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Before the Subcommittee on Criminal Justice and Counterterrorism

of the United States Senate Judiciary Committee

Hearing on “Behavioral Health and Policing: Interactions and Solutions”

April 22, 2021

Good morning, Chairman Booker, Ranking Member Cotton and members of the Subcommittee. I appreciate this opportunity to give my insights from my personal lived experience and professional life so that we can have a behavioral health crisis response system that works for people living with behavioral health disorders, their families and community where people desire to live work and play that is centered on race equity, rural and frontier communities.

My name is Keris Myrick and I was previously the president of the board of National Alliance on Mental Illness, and executive for the Substance abuse and Mental health services Administration and an executive with the largest public mental health system in the country – Los Angeles County Department of Mental Health. I am currently on the executive committee and board of the National Association of Peer Supporters and working with the Strategic Impact Initiative on Mental Health.

That is a snapshot of my professional self. Equally important is who I am as a person, I am a daughter, sister, cousin friend, Army brat, African American and person given a diagnosis of schizophrenia.

I recall when given a diagnosis of schizophrenia that I believed that no one would want to be my friend, that I was not worthy of help and worse that I was not worthy of love. I did not initially even believe that my struggles were due to having a mental illness. This is how I have felt often as a person of color in this country. I rejected any form of help and due to embarrassment and stigma of mental illness, I did not let people who loved and supported me the most – my parents - into the world that I was experiencing.

My first interaction with the mental health system during a crisis when I was in my 30's in Los Angeles went badly, very badly. My expectation was that an EMT or ambulance would come to my apartment for a "wellness" check when I was in emotional distress. I had been told repeatedly that a mental illness is like any other physical illness and should be treated as such. During a time of confusion, paranoia and extreme emotional distress, the police arrived at the small apartment building where I was the only African American resident. The officer banged on the door and loudly announced that he was from the police department sent to do a welfare check. As a black person, so many things ran through my mind – will the neighbors think that I fit some sort of stereotype about black people being criminals, was I safe to open the door to the police given the many horrific outcomes for African Americans and police interactions. My paranoia was not about my illness it was about the realities of what it is like to be black in America. I let the police in, fearing if I did not they would knock down my door. Being deemed a danger to self, I was handcuffed and taken the police station where I was then handcuffed to a chair while they spoke to an African American boy about stealing his grandfather's gun – on the table was a gun in a secure gun box. I was trying to understand how it is possible for me to be what everyone said "sick and needing mental health help" yet to be sitting handcuffed to a chair at a police station seeing for the first time in my life a real gun. This was my first experience being in such distress and needing mental health support. What I didn't need was the police response and being treated like a criminal. I needed health care and support.

I found what "care'" was all about – asking for help and getting instead handcuffs and being harmed physically and emotionally. From this, I was unwilling to seek the care I needed when I needed it most. All I can think is I am very fortunate not to have had the outcome of Ms. Mitrice Richardson, a 24-year-old African American woman known to have bipolar disorder was picked up by police in the Malibu/Calabasas area of Los Angeles because it was reported she was acting irrationally. Like me she was taken to a police station – but sadly for Ms. Richardson she was released from the station in the middle of the night with no car, phone, wallet or money. Her decomposed body was found 11 months later in the area not far from the police station.

Over the years, I have worked on advocacy and policy issues proclaiming that mental illness is like any other illness and services and supports should be on parity for both.

When someone has a heart attack, asthma, stroke, dementia or even ready to give birth – is this how they are treated? It is not the police who come (unless they are fist on the scene) it is Ambulance, Fire with EMTs. So why do we have police responding to mental health emergency situations when others are trained specifically to assess, provide support onsite, transport if necessary to respite, hospitalization and or refer to other community resources if needed?

Meeting a peer supporter especially one who looked like me, having access to supports in ways that I could enter in – like dipping a toe in the water – is how I and many of others with similar needs describe how peer support has helped them.

Peer Support Specialists[i] are trained in evidence- based practices such as seeking safety, wellness recovery action plan, intentional peer support and psychiatric advanced directives and with the addition of sharing their personal story of recovery to support another. We see and evidence has shown that people move from homelessness to being housed, unemployed or on disability to employment and from isolation to connection. Peer support has also proven[ii] to help people participate in and adhere to treatment, and for parents and family members to feel more confident in their ability to help their loved ones. Peer Support is cost effective and particularly valuable in rural and other areas that have been strapped for resources. Peer Support Specialists should be part of mobile crisis response with other behavioral health professionals as one of the ways to remove police from the behavioral health crisis response equation. Peer Respite[iii] while there is some funding in Medicaid for this cost-effective service, should also be fully funded by Medicaid and commercial insurance to enable people in behavioral health crisis who are not in need of hospitalization yet when in crisis have a safe and supportive place to recover.

These are unprecedented times – a world reeling from the pandemic, racial unrest, economic challenges and trauma especially for those who have been so disproportionately impacted. If we want people to engage in their recovery, build resilience and flourish, we need to create crisis response and systems that look like other health crisis response without police as first responders. We need Federal, State and local systems that can support people when they need help during a mental health emergency. Fortunately there are some blueprints from recent reports that can help us get there such as: The Group for the Advancement of Psychiatry (GAP) report : *"Roadmap to the Ideal Crisis Systems"*[iv], and a report of the Front End Project which is the only one that centers those with lived experience and race equity in the vision for crisis response reform: *"From Harm to Help: Centering Race Equity and Lived Experience in Crisis Response"*[v].

Developing the new 988 phone number for everyone to call specifically for these kinds of crisis situations in lieu of 911 is a start. This has created momentum for more comprehensive reforms. Yet, without the explicit inclusion of peer support throughout, centered on race equity and lived experience in the design, implementation and evaluation – we may not yield the systems that are most effective and one's people with mental health needs, their families, the communities they live in and even as the police have said they want.

This is what we need and today I ask that we support legislation and robust funding to ensure equity is really equity in behavioral health crisis response. I ask that if we are to move from handcuffs to help we must work together to ensure the safety of all including the police in creating systems that are humane, compassionate, effective and help people to flourish to their full potential.

Respectfully Submitted by

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4.22.2021

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[i] https://www.peersupportworks.org/resources/
[ii] https://www.samhsa.gov/sites/default/files/programs_campaigns/brss_tacs/value-of-peers-2017.pdf
[iii] https://www.livelearninc.net/peer-respite
[iv] https://www.thenationalcouncil.org/wp-content/uploads/2021/03/031121_GAP_Crisis-Report_Final.pdf?daf=375ateTbd56
[v] https://fountainhouse.org/reports/from-harm-to-health