://www1.nyc.gov/assets/nypd/downloads/pdf/crime_statistics/cs-en-us-city.pdf

We urge the City Council and the DOHMH to work with community leaders and community based mental health providers to identify credible messengers to conduct outreach. These messengers must be able to build trusting relationships with community members. Outreach workers should be from the community, speak the same language as the people they serve, and have an established rapport in the community.

Ensure clear delineation between NYPD officers and DOHMH providers

After a violent incident, communities are filled with police conducting investigations. People who are seeking mental health services may feel hesitant about speaking to someone who knocks on their door, especially if they are assumed to be NYPD officers or collaborating with NYPD.

Brooklyn is consistently the borough with the most Civilian Complaint Review Board (CCRB) complaints. In order for the program to be successful, clear messaging about the roles of NYPD and DOHMH in the community must be clear.

Take steps to ensure confidentiality of people accessing mental health care

For program success, we caution against the collection of any personal identifying information from community members seeking mental health support following a traumatic event. If referrals from DOHMH workers are tracked, people receiving mental health services must be made aware of the limits of confidentiality and the ability of the court to subpoena medical and mental health records. If there is any chance that case notes from program affiliated mental health providers will be subpoenaed, participants must be informed as a part of informed consent to participate in mental health services.

Recommendations

Additionally, BDS believe that to prevent community violence and to provide communities with the trauma-informed support and resources, the City must invest in the mental health of communities impacted by violence. This investment must include community lead mental health initiatives, increased access to long term mental health care, supportive housing, and programs that seek to minimize community violence and mitigate trauma exposure response. BDS respectfully offers the following recommendations:

Divest from NYPD and invest in communities

Bringing mental health resources to communities impacted by violence or trauma is a crucial service for New York City to provide, but equitable access to proactive, culturally competent and affirming mental healthcare is necessary. Trauma in Black and Latinx communities in the City is not only a response to crime in communities. We know that interactions with the police, community surveillance, racial profiling, and criminal legal system involvement are also traumatizing.

The majority of the 30,000 people we serve each year live in five neighborhoods in Brooklyn: East New York, Brownsville, Crown Heights, Bedford-Stuyvesant and Flatbush. Given the way that the criminal system targets communities of color, it is no coincidence that those are also the

five poorest neighborhoods in Brooklyn. Our clients live in neighborhoods where they are constantly assumed to be dangerous. They are constantly surveilled, stopped-and-frisked outside of their homes, required to walk through metal detectors in their schools, observe vertical patrols in their apartment buildings, and are confronted by armed NYPD who treat them with distrust. Community violence and traumatic events do not happen in a vacuum. Intergenerational trauma, systemic racism and discrimination, adverse childhood experience, the toxic stress of poverty and police violence all contribute to much of the violent or suicidal behavior in our City.

We are in a transformational moment in history—amidst nationwide uprising against racist policing and the unprecedented health and economic crisis that has resulted from COVID-19. The protests in the wake of George Floyd's death have drawn attention to the racial inequities that persist not only in policing but across all institutions. Black and brown people are disproportionately targeted by police, charged with higher-level crimes in courts for the same underlying conduct, and sentenced to longer periods of incarceration.[5] At the same time, Black and Latinx people are infected with and die from COVID-19 at higher rates than their white peers, in part due to health inequities stemming from systemic racism, structural inequities in communities of color, and the impacts of mass criminalization and incarceration.[6]

New York City must start divesting from law enforcement and invest in the needs of people who live here instead, with community resources such as mental health services, housing, healthcare, schools, and jobs.

Fund culturally competent mental health services

Cultural competency is a major barrier to services for many New Yorkers with mental health needs. The existing outpatient mental health programs are not equipped to address the extreme trauma and hardship faced by our clients. Receiving mental health care has cultural barriers and stigma for many of our clients. For people who do not speak English, are LGBTQ, have been incarcerated, or do not see their race or ethnicity reflected by mental healthcare providers, receiving mental healthcare that is affirming and culturally competent can feel impossible. For clients with complex trauma histories, the available low-cost mental health clinics do not have the competency or scope of services needed to treat our clients.

We urge the City to invest in free and low-cost mental health services that are designed for people who have experienced hardship, trauma, or incarceration. These programs must be equipped to meet the needs of people who are newly being introduced to mental health care, to create a familiar, nonthreatening therapeutic environment for those who may be hesitant to engage in treatment. Such programs must employ trained clinicians who are fluent in multiple languages. We must not place the burden on the patient to educate the clinician about the realities of incarceration, gun violence, or racism.

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[5] The Sentencing Project, Report to the United Nations on Racial Disparities in the U.S. Criminal Justice System, April 2019, https://www.sentencingproject.org/publications/un-report-on-racial-disparities/.

[6] Rashawn Ray, Why are Blacks dying at higher rates from COVID-19?, The Brookings Institution, April 2020, https://www.brookings.edu/blog/fixgov/2020/04/09/why-are-blacks-dying-at-higher-rates-from-covid-19/.

Increase number of mobile crisis units citywide

BDS was pleased to hear the Mayor's announcement on November 10th that the City will pilot a NYC Mental Health Team program to dispatch emergency medical technicians and mental health providers to 911 calls for mental health support. We are hopeful that this program will be successful and remove the burden from caretakers who have too often struggled to access mental health support and care for their loved ones due to fear of police escalation during a crisis.

Families and caretakers of people living with mental illness often feel that they have nowhere to turn when their loved ones are in the midst of a mental health crisis. They recognize the sad reality that in New York City, calling 911 to report a mental health crisis will likely trigger a response by NYPD. Our clients and their families are fearful that, instead of a trained mental health provider or emergency medical technician, armed officers may respond to a call and that may lead to someone being shot by police.[7]

Mobile crisis teams are an essential resource for New Yorkers, yet in a moment of crisis a caller must decide if they can wait 48 hours for a crisis team to arrive. In most mental health crisis, people need immediate care and cannot wait 2 days for an intervention. The current mobile crisis model requires that people remain at home or a fixed address while awaiting response. For clients experiencing homelessness or those who must appear in court, this intervention is not able to meet them where they are. BDS calls for the expansion of the mobile crisis teams so that individuals can receive crisis intervention in real time, just as EMS responds to medical emergencies.

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BDS is grateful to the Committee on Mental Health, Disabilities and Addiction for hosting this critical hearing and shining a spotlight this issue. Thank you for your time and consideration of our comments. We look forward to further discussing these and other issues that impact our clients.

If you have any questions, please feel free to reach out to Kathleen McKenna, Senior Policy Social Worker at 718-254-0700 x210 or kmckenna@bds.org.

[7]Leah Asmelash, Philadelphia shooting is just the latest case in a long history of mental health crisis calls that turned deadly in the US, CNN, October 29, 2020, Available online at https://www.cnn.com/2020/10/29/us/mental-health-crisis-police-trnd/index.html.