Key organizations and thought leaders - representing grassroots constituencies of people who have been incarcerated and people living with mental health concerns, as well as advocates and service providers who work with them - have developed this detailed Roadmap for Mental Health Resources and Diversion. The Roadmap contains vital demands including ensuring: that law enforcement are not the first responders in cases of mental health crises; supportive housing for people with a range of mental health and substance dependencies; investments to scale to provide people with the resources they will need to thrive and not return to jail; and pre-charge diversion that prioritizes treatment.

NYC ROADMAP FOR MENTAL HEALTH RESOURCES AND DIVERSION

Provide robust care in communities to prevent mental health crises and interaction with law enforcement

1. Expand supportive housing
    a. Supportive housing provides a critical aspect of stability for 33,000 New Yorkers with mental health needs and substance dependencies, and other units are currently in development through already approved contracts.
    b. Continue development of the Supportive Housing 15/15 program, expand the range of housing options to include more units that allow families to stay together, and accelerate the rate of development of new units to at least 1,000 per year.
    c. Allocate $20 million additional dollars to DOHMH for the continued operation of 1,800 scattered site supportive housing units.

2. Expand site-based treatment
    a. Create two more Crisis Respite Centers
        - Eight Crisis Respite Centers currently serve New York City, with a total capacity for 64 people.
        - Queens and Manhattan each need at least one more Crisis Respite Center.
            - Queens respite center should be in Jamaica, well-served by transportation.
            - Manhattan respite center should be in an area of upper Manhattan well-served by public transportation.
        - Each center must be ADA compliant. Only one of the existing centers is.
        - The referral process for Crisis Respite Centers should be changed to remove barriers to access. Anyone, including a family member, peer, program staff, therapist, doctor, should be able to refer someone who would like to utilize a respite center. The Crisis Respite Center will then do its intake as normal.
        - Cost could be projected based on the operating budget of existing Crisis Respite Centers
    b. Create five Mental Health Urgent Care clinics
        - Open one mental health urgent care stand-alone clinic in each borough. While these clinics exist for those with private insurance, there is currently no public option.

- Clinics should offer 24 hour, walk-in, mental and behavioral health services.
- Clinics should be staffed at any given time by a psychiatrist, a nurse, a therapist, and a couple of peers.
- The City should convene a group of Health and Hospitals Corporation staff, mental health advocates, and people with lived experience to develop specific plans for the urgent care centers.
- Cost is to be determined.

c. PROS clinics
   - Approximately 20 PROS clinics currently provide services in NYC, but should be expanded, with City funding
   - Clinics could be expanded in the precincts with highest number of mental health calls (referred to as "EDP calls" by NYPD)
   - Peer support should be utilized further through the intake and treatment process

3. Expand field-based treatment
   a. Fund more mobile, intensive case management, modeled on the state-funded Assertive Community Treatment (ACT) teams, with expanded eligibility.
      - Eligibility should include those currently eligible for ACT *and* people with substance use disorders, personality disorders, cognitive and developmental disabilities, and history of severe trauma.
      - With the flexibility of City (rather than State funding) clients can also keep their ACT team assignment even if they are incarcerated or unreachable for a period of more than 90 days.
      - The City should fund 10 additional teams with capacity to serve 620 people: 8 teams with a caseload of 68 people each, and 2 teams working with unstably housed people with a caseload of 38 people each. This expanded capacity could address the current waiting list (approximately 500) and some of the additional demand that would come from expanded eligibility.
      - This would require an investment of $10.5 million ($1,055,000 per team x 10 teams), plus additional funds to build capacity at DOHMH to manage a larger number of teams.
   b. Fund more Intensive Mobile Treatment (IMT) teams
      - IMT teams have been very effective in meeting the needs of clients who are often hardest to reach, including people who live in unstable housing or are unsheltered. These teams have a lower ratio of clients to staff -- each team serves 27 clients, and there are 7 teams City-wide.
      - Because these teams use City funds, they have greater flexibility, and are not reliant on State budgets or Medicaid billing.
      - The City should fund at least one more team, with a capacity to serve 27 people.
      - This would require an investment of $1,095,880 (the current cost of one IMT team)

c. Address recruitment and retention challenges among field-based treatment teams
    - Fund pathways for workforce development, with a focus on recruiting more people of color and people with lived experience.
    - Assess salaries and increase compensation (and total budget per team) to ensure salaries competitive enough to attract and retain skilled people.
    - Offer resources for self-care, including addressing vicarious trauma, burnout, and workplace environment
    - Cost to be determined

When someone experiences a mental health crisis, ensure that law enforcement are not the first responders

1. Building on the Staten Island Call Diversion pilot, expand 911 mental health call diversion to health-only responses as recommended by the Mayor's Behavioral Health Task Force. Expansion should focus on the five precincts with the highest number of mental health calls (referred to as "EDP" by NYPD) and precincts in which police have killed or harmed people when responding to mental health calls.

When someone experiencing a mental health crisis interacts with law enforcement, ensure that they are diverted to treatment as early as possible, and are not subject to further law enforcement response or penalties

1. Create four more diversion centers with expanded eligibility
    a. After many delays, two diversion centers (with a total of 40-50 beds, serving up to 2,400 people per year) are set to open this fall in the Bronx and upper Manhattan, each serving three precincts. When police interact with people in crisis or people for whom mental health needs appear to be the cause of unusual behavior, police can bring them to these 24-hour diversion centers to receive services, and they will not be arrested or booked.
    b. While New York City is just starting to develop these centers, they have been an important part of the mental health and crisis management landscape in Los Angeles for a long time.
    c. The City should create four more diversion centers in the short term - with centers sited in the precincts that log the highest numbers of mental health calls for people in crisis.
        i. In Brooklyn, a diversion center should be located in East New York or Brownsville, to serve the 75th and 73rd precincts (with the 1st and 7th highest numbers of EDP calls in 2018)
        ii. In Queens, a diversion center should be located in Southeast Queens, to serve the 105th and 103rd precincts (with the 12th and 16th highest numbers of EDP calls in 2018)
        iii. In the Bronx, an additional diversion center should be developed in the South Bronx, to serve the 44th, 40th, 42nd, and 43rd precincts (with the 2nd, 3rd, 8th, and 14th highest numbers of EDP calls in 2018)

iv. In Manhattan, an additional diversion center should be developed between Midtown and Lower Manhattan, to serve the 14th and 13th precincts (with the 5th and 11th highest numbers of EDP calls in 2018)

d. The current guidelines give police discretion over who is brought to a diversion center, and allow them to exclude people whose behavior could be grounds for a felony charge.
    i. Police discretion should be minimized, given the well-documented patterns of racial bias in policing in which Black people are perceived as more threatening (and less deserving of diversion)
    ii. Eligibility should not exclude people who could be charged with a felony, but should rather be based on an observation of symptoms of mental distress such as:
        1. Responding to internal stimuli (likely hallucinations or delusions)
        2. Incoherent statements, tangential or loose associations
        3. Excessive tearfulness, fearfulness, or irritability
        4. Evidence of cutting themselves or other self-harm
        5. Wandering mind
        6. Slurred speech
        7. Disregard for personal appearance or hygiene
        8. Speaking in tongues
        9. Communicating with saints/spirits/demons
        10. Fervent religious/spiritual agitation all which are perfectly normal to many spiritual communities of color
        11. Kicking, screaming/yelling
        12. Pushing/pulling
        13. Using the word stop
        14. Complete lack of response
    iii. If Emergency Medical Services (EMS) arrives on the scene, they should transport people to diversion centers rather than police, if this does not delay transportation to a diversion center.
e. Staffing for these centers should ensure that there are peer specialists on staff during every shift (twenty-four hours per day, seven days per week)
f. This would require an investment of approximately $20 million annually ($5 million per center x 4 centers)

When someone with serious mental health needs (also referred to as SMI - Serious Mental Illness) is arrested, ensure opportunities for pre-charge diversion are identified and pursued as early as possible

1. Engage peers in the process to advocate for people with serious mental health needs who are facing charges
    a. Staten Island had a pilot program using peers to support defendants during the arrest & arraignment process
    b. Peers could be included on defense teams, to address any concerns about protecting attorney-client privilege

2. Strengthen connections between defense teams and mental health care teams
    a. DOHMH (which has access through SPOA to lists of people who have a field-based mental health treatment team and have been arrested) should facilitate connections between defense teams and treatment teams.
3. Educate judges on importance of and opportunities for diversion
    a. Existing models include
        - Council of State Governments and American Psychological Association have partnered to conduct trainings for judges
        - CUCS offers trainings for lawyers which could be adapted to train judges

When someone with serious mental health needs (also referred to as SMI - Serious Mental Illness) is arraigned, provide an alternative to detention or Department of Corrections custody

1. Train and educate judges to consider Crisis Respite Centers as an option to support Release on Recognizance
    a. As required under new state laws, judges must first consider Release on Recognizance (ROR) in every case. If they can make a justification for why ROR cannot be considered, they must then consider the least restrictive conditions that would ensure return to court
    b. In cases of people with serious mental health needs, judges could release defendants on their own recognizance, and include admission to a Crisis Respite Center as a condition of that release
2. Train Educate District Attorneys to expand the number of cases with are directed to Mental Health Court

When a person with serious mental health needs is ordered by a judge into a City detention facility, ensure that they are in a treatment-focused setting

1. Models like current PACE (Program to Accelerate Clinical Effectiveness) units, or Bellevue forensic ward, provide treatment-focused settings with minimal involvement from guards or security personnel. Primarily, people with serious mental health needs should not be in the custody of the Department of Corrections (DOC), but when they are ordered into DOC custody by a judge, this is the best option. The City's borough based jail plans already account for creating PACE units to scale.
2. When DOC is present, ensure that a CIT (Crisis Intervention Training) trained officer is rotated in when a trained officer is absent.
3. Institute racial equity training for all Correctional Health Services employees
    a. Cost of trainings to be determined.

When a person with mental and behavioral health needs is released from jail or prison, provide the supports they will need to thrive and not return

1. Supportive housing
    a. The City should amend NYC 15/15 to allow people who are homeless who have been incarcerated for 90 days or more to be eligible for these units (assuming they meet other NYC 15/15 eligibility requirements). Currently, the initiative only

targets people who meet the HUD definition of chronically homeless, thereby disqualifying those incarcerated for 90 days or more.

b. The City should prioritize incorporating NYC Department of Correction data when assessing vulnerability for individuals and families in CAPS (Coordinated Assistance and Placement System). Currently other systems' data is taken into consideration when looking at multiple systems touches, but not DOC.
c. Human Resources Administration (HRA) must ensure that providers interview clients who are in NYC jails - using either the Telehealth system or in-person. HRA must enforce this as a requirement for contracts.

2. Affordable housing
    a. For people with a lower level of mental health need, affordable housing available through Housing Connect, paired with care coordination, can provide well for their needs. But the City currently screens applicants for criminal history. Questions regarding prior convictions should be removed from Housing Connect applications, and HPD's *Marketing Handbook: Policies and Procedures for Resident Selection and Occupancy,* Section C4b (page 28) must be amended to remove "Criminal history" as a justifiable cause for rejecting an application.
    b. For people with a lower level of mental health need, affordable housing available through NYCHA, paired with care coordination, can provide well for their needs. But the City maintains barriers that prevent many people with criminal records from reuniting with their family members in NYCHA housing. These barriers must be removed entirely, including fully funding program providers designated to facilitate NYCHA family reunification.

3. Field-based treatment
    a. Fund more mobile, intensive case management (modeled on the state-funded Forensic Assertive Community Treatment teams) with expanded eligibility
        i. Eligibility should include those currently eligible for FACT *and* people with substance use disorders, personality disorders, cognitive and developmental disabilities, and history of severe trauma.
        ii. The City should fund two more teams, with a capacity to serve 116 people. Currently there are 5 teams with 68 clients each, and a waiting list of approximately 50 people (based on current eligibility).
        iii. This would require an investment of $2.1 million ($1,098,757 per team x 2 teams), plus additional funds to build capacity at DOHMH to manage a larger number of teams.

4. Addressing mental health needs in the shelter system
    a. While people exiting jails and prisons will ideally be connected to housing, many are not, and are released to the shelter system. All men coming into the shelter system go first through Bellevue Men's Shelter to be assessed and assigned elsewhere. Mental health supports are lacking there, and people in need of them often fall through the cracks.

b. Department of Homeless Services (DHS) must use Correctional Health Services assessments to assign men directly to mental health shelters, rather than require them to be assessed at Bellevue. The Brad H settlement already allows for DHS and CHS data sharing, and some people with mental health needs are placed directly into program shelters, but not consistently.
c. DHS must develop a similar system with NYS Office of Mental Health (OMH) so that people with serious mental health needs released from state prison can similarly bypass the assessment period at Bellevue.

***Organizations who consulted on this Roadmap**: Brooklyn Defender Services, BronxDefenders, Community Access, Corporation for Supportive Housing, From Punishment to Public Health - John Jay College of Criminal Justice, Jails Action Coalition, JustLeadershipUSA, Mental Health Project - Urban Justice Center, A More Just NYC, New York Lawyers for the Public Interest - Disability Rights Initiative, Women's Community Justice Association*
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