Responding to a Psychiatric Emergency:
A Vision for Public Health Reform in New York City

A Discussion Paper by Community Access

Executive Summary

In 2017 New York City's emergency call center (911) received 170,000 calls classified as "…people in an apparent mental health crisis." The standard protocol for responding to these calls is to deploy an ambulance and police officers.

What happens next can vary widely, depending on the training of the officers involved; their state of mind on that particular day; the ethnicity and social backgrounds of the participants; the attitude and behavior of the person experiencing the apparent mental health crisis; and much more.

The potential for the encounter to become confrontational, and even violent, is quite high.

In 2012, Community access and small group of activists formed the Communities for Crisis Intervention Team Training to advocate for improved officer training using the 40-hour "Memphis Model." This effort resulted in the adoption of CIT training by the NYPD in 2015. To date, almost 10,000 officers have been trained, but incidents involving officers and community members in need continue to occur, including 11 deaths over the past four years.

This discussion paper reviews the city efforts to improve crisis outcomes for people with behavioral health conditions, including, most recently, the recommendations developed by the Mayor's Task Force on Crisis Prevention and Response.
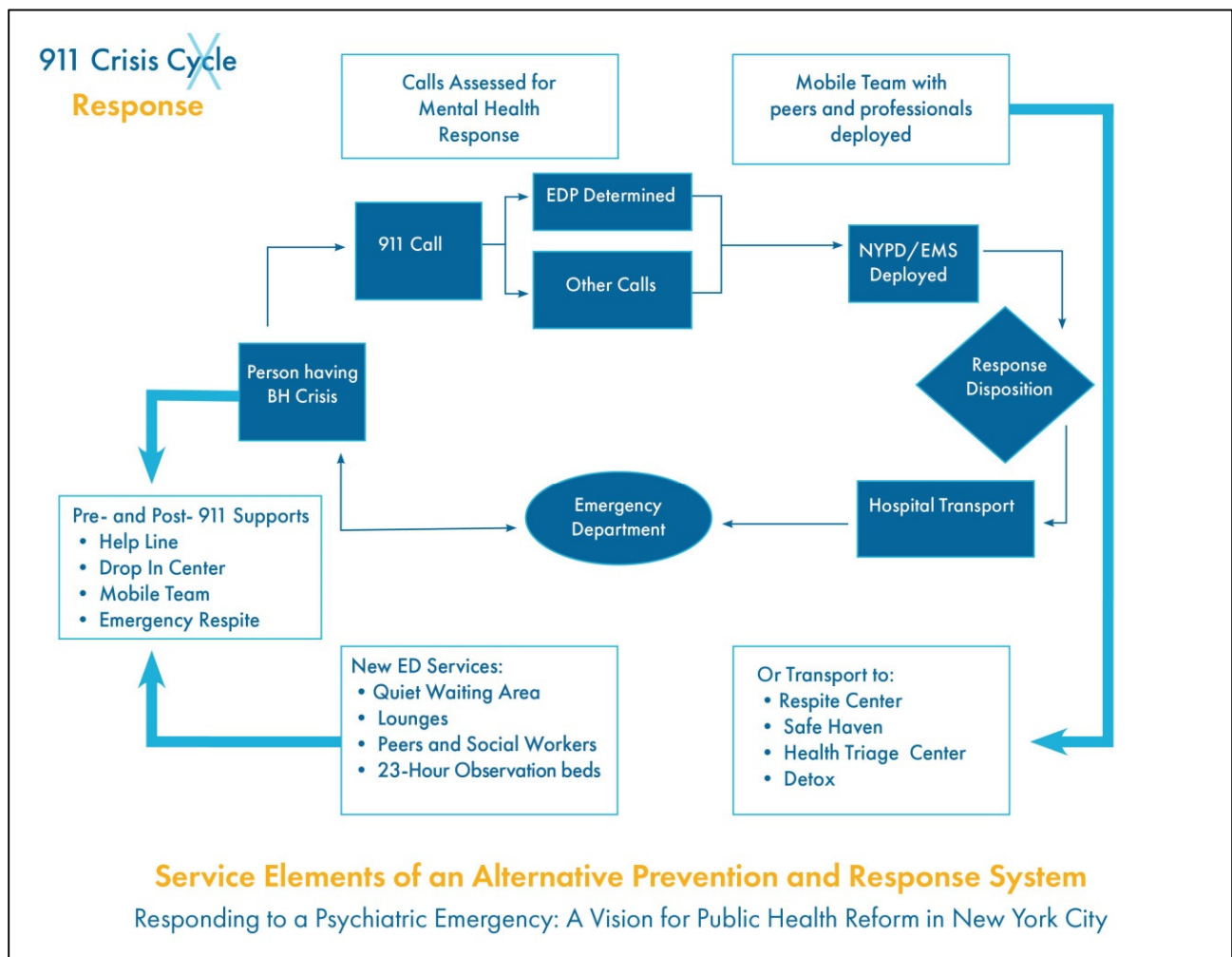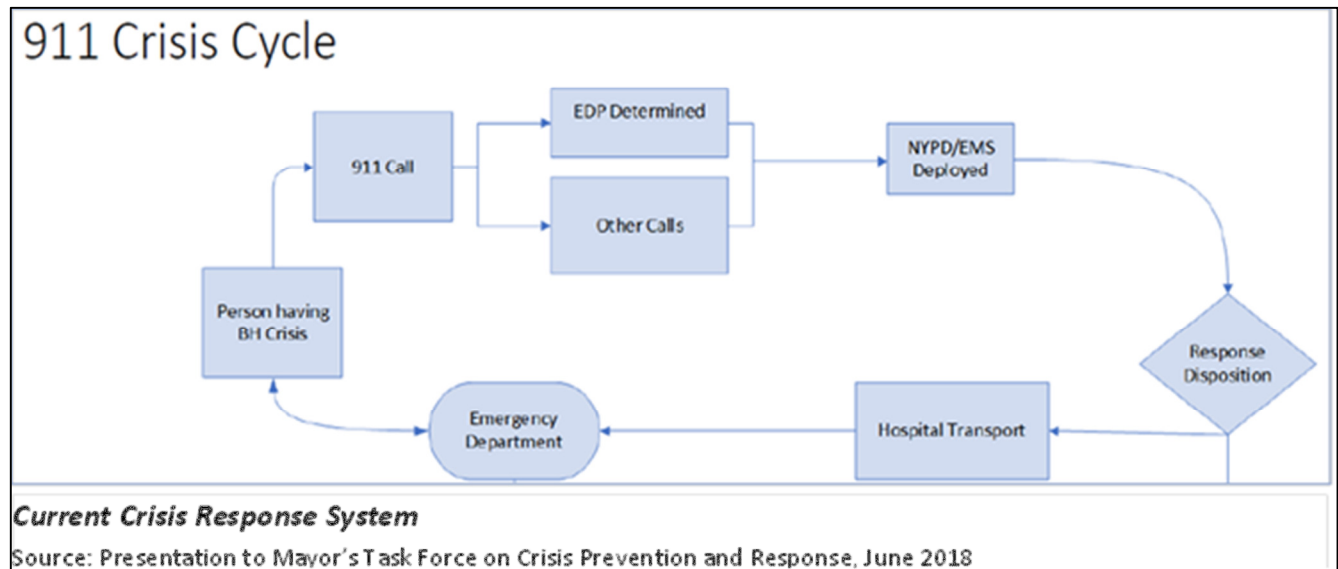
Our views have evolved since we first organized the CIT consortium in 2012. We have come to believe that the best possible strategy for assisting people in crisis is to:

1. Offer an array of supports so that a 911 call is rarely made

And,

2. Treat emotional crises as a health care issue and respond with a two- or three-person team that includes an EMT, crisis counselor, and peer specialist.

The diagrams below illustrate what a reformed crisis response might include:

911 Crisis Cycle

Current Crisis Response System
Source: Presentation to Mayor's Task Force on Crisis Prevention and Response, June 2018

911 Crisis Cycle Response

Service Elements of an Alternative Prevention and Response System
Responding to a Psychiatric Emergency: A Vision for Public Health Reform in New York City

Using a public health framework to examine this issue allows us to move beyond developing a better response to the 170,000 mental health-related calls made annually, and look at the reasons those calls are made in the first place. We believe this analysis would lead to community-based prevention strategies and the development of more cost-effective alternatives, such as those proposed in the diagram above.

Designing, implementing and sustaining such a vastly different approach to crisis services will be a monumental task, and one that will require government to fundamentally rethink its role as the master planner and policy expert. The real experts are those closest to the problem and if they are sufficiently engaged through a person-first, community-led planning process they will be able to clearly articulate what types of supports are needed.

On January 18, 2019, we took the beginning steps to rethink our crisis system by inviting over 70 people who had experience with a mental health crisis, either directly as the person in need, as a friend or family member, or as part of a community-based organization. Some of their ideas and suggestions are reflected in the chart on the previous page.

Community Crisis Forum - 1.18.19

We urge the city to greatly expand upon this type of planning effort and avoid the standard RFP process whereby city planners create a new program in isolation from the end users, task community organizations to implement a plan they had no role in creating, impose a rigid line item budget and scope of work, and set a reimbursement rate that does not fully support the true cost of meeting the project's objectives.

Introduction

On June 22, 2018, the Mayor's Task Force on Crisis Prevention and Response was convened with the charge to "…develop [a] comprehensive, citywide strategy to prevent mental health crises and improve the City's response to emotionally distressed New Yorkers."[1] By December 2018, the Task Force participants had met several times and issued a set of draft recommendations, which will become the basis of a future strategic plan to create a new and improved crisis response system.[2]

Because a final plan has yet to be formulated, we believe this is an opportune moment to review the many plans and initiatives launched by the current administration for improving mental health care and the degree to which those initiatives can assist people with behavioral health challenges, thousands of whom lead an uncertain existence cycling through shelters, jails, hospitals, and the streets.

The compelling motivation for creating the current crisis response task force was to improve the city's response during and following 911 calls. Despite a comprehensive crisis training program instituted in 2015, police officers continue to struggle to adequately assist people deemed "emotionally disturbed persons," or EDPs (a pejorative term that contributes to the de-humanization of people in need of help). As a result, there have been unnecessary injuries to officers and people in need, as well as nine police-involved killings of people in distress between 2015 and 2018.

Viewed broadly, we believe these traumatic encounters between the police and people in crisis are the consequences of a social support and public health system that fails to provide:

1. Assistance to people well <u>before</u> a 911 call is made

2. Adequate support <u>after</u> the encounter with emergency services, to reduce the likelihood of a repeated crisis

Without effective interventions, this expensive and frustrating cycle repeats itself, leaving police officers to cope with a social problem that was not of their making, and for which they receive very little training or support.[3]

The time period <u>after</u> calling 911 often results in a chaotic scene in which persons in crisis and their friends and family—who probably requested help in the first place—lose much of their decision-making authority. The "best case" outcome in this situation typically includes the person in crisis being handcuffed and sent to a psychiatric emergency room, which is an even more chaotic setting for someone who needs exactly the opposite.

Developing new and better solutions to both reduce the number of crises in the first place, and to respond effectively afterwards, will require sustained commitment across multiple mayoral terms.

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[1] https://www1.nyc.gov/office-of-the-mayor/news/203-18/mayor-de-blasio-first-lady-mccray-launch-nyc-crisis-prevention-response-task-force

[2] See https://www.communityaccess.org/crisis-discussion-paper for Task Force presentations and its membership. Its draft recommendations, distributed to the members on December 14, 2018, are not available for public distribution by Community Access. All inquiries should be directed to Ayesha Delany-Brumsey, Ph.D., Dir of Behavioral Health Research and Programming, Mayor's Office of Criminal Justice. adelanybrumsey@justice.nyc.gov

[3] The Crisis Intervention Team training, the most comprehensive preparation available, is only 40 hours, which is far less than the four to five years of schooling and training devoted to obtaining a clinical social work degree.

It will also require creative problem solving, accurate data, and engagement with a broad spectrum of stakeholders—including those members of our community who have been homeless, incarcerated, and subject to mental health care.

This also means working closely with the communities most affected by the challenges of long-term poverty and racism. It is a simple fact that people of color are overly represented in our shelters, public hospitals, and jails. Addressing the social determinants of health[4] that produce this disparity is essential for creating a truly just and effective long-term strategy.

Improving and repairing the crisis response system is really an opportunity to create a community-based health care and social support system that responds to our most vulnerable citizens when and where they need assistance.[5]

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[4] Lack of housing, stress, poverty, and social isolation all contribute to poor health outcomes.
   www.euro.who.int/__data/assets/pdf_file/0005/98438/e81384.pdf
[5] See Attachment 2 for A Note On Involuntary Treatment

<u>Campaign for Reforming Police Training Organizes in 2012</u>

Anticipating the election of a new mayor for New York City in 2013, an advocacy campaign was launched in October 2012 called <u>Communities for Crisis Intervention Teams</u>.[6] The campaign's goal was to educate the candidates, and the public in general, about alternatives to the city's approach in responding to mental health crises, starting with enhanced training for police officers. Called Crisis Intervention Team (CIT) training, it was originally developed in Memphis in 1986 and has been adopted in some form by over 3,000 other communities.[7]

Bill de Blasio was elected mayor in November 2013 and in December the mayor-elect named William Bratton as the new Police Commissioner, replacing Raymond Kelly, who had consistently resisted calls for reform of police training and tactics. Commissioner Bratton, who had previously been NYC's Police Commissioner between 1994 and1996, brought fresh experiences and ideas from his stint as the Los Angeles Chief of Police between 2002 and 2009.

During Bratton's tenure in Los Angeles, the city expanded CIT training, created a special mental health triage unit to assist officers in the field, and adopted co-response teams that paired officers with trained clinicians. We were optimistic that the new Commissioner would be responsive to the CIT Campaign's reform agenda.

<u>Mayor's Task Force on Behavioral Health and Criminal Justice</u>

Our hopes for a change in police training and protocols were realized within a few months. In June 2014 Mayor de Blasio formed the first-ever Task Force on Behavioral Health and Criminal Justice. By December 2014 the Task Force issued a comprehensive Action Plan to:

> …address how the criminal justice and health systems can work together better to ensure that we are reserving criminal justice resources for the appropriate cases and deploying treatment and other proven effective remedies to interrupt those needlessly cycling through the system.[8]

The report noted that while the overall jail population had decreased by 15% over the previous five years, the percentage of people in jail with "mental health issues" rose from 29% to 38%, meaning the number of people with mental health challenges in jail actually increased over this period from around 3,500 to over 4,000.

This trend has only increased: in 2016, 42% of the people in jail had a "confirmed" mental health diagnosis.[9]

More and more, our jails are becoming de facto psychiatric facilities.

The Action Plan was a well-conceived proposal to reverse this trend by diverting people with behavioral needs into treatment and away from the criminal justice system. Notably, the plan relied

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[6] See www.ccitnyc.org
[7] See www.cit.memphis.edu
[8] BF and CJ Action Plan 2014 also at: https://www.communityaccess.org/crisis-discussion-paper
[9] https://rikers.wpengine.com/wp-content/uploads/Justice-Brief_Jail-Population_.pdf

heavily on proven approaches that had been widely embraced elsewhere and promoted by the Council of State Governments Justice Center under its Stepping Up Initiative.[10]

Central to the Justice Center's approach is the sequential intercept model:

> …when appropriate, individuals with behavioral health needs:
>
> - do not enter the criminal justice system in the first place;
> - if they do enter, that they are treated outside of a jail setting;
> - if they are in jail, that they receive treatment that is therapeutic rather than punitive in approach; and that
> - upon release, they are connected to effective services.[11]

Over 20 different recommendations were described in the Action Plan, from enhancing police training and creating community diversion centers, to adding behavioral teams in probation departments to reduce recidivism.

Below is a diagram of a sample sequential intercept strategy.[12] Note the "Intercept 0" box, which references community-based <u>crisis prevention</u> strategies, <u>was not</u> included as a recommendation in the Action Plan, but has been part of the Thrive NYC initiative (described below).
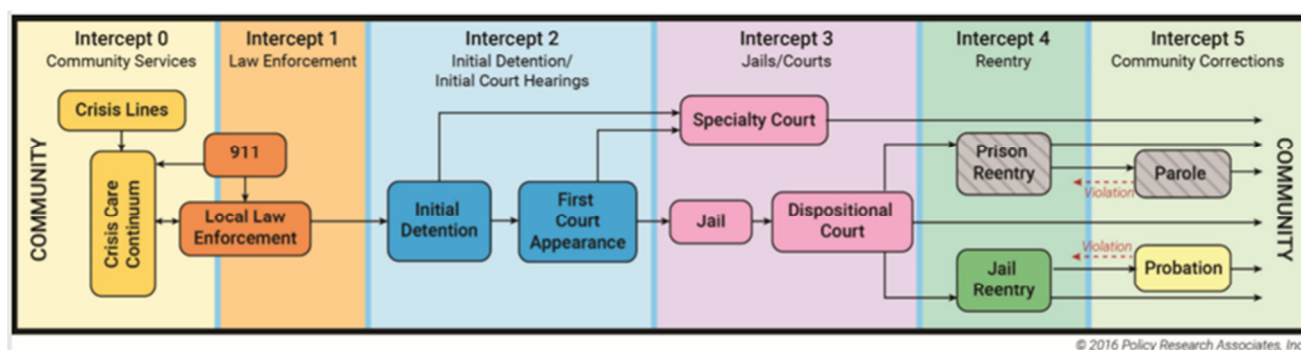
In July 2015 the city issued the first and only progress report on implementation of the Action Plan.[13] Of the 24 recommendations (See Attachment 1), some were identified as being 100% complete, such as "Establish a working group to coordinate all discharge planning," and "Provide specialized services to adolescents."

Unfortunately, verifying the accuracy of these claims is not possible without specific data. For instance, related to discharge planning, the report states that an "…electronic system has been created that shares appropriate information about clients being served by each agency, which helps to avoid duplication of services." If this system has been established, is it working? How many people have been helped and how?

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[10] https://csgjusticecenter.org/mental-health/county-improvement-project/stepping-up/
[11] ibid
[12] https://www.prainc.com/sim/
[13] Called the "First Status Report," it implied that subsequent reports would be issued.
https://www.communityaccess.org/crisis-discussion-paper

One area of easily documented improvement has been the report's first recommendation: "Expand training for first responders to recognize behavioral health needs." The responsibility for the new program was given to the NYPD, which adopted the "Memphis model" of CIT training: a method that features small classes and 40 hours of intensive examination of mental health issues from the perspective of people who have experienced both psychiatric crises and encounters with police officers. By December 2018 over 10,000 officers had been trained.[14]

Progress on a companion recommendation, opening community-based diversion centers, was reported as 25% complete: "…in the spring of 2016, the first of two clinical drop-off community centers will open. These centers will provide an important alternative to jail or hospitalization, assess needs and provide short-term care."

After a failed RFP process in 2015, the city issued a solicitation for a negotiated acquisition in 2016,[15] after which two vendors were selected to operate centers in the Bronx and East Harlem. On December 7, 2018, the Mayor's Office issued a press release announcing that these centers are now projected to open in late 2019.[16]

No further status reports were published related to the Action Plan and the web link to the original Plan itself has been taken down.

Of greater concern than the lack of transparent reporting around the Action Plan, has been the continued police-involved shootings of people who are experiencing an emotional crisis. Between June 2015 and January 2018, at least nine people were shot by officers responding to 911 crisis calls .[17]

We believe many of these incidents could have been prevented with better planning and a coordinated implementation strategy based on existing best practices. Several recommendations of this type have, in fact, been offered to the city but have not been implemented.

In 2016, the Mayor's Office of Criminal Justice commissioned a review of its Action Plan by the Council of State Government Justice Center (CSGJC).[18]

CSGJC review, while generally positive, identified several areas of possible improvement, including the 911 call center:

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[14] NYPD Quarterly Stakeholders meeting, December 17, 2018
[15] Notice of Solicitation https://www.communityaccess.org/crisis-discussion-paper
[16] Locations of Two Planned City Health Diversion Centers https://www.communityaccess.org/crisis-discussion-paper
[17] https://www.amny.com/news/mental-health-nypd-1.16925317
[18] *Brief Assessment of New York City's Behavioral Health and Criminal Justice Systems*, November 2016, also here:
https://www.communityaccess.org/crisis-discussion-paper

- Implement a division of NYPD that oversees all specialized behavioral health responses by the NYPD. A division that oversees all behavioral health responses in the NYPD could help to ensure that there is consistency in responses.

- Create a standard set of questions for 911 dispatchers to ask to identify whether the call is related to a mental health crisis.

- Establish a triage desk to assist with all 911 calls coming into NYPD identified as behavioral health crisis calls.

- 911 dispatch should develop a protocol to divert responses to the Mobile Crisis Unit, i.e., a non-officer response.

Other communities have instituted similar, best practice reforms that have allowed them to better track why people are calling for 911 assistance and, in some instances dispatch specially trained crisis workers instead of police officers.[19] Also, identifying repeat callers means interventions can be arranged to assist people who would otherwise use 911 as their de facto health care resource.

Growing frustrated with the city's slow progress in implementing the Action Plan—or at least the lack of transparency in what was actually being accomplished—the CCIT coalition pushed for the city to reactivate the original task force to re-examine the action plan and develop a new approach that would:

- be informed by all stakeholders, including people who had been subject to police interactions,
- have clearly defined objectives backed by data, and
- issue regular reports outlining progress on the plan's implementation.[20]

Responding to the attention generated by the coalition and a to requests from the city council, in April 2018 the mayor's office announced that new task force was going to be created.[21]

Mayor's Task Force on Crisis Prevention and Response

On June 22, 2018, Mayor de Blasio convened a second task force related to mental health issues, this one to address the specific issues connected with 911 calls and their aftermath.

This is an issue that is consuming a tremendous amount of public resources: In 2017 there were 170,000 calls related to "…an apparent mental health crisis." In 57% of the cases a person was transported to a hospital, either with a NYPD officer (43%) or solely with EMS (14%). Further, the trips to emergency rooms and hospitalization rates are uneven across the city and fall most heavily on communities of color with high rates of poverty and other social challenges.

The Task Force included over 80 individuals, drawn from city agencies, hospitals, legal services, and community-based organizations. Community Access's Advocacy Coordinator, Carla Rabinowitz, and CEO, Steve Coe, were both active members.[22]

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[19] Cahoots program, Eugene, OR. https://whitebirdclinic.org/wp-content/uploads/2018/11/20181125-wsj-cahoots.pdf

[20] https://www.ny1.com/nyc/all-boroughs/news/2017/10/18/activists-call-on-city-to-reactivate-task-force-on-mental-health-and-policing-on-anniversary-of-fatal-shooting

[21] https://nycprogressives.com/2018/04/20/progressive-caucus-statement-on-the-formation-of-mayors-edp-task-force/

The overall charge for the Task Force was to develop a comprehensive strategy to improve the City's 911 response to people in mental health crisis and was summarized as follows:

1. When there is a call to 911 for a mental health crisis, what can we do to improve the response?

2. What supports can we connect people to in order to avoid future mental health crisis calls to 911?

Within this broad mandate, four strategy areas were described:

- <u>Prevent mental health crises before they happen</u>: develop strategies and supports to prevent crises, including community and family support, peer engagement and respite services.

- <u>Enhance coordination between the city's safety and health systems</u>: create strategies that allow better coordination between our health and public safety systems.

- <u>Enhance ongoing support to reduce mental health crises over the long-term</u>: develop services to prevent future crises, such as intensive engagement, connection to ongoing support and treatment, enrollment in benefits, and help with housing and employment.

- <u>Share data across systems to refine the approach over time</u>: develop sustainable ways to share data and to monitor and analyze the effectiveness of these strategies.

The Task Force adopted the following <u>guiding principles</u>, which make explicit the role that race and poverty play in contributing to the differences in accessing services and the value of including citizens who have been closest to the issue in developing solutions:

- Ensure the advancement of racial equity and improve outcomes for communities of color

- Meaningfully include people with lived experience of the crisis system in the design and operation of the crisis system

- Invest in community capacity to design and operate supports for people who experience crises

Initially, the members for the Task Force were divided into four self-selected subcommittees: prevention, early intervention, response, and post-stabilization. These subcommittees met twice during the summer and generated a list of 35 preliminary recommendations, which fell into four broad groups:

- Prevention: Enhanced Services at the Community Level

- Crisis Response: First Responder Protocols

- Crisis Response: Service Alternatives to ERs

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[22] https://www1.nyc.gov/office-of-the-mayor/news/203-18/mayor-de-blasio-first-lady-mccray-launch-nyc-crisis-prevention-response-task-force

- Implementation: Need for an Independent Oversight Body

While the ideas were all sensible, the preponderance of the recommendations dealt with prevention and enhancing community resources. Again, we believe there are some significant opportunities to decrease the use of 911 as a crisis tool if there were more access to appropriate community-based resources.

Overall, we applaud the goals of the Task Force and its broad mandate to develop comprehensive, long-term strategies for a truly effective crisis response system. Such a system will not only save millions in unnecessary police and emergency services costs but will produce better outcomes for people who need access to compassionate and responsive treatment.

The challenge moving forward will be to develop a plan and oversight system that will ensure that proposed initiatives and strategies live up to key principles and remain flexible so that new ideas can be tested, revised, and expanded based on objective criteria and solid data analysis.

And as will be discussed below, there was consensus that an independent oversight body needs to be created that can execute and sustain a reform effort over the course of multiple administrations.

As was stressed to the Task Force in December:

"Work remains to edit, refine, determine which [recommendations] will be adopted, and develop operational plans."[23]

Our Recommendations

1. **Behavioral health crises are a <u>public health</u> issue, not a law enforcement and criminal justice problem.**

The 170,000 mental health-related 911 calls made in 2017 were the symptom of a public health system that is not helping people cope with complex social, economic, and chronic health issues at a much earlier point. Improving the skills and protocols of first-responders, while important to reduce the violence and trauma people in crisis often experience, will not fundamentally create an alternative pathway for more effective care.

Many of the recommendations that flowed from the recent Task Force acknowledge this fact and suggest many possible strategies that add new options. Such options include community-based behavioral urgent care and respite centers, alternative forms of crisis response, and enhanced training for local institutions that people already trust and use.

There are many examples of different diversion models throughout the U.S. and elsewhere that should be studied for testing and possible replication.

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[23] Presentation: Crisis Prevention and Response Task Force, Full Work Group Meeting, December 14, 2018: https://www.communityaccess.org/crisis-discussion-paper

2. **User feedback is essential.**

Any strategic plan created by the city policy makers should be informed by direct user input, which means people who have experienced crises, their friends and family members, and local community institutions.

This approach goes by many names, such as Community-led Development (CLD), a planning and development approach that incorporates five core principles.[24]

1. Grow from shared local visions

2. Build from strengths

3. Work with diverse people and sectors

4. Grow collaborative local leadership

5. Learn by doing

In 2017, Mayor's Office of Criminal Justice undertook such a planning process, called the *Neighborhood Activation Study: Crime Prevention Through Community Design and Problem-Solving.*[25] The project conducted in-depth research in two precincts with the highest rates of serious crime, asthma and diabetes, low educational achievement and employment – the 42nd in Morrisania and the 73rd in Brownsville. For the 42nd precinct alone, over 30 different community-based organizations were interviewed, as well as hundreds of neighborhood residents.

Similar community-led strategic plans focused on racial equity and social justice—key principles of the Task Force—have been undertaken in other communities. In King County, Washington, the community has created a six-year plan that shifts "…away from policies and practices that react to problems and crises toward investments that address the root causes of inequities…"[26] A key feature of their planning process was deep engagement with all stakeholders, from government employees to community members.

Reforming Crisis Services in NYC: A Community Forum[27]

To help inform our understanding of the issues from a user's perspective, Community Access convened a Community Forum on January 18, 2019 and invited people who have had a personal experience with a 911 call, or a police interaction during a crisis, either as a peer, family member, or community-based organization working closely with people who have frequent contacts with the police. Over 70 people responded.

The focus of the forum was to review and distill the many ideas (over 40) that had been generated by the task force between June and December. We did not rank or suggest which ideas had been presented

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[24] http://inspiringcommunities.org.nz/resources/about-cld/principles/
[25] https://criminaljustice.cityofnewyork.us/reports/neighborhood-activation-study/
[26] https://www.racialequityalliance.org/2017/04/06/king-county-built-strategic-plan-equity-social-justice/
[27] www.communityaccess.org/crisisservicesforum

as the final recommendations at the December 14 task force meeting. We asked the group to create a list of five to seven recommendations that they felt should be included in a crisis response plan. The group was also free to develop any new ideas that had not already been put forward.

Following a three-hour brainstorming and sorting session, the group came to a consensus around the following items:

a) **Change the Number: Alternatives to Calling 911**
   - The new number should be easy to remember

   - Creates an environment that changes how people think about and respond to crises

   - Fewer calls to police/fewer police interactions with people in mental health crisis and reduce number of potentially violent interactions

   - Previous success: "311" rollout

   - Possibly use NYC Help

b) **Create Alternatives to Hospitals**
   - Add More Respite Centers: 7-14 day stays

   - Open Diversion Centers for police drop off

   - Mental Health Urgent Care Centers
     o Mental health team and peers
     o Similar to urgent care, as when one cuts a finger

   - Incorporate mental health services into all existing medical care centers

   - Expand low threshold housing, e.g., safe havens

   - Improve shelters
     o Should not evict people during the day
     o Change the culture of shelters to be recovery oriented
     o Involving shelter residents in decisions about the shelters and employing shelter residents during the day

   - Drop-in centers like senior & youth centers

c) **Expand Mental Health Education and Training**
   - Community awareness of existing resources

   - Community education about mental health in schools and communities

   - Examples include training at: houses of worship, community centers, libraries, social media, local community organizations, and community boards

   - Bus ads are not enough; training and education needs to be firsthand

d) Expand CIT and De-escalation Training
- Select police officers who exhibit the skill set to work with mental health recipients in distress

- Conduct annual refresher training

- Conduct annual basic training for de-escalation and stigma-busting training for all officers and rookies

- Include an array of instructors with a mind to cultural diversity for all training

- Encourage mental health disclosure by instructors of CIT training

- In addition to the NYPD, include all safety and security officers in NYC government agencies, such as shelters and HRA offices

e) Peer Involvement
- Involve peers at all levels of implementation of task force

- Engage peers in policy discussions and policy decision-making of NYPD and the city relating to CIT

- Increase salaries and supports for peers in CIT work, as with other professionals

- Increase access of peers in CIT work to well-designed training: recovery training, cultural competence, and ethics

f) Alternatives to Police Responding to 911 Calls
- People in emotional distress need health care and trained crisis workers, including peers—not law enforcement—should be first responders

- Include trained peers in the 911 call center to assist in screening and responding to callers requesting mental health support

- Peer-to-peer work has proven results in improving the lives of peers
  - Trained peers have strong track records in de-escalating mental health crisis issues
  - Peers understand the importance of respectful communication, especially in working with people in distress
  - Most peers are trained in trauma-informed care and can respond without re-escalating the trauma of the person in distress

This very brief forum and brainstorming session was in no way a substitute for genuine community input. The 70-odd people and organizations we assembled could be multiplied by a factor of 100 to generate even more ideas.

In the end, a well-conceived strategic plan "…can make government more responsible and accountable because it is all based on the desires and feedback of community partners, residents and employees."[28]

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[28] https://www.racialequityalliance.org/2017/04/06/king-county-built-strategic-plan-equity-social-justice/

3. **The creation of an independent planning body to oversee a vast and long-term reform effort is essential.**

Developing and implementing a comprehensive, multi-year strategic plan cannot be accomplished within the span of a single administration. As an example, two highly-regarded jail diversion programs, one in San Antonio (Bexar County), Texas and the other Miami-Dade County, were launched almost two decades ago following a collaborative community-wide planning process.

> In April 2002, a stakeholders meeting was convened in Bexar County [Texas] with the representation from 22 city, county, and state law enforcement, judicial, and health care entities. The result of the collaboration was the development of a comprehensive Jail Diversion Program Model, under the direction of The Center for Health Care Services (CHCS), the mental health authority in Bexar County.
>
> *- The Bexar County Jail Diversion Program*, December 2004[29]

> In the year 2000, the Eleventh Judicial Circuit [Miami-Dade County] Criminal Mental Health Project was created. Under the leadership of the Honorable Steven Leifman, Associate Administrative Judge, Circuit Court Criminal Division, partnerships were formed with the Florida Department of Children and Families (DCF), Jackson Memorial Hospital ("JMH"), The National Alliance for the Mentally Ill ("NAMI"), several police departments and the criminal courts. The goal was to develop better ways of dealing with the number of repeat misdemeanor offenders who suffered from mental illness and were coming in contact with the criminal justice system.
>
> *- Final Report of the Miami-Dade County Grand Jury*, Spring 2004[30]

Replicating elements of these successful programs will require a similar multi-agency and community collaboration effort to plan, implement, and monitor the progress of the overall program. The Miami-Dade program has been operating under the jurisdiction of the court system, a unique arrangement that is probably not possible elsewhere.

One example on an independent planning body might be found in Baltimore County, which created Baltimore Crisis Response, Inc., 501(c)(3) established by the Baltimore County Mental Health System.[31]

No matter the eventual entity that is created to develop and oversee the implementation of a strategic plan, the key stakeholders who informed the plan must continue to be engaged and informed about its progress. An example of such a program is the Diversion First initiative in Fairfax County, VA., which was launched in 2015. The county holds regular stakeholder meetings with detailed reports covering each aspect of the plan. And unlike the missing links to the NYC Action Plan mentioned above, all the references and meeting reports can be found on the County's Diversion First site.[32]

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[29] Bexar County Jail Diversion Program, Michael Johnsrud, PhD
[30] www.miamisao.com/publications/grand_jury/2000s/gj2004s.pdf
[31] https://bcresponse.org
[32] https://www.fairfaxcounty.gov/topics/diversion-first/references

In Miami-Dade, the director of the county court's Mental Health and Police Collaboration project coordinates two to three meetings per year. Attendance is mandated for all receiving hospitals (21) and CIT liaisons from every police department (30), and the meetings also include peers, providers, court and government officials.[33]

4. **Human-centered planning that allows the City to start small and scale up will ensure greater flexibility and effectiveness.**

Developing new services or products with the customer as the primary beneficiary is a common practice in business and relies on a set of tools to carefully define the problem, generate dozens of possible strategies, and systematically test, review, and re-test the most practical approaches.

In the public and social sectors, however, this approach is rarely employed. Instead, planners often develop a "solution" without thoroughly testing its merits and ask providers to respond to an RFP to execute the plan. The resulting program commits the provider to a rigid "scope of services" and a corresponding line item budget that are extremely hard to amend.

An alternative, non-linear, approach starts small and iterates fast. Using structured problem-solving techniques found in human-centered design, or design thinking, frequent user feedback is solicited for each new version of a service or product. New approaches that eventually meet a degree of positive consensus from stakeholders can be tested in the field and further measured and evaluated before taken to scale—at which point a request for proposals may be the best approach.[34]

As part of the "solution-finding" process, the city needs to evaluate and measure the many other mental health-related initiatives it currently has underway, which could directly support a crisis strategy and the recommendations cited above, especially as they relate to enhanced community-based supports and crisis prevention.

Two program areas of note include Thrive NYC and the newly-created Center for Racial Equity. The former is directed within the Mayor's Office and the latter is a division of city's Department of Health and Mental Hygiene, meaning they have completely separate leadership, budget authority, and strategic oversight. These two programs alone contain over 50 separate initiatives.

Bringing all the city's initiatives into a coordinated strategic plan, under centralized leadership, will be critical for the overall success of any reform effort. As is the case with Miami-Dade and Bexar Counties, mentioned above, there are many state and local agencies responsible for the funding the oversight of these initiatives. [35]

A fully realized crisis response system was described in a monograph prepared in 2005 by the Technical Assistance Collaborative, called the Community-Based Comprehensive Psychiatric Crisis

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[33] For more information, contact: Habsi Kaba, Director of CIT Miami-Dade and Police Mental Health Collaboration 11th Judicial Circuit Criminal Mental Health Project at hkaba@jud11.flcourts.org

[34] An excellent review of this approach is *Lean Impact: How to Innovate for Radically Greater Social Good* https://leanstartup.co/social-good/

[35] See ThriveNYC: A Roadmap for Mental Health for All and A Service Matrix distributed to the Crisis Task Force that outlines several of programs and services related to improving crisis services: https://www.communityaccess.org/crisis-discussion-paper

Response Service.[36] The report stresses the need to view a crisis response system as part of the large public health and social support network:

> There is growing recognition that psychiatric crisis services cannot and do not operate on the fringe of the health care system, but rather are mainstream activities necessary to complete the health care continuum. Crisis services cut across many different systems, including:
>
> - Social services: Housing, medical benefits, child welfare, etc.;
> - Legal: Detainment for the purpose of treatment and evaluation;
> - Health: Medical services; and
> - Community and personal safety: Law enforcement assessment of danger to self or the community[37]

5. **The City must focus on social determinants of health, especially stable living situations that may not necessarily be an apartment with a lease.**

A stable living situation is probably the single most critical factor in preventing crises from occurring in the first place and assisting people access the wide array of financial and social supports needed to live successfully in the community. While the city and state each have extremely ambitious supportive housing initiatives, the need far outstrips the production capacity of these programs.

One approach is to reform the shelter system, especially the mental health shelters, to make them more attractive options for people. Improvements would include private, or semi-private rooms, ample community space to accommodate a range of activities, and recovery-oriented services and training opportunities.

Greatly expanding the Department of Homeless Services' Safe Haven program should also be considered. These are small-scale facilities specifically targeted to homeless individuals who may be resistant to accepting other services, including traditional shelters. There are currently 1,200 Safe Haven beds for men and women.

"Safe Havens are equipped with on-site services and outreach staff who work closely with clients to deepen relationships, help stabilize their lives, and, ultimately, encourage them to transition further off the streets and into permanent housing."[38]

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[36] http://www.tacinc.org/knowledge-resources/publications/manuals-guides/crisis-manual/
[37] ibid
[38] https://www1.nyc.gov/site/dhs/about/press-releases/safe-haven-tour-advisory.page

Summary

The city is on the verge of creating a new plan to tackle an extremely complex social problem, one that has bedeviled the best efforts of many communities.

The good news is that there are projects and initiatives around the country that are working, that is, reducing the violence inflicted on people experiencing an emotional crisis, successfully diverting people with behavioral needs from the criminal justice system, and creating a range of service options that allow consumers a choice in the type of help they want to use. Many of the most effective programs have relied on a best-practices type framework, such as the Stepping Up Initiative developed by the County of State Governments Justice Center.[39]

In addition to service models, there are better ways to plan, implement, measure, and execute a new approach. We have mentioned a few ideas in this paper, but we encourage the city to engage with experts that have produced good results for other communities. One such project, called "Aging By Design: Design Days," was developed by a human-centered design firm, Overlap Associates,[40] and was commissioned by the Health Foundation of Western and Central New York to improve services for vulnerable older adults.[41] This project has:

> "…reached more than 4,000 older adults and 700 caregivers and has resulted in fewer falls, improved Timed Up and Go (TUG) scores, reduced home hazards and increased awareness of risks among older adults."[42]

Another example is a project to reduce jail recidivism developed by the human-centered design firm, DC Design, and the County of Santa Clara. [43] The design process led to the

> "…Santa Clara County Reentry Network, an organization composed of the key leaders in the county criminal justice system—the Sheriff, the District Attorney, the Public Defender, a County Supervisors, the Director of Reentry Services, the Head of Parole, the Director of Behavioral Health and 20 other leaders and community members."[44]

Finally, racial and social justice considerations need to be at the core of any solution that hopes to address the challenges faced by people who are in frequent contact with the mental health and criminal justice system. For this to happen, the investigation into what will truly help people needs to include a "…significant focus [on] learning about people's lives outside of service."[45]

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[39] https://stepuptogether.org/
[40] https://www.overlapassociates.com/about-overlap/
[41] https://hfwcny.org/program/aging-by-design/
[42] https://hfwcny.org/program/step-stop-falls/
[43] https://medium.com/dc-design/is-building-more-jails-the-answer-to-californias-prison-problems-a0f8e046cdd3
[44] *Applying Design Thinking to the Criminal Justice System* and *DC Design Santa Clara County Reentry Services Findings and Recommendation Report* https://www.communityaccess.org/crisis-discussion-paper
[45] http://designingbetter.ca/why-we-did-it/

About Community Access

Community Access is a pioneer of supportive housing and social services in NYC for people with mental health concerns. As part of our core mission we lead advocacy efforts that promote human rights, social justice, and economic opportunities for all.

For further information go to www.communityaccess.org or phone us at 212-780-1400, ext. 7711.

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February 2019

Behavioral Health Task Force First Status Report – June 2015

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ON THE STREET

Recommendation	Percentage Complete
Expand training for first responders to recognize behavioral health needs	▬
Open two clinical community public health diversion centers (drop-off centers)	▬

FROM ARREST TO DISPOSITION

Recommendation	Percentage Complete
Add 2,300 slots to citywide supervised release	▬
Develop a scientifically validated risk assessment tool and deploy citywide	▬
Implement physical and behavioral health screening pre-arraignment	▬▬
Identify and divert veterans	▬▬▬
Develop a strategy to reduce reliance on monetary bail	▬▬
Develop a strategy to significantly shorten case processing times	▬▬▬▬

INSIDE JAIL

Recommendation	Percentage Complete
Implement Crisis Intervention Teams	▬▬
Reduce the use of punitive segregation	▬▬
Revise the Department of Correction's use of force policy and update training materials	▬
Establish four units to provide intensive care to inmates with behavioral health needs	▬▬▬
Provide additional mental health training for corrections officers	▬▬▬
Provide specialized services to adolescents	▬▬▬▬
Develop a plan to expand substance use disorder treatment	▬▬▬▬
Develop a plan to reduce idle time and violence	▬▬

RELEASE AND RE-ENTRY

Recommendation	Percentage Complete
Expand discharge programs to serve an additional 4,100 individuals	▬▬▬
Minimize disruption in public health insurance coverage	▬
Connect eligible individuals to Health Homes	▬▬
Establish a working group to coordinate all discharge planning	▬▬▬▬

BACK IN THE COMMUNITY

Recommendation	Percentage Complete
Create 267 supportive permanent housing slots	▬
Launch behavioral health services teams at the Department of Probation	▬▬▬▬
Create a planning team to increase supportive affordable housing	▬▬▬
Develop a plan to expand supported employment	▬

A Note on Involuntary Treatment

Some pundits have blamed the closing of the state's large psychiatric centers as the culprit for today's scourge of overburdened psychiatric emergency rooms, courts, and jails.[46] If there were more "treatment beds" available, the reasoning goes, people would get the help they needed and be able to live in a protected environment that would serve their best interests and that of society at large.

Building "asylums" (from Greek, meaning "refuge") is a social experiment that has been attempted many times over the centuries and the outcomes are always the same—well-meaning crusaders are eventually replaced by administrators, the institutions compete for scarce funding, and what began as a place to restore people instead becomes a human warehouse.[47] And, since the U.S. Supreme Court's Olmstead ruling,[48] such an approach is considered an unconstitutional violation of basic human rights.

It is also a fact that involuntary services, be they inpatient or outpatient (such as Kendra's Law orders), are not race-neutral and fall disproportionately on low-income people of color, as a quick visit to any public psychiatric hospital or jail will confirm.

Rejecting hospitals does not mean leaving people to cope as best they can. Until we create a range of community-based options and supports—few of which exist today—and enough affordable housing for everyone who needs a home, we should not be contemplating more restrictive options. And, even for people who absolutely require a protected environment, building and operating small-scale residences remains far more humane and cost-effective than the state-run facilities of the past.[49]

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[46] https://mentalillnesspolicy.org/insane-consequences.html

[47] See Joint Commission Accredited More Than 100 Psychiatric Hospitals Despite Abuses: https://www.communityaccess.org/crisis-discussion-paper

[48] https://en.wikipedia.org/wiki/Olmstead_v._L.C

[49] A unit in a small-scale (under 16 beds), well-funded, licensed community residence cost $100,000 annually versus $250,000 for a public hospital bed and is eligible for Medicaid funding under current law.