

Reimagining Paths to

HEALING & JUSTICE

*Perspectives on
Community Diversion*

Acknowledgements

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Executive Summary

Throughout the country, the mental health and criminal legal systems, both independently and as cross-systems, are failing those with mental health concerns. In New York City, people with mental health concerns are: incarcerated at higher rates and endure horrendous jail conditions, which sometimes lead to death, with BIPOC, particularly Black people, bearing the most harm; over policed, oftentimes leading to living on the streets; failed by ineffective hospitalization and other supportive services; and murdered on the streets by vigilante justice.

Thus, it is not surprising that addressing the mental health crisis and diverting people with mental health needs from incarceration has become a priority for elected officials, throughout the country. In New York, many of Governor Hochul's and Mayor Adams' proposals to improve the mental health crisis heavily focus on interventions and not enough on preventive services. In addition, Adams' administration's proposals center greater law enforcement interventions. This approach will only continue to fuel tensions between law enforcement and the public, exacerbate our mental health crisis, perpetuate false messaging around this population, reinforce the current policing/incarceration culture, and, ultimately, put more lives at risk. In addition, other key stakeholders, including city-elects, direct service providers, mental health and criminal legal advocates, and those directly impacted by the systems have proposed judicial, legislative, and programmatic change to address New York's mental health crisis.

In 2020, while COVID-19 further revealed the cruel inhumanity of incarceration, it also provided an example of achievable and successful decarceration policymaking. To prevent the spread, jurisdictions throughout the country released people from incarceration. Between

2020 and February 2021, there was a 16 percent national decrease in the total number of people incarcerated.⁰¹ In addition, nearly 40,000 people were released early from prison.⁰² At the onset of the pandemic, New York City implemented the Early Release (6-A) Program, an initiative to reduce overcrowding in City jails, and nearly 300 individuals were released. With the release program and the collaboration of criminal legal system stakeholders, the City jail population reached a record low of less than 4,000.^{03 04} Nevertheless, even with the benefit of the early release program, people with a mental health diagnosis were less likely to be released. And, unfortunately, the decarceration advances made under the release program are being reversed with the Rikers population steadily increasing. In fact, since 2020, there has been a 20 percent increase of people with serious mental health concerns in city jails.^{05 06}

Even with a crisis at its apex and successful decarceration model, priority from the highest elected officials, and endless recommendations from critical stakeholders, mental health crisis reform measures continue to lag. And, interestingly, amongst the numerous recommendations, there are very few, if any, which solely elevate the expertise of those directly impacted by the systems and those who serve them. This report seeks to address that gap.

From September 2022 through June 2023, the Urban Justice Center, Mental Health Project (MHP) interviewed 46 stakeholders. We spoke to those directly impacted by the systems, including those who experienced incarceration and their families. We interviewed experts who served the population, including defense attorneys, prosecutors, judges, treatment providers, mental health and criminal legal advocates, and peers. Our interviewees represented all five boroughs.

We conducted two rounds of interviews. We then presented our preliminary findings to an internal committee, members of the Treatment Not Jail Coalition and the Campaign to Close Rikers. We then used their responses to guide our third and final feedback interview round. We consulted with staff from Fountain House, CASES, Exodus Transitional Community, CUCS, EAC, Fortune Society, Homeless Services United, Corporation for Supportive Housing, Independent Commission on NYC Criminal Justice and Incarceration Reform, Center for Justice Innovation, Brooklyn Movement Center, Department of Health and Mental Hygiene, and the Mayor's Office of Criminal Justice.

The people who we interviewed elevated several issues in the individual criminal legal and mental health systems, as well as cross-systems, including nonexistent preventive measures, a lack of community diversion options, over-policing and incarceration, poor quality of care in the carceral system, inadequate, under-funded and resourced supportive services, particularly in housing and reentry, inadequate systems coordination, and untrained staff, particularly in racial equity and cultural responsiveness. Our interviewees' responses are supplemented by a robust literature review, MHP staff's professional and personal experiences, and empirical research and data. It is from this that MHP developed the ten recommendations proposed in this report.

The Mental Health Project (MHP) is well positioned to lead this effort. For almost 25 years, MHP has been working to decriminalize mental illness and is central to the numerous efforts to transform punitive responses to people with mental health needs. Through the *Brad H.* litigation, MHP established the right to discharge planning for people who receive mental health treatment in City jails. Since the settlement, in 2003, MHP has continued to monitor the City's compliance with the agreement. MHP was instrumental in forming the Jails Action Coalition, which successfully advocated for the Board of Correction to adopt limits on the use of and entirely exclude people with a serious mental illness from solitary confinement. We form, lead, and participate in numerous taskforces and coalitions. Currently, we are active members of the Treatment Not Jail Coalition, which supports legislation to expand access to treatment court and serve as a

coordinating committee member on the Campaign to Close Rikers, just to name a few.

It is our hope that the ten recommendations elevated in this report, which are specifically crafted around our interviewees' responses, are used by elected officials, policymakers, program staff, and other key stakeholders to adopt laws and programs that aim to reduce the involvement of those with mental health concerns from the criminal legal system. Finally, while the focus of this report centers New York, MHP believes these ten recommendations can be used as a framework for mental health reform throughout the country. The mental health crisis, as described throughout the report, is true throughout the nation. Unfortunately, New York is not an anomaly.

The time is now to make real, significant change to our mental health system.

We have the precedent and unwavering will!



Demetrius Thomas
Managing Director
Urban Justice Center Mental Health Project

QUICK FACTS: *Mental Health & the Criminal Legal System*

MENTAL HEALTH

- People with mental health challenges are more likely to be victims of crime than perpetrators.⁰⁷
- People with mental health challenges are better served in the community than jail.⁰⁸

INCARCERATION

- Incarceration has little effect on crime rates, especially violent crimes.⁰⁹ In fact, Incarceration may increase crime in certain circumstances.¹⁰
- More than half (58.8%) of the people incarcerated in NYC jails are Black.¹¹ Moreover, while the total jail population decreased, the proportion of Black people increased.¹²
- The number of Transgender, Intersex, and Non-binary identifying people incarcerated in New York City jails almost tripled between 2019 and 2022.¹³
- Since January 2022, there has been a 41.5 percent increase of people with serious mental health concerns in city jails.¹⁴
- People with mental health challenges in NYC jails, on average, languish longer than people who do not have mental health issues.¹⁵

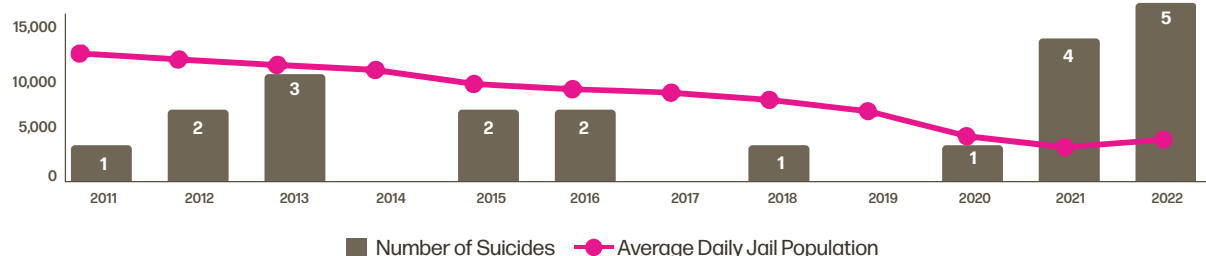
CORRECTIONAL HEALTHCARE

- In the U.S., more than 20 percent of people with a persistent medical condition go without care in state institutions. That number jumps to more than 68 percent in local jails nationally.¹⁶
- Suicide was the leading cause of death in New York City jails in 2022.¹⁷
- The Board of Correction found that in the 19 deaths that occurred in NYC Department of Correction custody in 2022, officers failed to provide first aid in five instances and did not properly tour the facility and supervise people in custody in 13 of the deaths.¹⁸

COMMUNITY HEALTHCARE

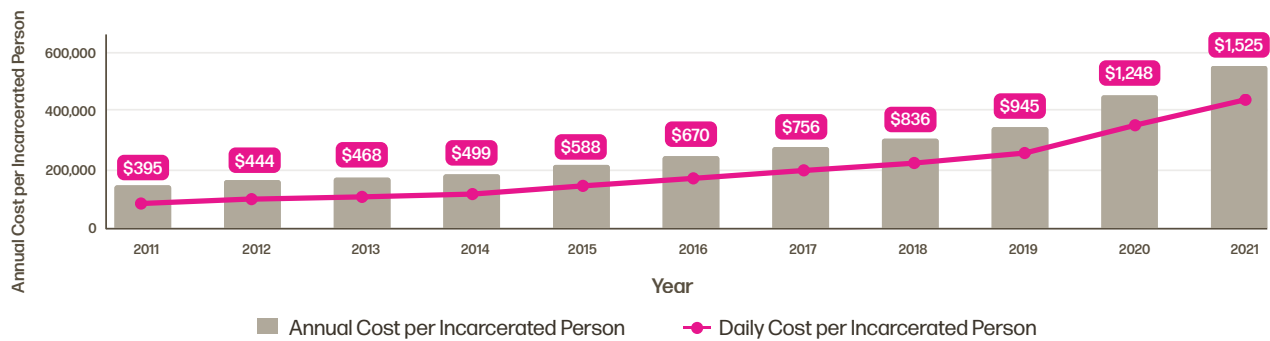
- Black and Latinx communities disproportionately experience chronically insufficient health care and often worsening health outcomes after incarceration.^{19 20}
- In New York City, there is a radical shortage of mental health facilities, clinicians, and other providers in most boroughs other than Manhattan.²¹
- In 2013, 13 percent of people who were psychiatrically hospitalized were re-admitted within 30 days, and 22 percent were readmitted within 90 days.²²

Rate of Suicides in NYC Jails



Source: MHP's Analysis of Board of Correction Data on NYC Jail Deaths from 2011 to 2022.

What NYC Pays to Incarcerate



Source: NYC Comptroller Annual Comprehensive Financial Reports for FY 2011 - 2021, NYC Office of Management and Budget Message of the Mayor and Budget Function Analysis for FY 2012 - 2022, NYC Financial Management System, Mayor's Management Reports for FY 2011 - 2021.

COMMUNITY HEALTHCARE

- Discharge planning that includes outpatient mental health scheduling improves engagement, for people in inpatient psychiatric units, especially those who were not previously in outpatient treatment in the six months prior to hospitalization.²³

HOMELESSNESS

- People who have been incarcerated are almost ten times more likely to be homeless than the general public.²⁴
- Providing housing and wraparound services to people at high risk of homelessness upon release from prison reduces recidivism.²⁵ Permanent supportive housing for people with histories of homelessness and incarceration improved housing stability, reduced jail and shelter stays, and reduced substance use.²⁶
- People with mental health concerns are homeless for longer periods of time compared to homeless people without mental health concerns.²⁷
- In New York, BIPOC communities, particularly Black people, are disproportionately impacted by evictions.²⁸
- Between January 2018 and January 2022, DHS failed to place 26% percent of people who were identified as having a serious mental health concern and 49 percent% of people who were identified as having a substance use concern in specialty shelters.²⁹

CRISIS RESPONSE

- In 2020, NYPD responded to about 168,000 of the 170,000 mental health calls to 911.³⁰
- A community response program reduced less serious criminal offenses (e.g., trespassing, public disorder, and resisting arrest) by 34 percent through both decreasing the designation of individuals in crisis as criminal offenders and decreasing the actual level of crime.³¹

DIVERSION

- Black and Latino men charged with felonies in state courts are 28 percent and 13 percent, respectively, less likely to receive pretrial diversion than white men with similar legal characteristics.³²
- Studies confirm that ATI participants with felony charges are significantly less likely to be rearrested than similar people incarcerated in city jails.³³
- Only two NYC-funded ATI programs specifically serve people with serious mental health conditions, and some explicitly exclude people with more serious mental health treatment needs.³⁴
- Prosecutors determine whether a case can be transferred to mental health court and considered for community-based treatment.

PEER SUPPORT

- Peer specialists can help lower recidivism risks, increase engagement with treatment, and improve compliance with court obligations.³⁵
- People who upon release from jail received services from a Community Support and Recovery Center that provided peer support, case management, and navigation for behavioral health and housing services had significantly lower rates of arrest than those in the comparison group that did not receive such services.³⁶

COSTS

- Diversion and treatment are more effective and less expensive than incarceration.^{37 38}
- New York State spent \$18.2 billion on policing and corrections in 2019, approximately three times more than was spent on supportive services for mental health, youth programs, elder services, recreation, and public health.³⁹
- It is estimated that incarceration costs families up to \$1.9 billion in potential earnings each year.⁴⁰
- It costs \$1,526 per day to incarcerate one person at Rikers Island - over half a million dollars per year.⁴¹





RIKERS ISLAND



“

My son has a diagnosis of autism spectrum disorder. (His) motor skills were delayed. He always had occupational therapy and physical therapy. He can't button a shirt; he can't tie a shoe. All the signs were there...So eventually, it snowballed into this interaction with the criminal legal system. . .

Since my son's been on Rikers Island, he's been stabbed twice, a door slammed on his hand, and he lost a part of the middle finger on his right hand. He was having a mental health episode when he first got there because they don't evaluate you. My son has a thyroid issue. They have no blood work. . .

And then he's having a mental health episode, they pepper sprayed him. And that's the system we have right now. He's gone weeks, even months, without his medication. He's supposed to be on medication for depression and anxiety. He's gone months without that. It's horrible!

Mother, Directly Affected Person

”

I.

MASS INCARCERATION PERPETUATING RACISM & OTHER SYSTEMIC OPPRESSION

The United States is the most incarcerated nation in the world.⁴² With only five percent of the world's population, the U.S. lays claim to more than 20 percent of the world's incarcerated population, incarcerating people at a rate nine to ten times higher than most European countries.^{43 44} This amounts to approximately 1.2 million people who are incarcerated in state and federal prisons as of 2022.⁴⁵ In the U.S., one in every 28 children has a parent in prison.⁴⁶

Today, the number of people incarcerated in jails and prisons has quadrupled since 1980.⁴⁷ Despite these figures, empirical analysis has demonstrated that these high rates of incarceration bear little to no effect on the reduction in crime rates in the past several decades.^{48 49}

Many of those incarcerated, 43 percent of those held in state prisons, have a mental health concern. The overrepresentation of people

with mental health challenges in the carceral system is rooted in the failed implementation of deinstitutionalization.^{50 51} Mid-20th century reports shined a light on the cruel and inhumane warehousing of people with serious mental health concerns in psychiatric facilities.⁵² In response, in 1963, the Community Mental Health Act (CMHA) sought to transition people with mental health concerns out of psychiatric facilities and into the community.⁵³ Transitioning to a community-based model of mental health treatment was based not only on the promise of advances in psychiatric medication and other treatments, precluding the need for long-term institutionalization, but also on the desire to save taxpayer money. However, the goals of the CMHA did not come into fruition. Inadequate funding meant that only about half of the promised community-based mental health centers were actual built. Additionally, piecemeal construction of these community-based solutions made it challenging, if not impossible, to provide holistic and streamlined services.⁵⁴ Without consideration for the other factors that are critical to remaining stable in the community - housing, financial security and reliable, high-quality treatment - individuals found themselves released from institutions, but with no mechanisms in

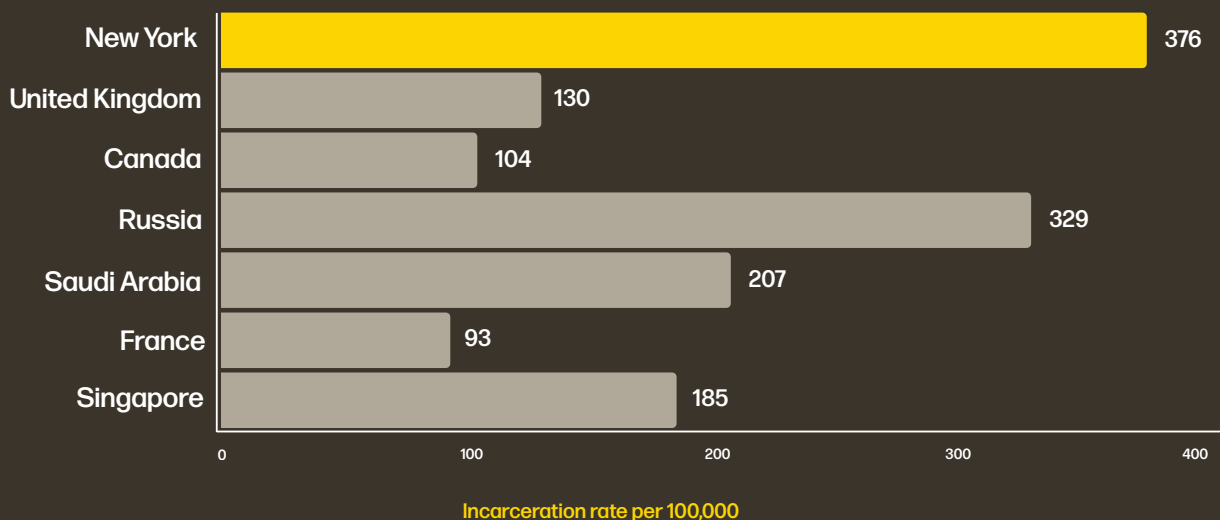
place to help them once released. Despite the prevalence of this population in jails and prisons, 63 percent of people with mental health concerns do not receive treatment while incarcerated.⁵⁵



New York State followed the national incarceration trend with a 64 percent increase in jail and prison incarceration rates from 1983 to 2015.⁵⁶ However, changes to drug laws and other reforms have resulted in the reduction of New York incarceration rates in the last 15 years.⁵⁷ New York City made progress in reducing its jail admissions by 72 percent from 1995 to 2019,⁵⁸ and in 2017 adopted a plan to close Rikers Island, the largest jail in NYC

New York's Incarceration Rate in the Global Context

This graph shows the number of people in state prisons, local jails, federal prisons, and other systems of confinement.



Source: Widra, E., & Herring, T. (2021, September). States of incarceration: The Global Context 2021. <https://www.prisonpolicy.org/global/2021.html>

“

I got arrested in November 2008 in a psychiatric ward. The medication I was taking was making me aggressive. I got into a fight with a guy. So they arrested me for an assault, and I was in Rikers, and they bumped up the charges to attempted murder, even though the guy was fine and had no injuries. And I stayed in Rikers for about four years as a pretrial detainee.

But I beat the charges. The Judge threw out the charges. So, I don't have that attempt-to-murder case on my record, but while I was in Rikers, I got into two fights, and that's the only thing on my record now. Now there are fights from when I was in Rikers when I wasn't supposed to be there in the first place.

Directly Impacted Individual

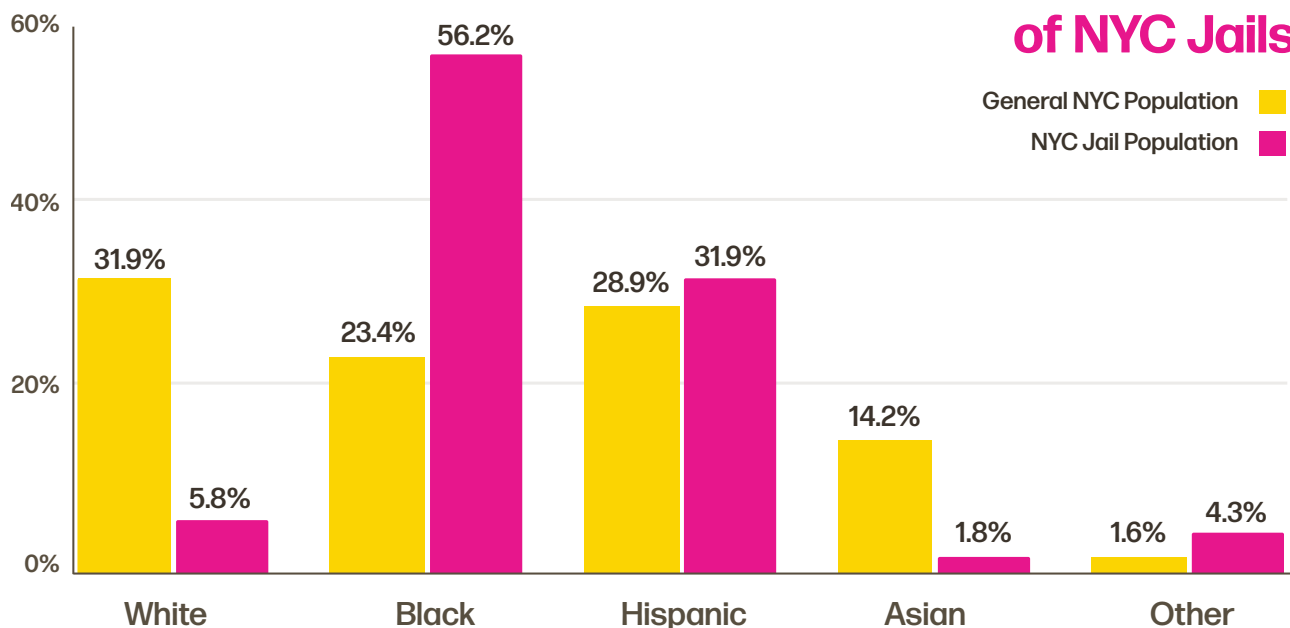
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and second largest in the country, and reduce jail capacity to 3,650 or lower by 2027.^{59 60} But as of November 26, 2023, 6,129 people are in New York City jails.⁶¹

New York has also struggled with deinstitutionalization. Rent-controlled apartments and single room occupancy units provided housing for people who had been released from state psychiatric institutions in the 1960s and others with mental health concerns who struggled financially.⁶² However, in the 1970s and '80s, several city and state-level policies significantly reduced the number of these units, and as a result, many people with mental health concerns became homeless. As of 2021, more than half of NYC's incarcerated individuals had a mental health diagnosis as compared to 32 percent in 2011.⁶³ City jails have proven incapable of providing quality mental or physical health care. Nonetheless, more than 3,300 people are currently relegated to receive their mental health treatment in city jails.⁶⁴

New treatment models designed to better support people with severe mental health concerns in their homes and communities, such as mobile treatment teams and supportive housing, were developed and have evolved over the last four

Racial Breakdown of NYC Jails



Sources: United States Census Bureau. (n.d.). QuickFacts: New York City, New York. <https://www.census.gov/quickfacts/fact/table/newyorkcitynewyork/PST045222>; City of New York. (n.d.-a). Population Demographics Report - FY22 Q1. <https://www.nyc.gov/assets/doc/downloads/pdf/Population%20Demographics%20Report%20-%20FY22%20Q1.pdf>



decades. In addition, Medicaid has become more accessible in New York State. Despite this and significant financial investments in NYC’s mental healthcare system, access to adequate and racially and culturally competent care continues to be an issue, and, again, this is particularly acute for BIPOC communities, those who reside in low-income areas, LGBTQI, and people who have Medicaid.^{65 66}

The mass incarceration crisis disproportionately impacts BIPOC communities and people with mental health concerns. Today, although the Black and Latinx populations comprise 31 percent of the U.S. population, their presence in the jail population amounts to 58 percent.⁶⁷ One in four Black adults are incarcerated in state prisons, a rate four times greater than white adults.⁶⁸

Similarly, in New York, BIPOC communities are disproportionately represented in NYC jails. While Black and Latinx people make up approximately 52 percent of the general population of New York City, they made up almost 90 percent of jail

admissions in 2021.⁶⁹ The disparity by race is stark: in Manhattan, Black people are nearly thirty times more likely to be jailed than white people.⁷⁰ The New York City Department of Correction reports that Black individuals comprise more than half the NYC jail population at 58.8 percent.⁷¹ This statistic points to a lingering sentiment of anti-Blackness that persists in carceral and judicial systems. High incarceration rates worsen mental health conditions, limit access to care, increase violence exposure, sustain instability cycles, disrupt social networks, and perpetuate inequity in health outcomes.⁷²

The historical and sociostructural factors that have led to mass incarceration in the United States have created prison conditions that incite, and even worsen, chronic, communicable, and behavioral health conditions, highlighting the need for public health research and intervention to improve the health of incarcerated people, including decarceral solutions that can profoundly minimize—and perhaps one day help abolish—the use of prisons.

II.

CHANGING THE SYSTEM SUCCESSSES & LIMITATIONS

The Rikers Island Problem

For decades, New York City jails, especially those on Rikers Island, have been plagued with issues from staff brutality, corruption, medical neglect, inhumane conditions, and general mismanagement.⁷³ Yet the jails are the site at which about 3,300 people (more than half of the jail population) are relegated to receive mental health treatment.⁷⁴ Despite the constitutional requirement to provide healthcare to everyone in its custody, New York City continues to fall short of this mandate.⁷⁵

Specifically, NYC Department of Correction (Department) staff's excessive use of force and their inability to protect people have led to repeated lawsuits.⁷⁶ The Nunez class action about the Department's practice of unnecessary and excessive force was settled in 2015, and a monitor was appointed to oversee implementation and compliance.⁷⁷ In October 2023, the monitor described the current state of the jails as "dangerous and unsafe" and "a pervasive, imminent risk of harm to both people in custody and staff."⁷⁸ And, the federal judge presiding over the Nunez litigation - who will decide whether to appoint an outside authority, known as a receiver, to temporarily take control of the jails - stated that, "[t]he court is disturbed that the conditions of the jails at Rikers - which were already notoriously

dangerous - continue to deteriorate, and that effective administrative reform remains elusive, despite the clear requirements detailed in the consent judgment and recent court orders."^{79 80} The flagrant disregard for incarcerated people has led to the deaths and serious injuries of people in custody.^{81 82} In a four-month period, the Department reported 380 incidents of self-injury or suicide attempts, and the Monitor's review of the incidents found that staff generally fail to respond appropriately despite efforts to improve staff practices.⁸³

The Department also continues to use solitary confinement, which is harmful to all incarcerated people, especially those with mental health concerns. Its detrimental effects have been widely documented by both the people who have survived it and those who research it. People exposed to solitary are: almost seven times more likely to attempt to hurt or kill themselves than other incarcerated people; at higher risk of heart attack, stroke, and hypertension; more likely to die in the first year after release from incarceration, die of an opioid overdose in the first two weeks after release, and be reincarcerated.^{84 85 86} Due to the efforts of the #HALTsolitary Campaign and Jails Action Coalition, as well as hundreds of individuals and organizations, and the leadership of directly

affected individuals, the Department’s authority to impose solitary confinement has been significantly restricted. In 2015, the Board of Correction adopted regulations limiting the use of solitary confinement and approved regulations requiring an entirely new disciplinary model in 2021.⁸⁷ Earlier in 2021, the State enacted the Humane Alternatives to Long-Term Solitary Confinement Law, which among other things, placed a 15-day limit on solitary confinement and prohibited its use for people with disabilities.⁸⁸ Flouting the law, the Department continues to use solitary under various guises and euphemistic labels.^{89 90}

Rikers Island’s chaotic and dangerous conditions make providing healthcare virtually impossible. In fact, the Department’s failure to provide incarcerated people with access to medical treatment has also been the subject of litigation.⁹¹ In 2015, Correctional Health Services (CHS), a division of NYC Health + Hospitals, took over the provision of healthcare in the jails from the for-profit company Corizon, after the horrific deaths of Jerome Murdough and Bradley Ballard

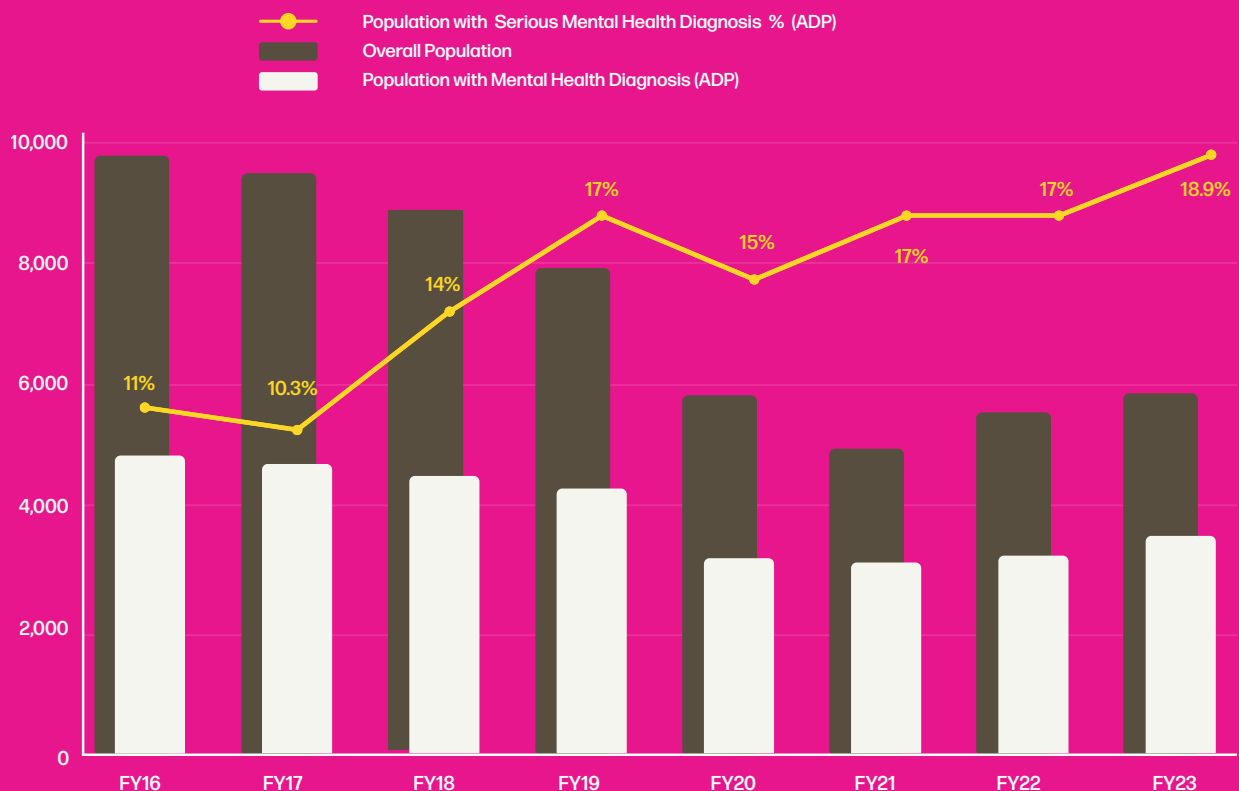
in jail mental health units.⁹² CHS improved the quality of healthcare provided to incarcerated individuals generally, and enhanced the quality of jail mental health care by developing PACE (Program to Accelerate Clinical Effectiveness) units staffed with a multidisciplinary mental health treatment team and correction officers who receive specialized training in dealing with the population.⁹³ People treated on PACE units had fewer injuries due to violence and improved medication adherence.⁹⁴ Unfortunately, the quality of care on PACE units has also been impacted by the COVID-19 pandemic and DOC’s dysfunction.

“Our clients seem to do better in PACE units, but there’s a waitlist to get into the PACE units. That being said, jail is just altogether a horrible place for people to be.”

Defense Attorney

Gains made in providing discharge planning services to incarcerated people with mental health concerns have also been eroded. The obligation to provide these services, which assist people

Mental Health & the NYC Jail Population



Source: Mayor’s Management Report, Sept. 2020 and Preliminary Mayor’s Management Report, Jan. 2023



in transitioning from jail mental health treatment to community care stems from the *Brad H.* class action lawsuit filed in 1999 by MHP, New York Lawyers for the Public Interest, and Debevoise & Plimpton on behalf of people receiving mental health treatment in City jails.⁹⁵ The City has never fully complied with the 2003 court-ordered settlement agreement specifying the services required, and it has been extended repeatedly. Since 2020, there has been a dramatic decline in the quality of discharge planning provided to those released from NYC jails. Much of which can be attributed to the inability of the Department to bring incarcerated people to their mental health and social work appointments.⁹⁶

“The pandemic kind of shattered everything in the jail. Consistent staffing models don’t exist anywhere anymore.”

Anonymous

“

One thing that we notice in our population is [that] **they have almost always been touched before by the hospital system[,] and they're taken in usually as an emotionally disturbed person. They are seen and maybe held for three days... they're just sent back to the street. And that cycle continues and continues until they commit a crime that is serious enough to get them onto our desks.**

I would say there is great frustration with all the systems that come before the criminal justice system. I don't know how to solve that, I'm not a physician.

Prosecutor

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Hospital System

The traditional law enforcement policing method is to use hospital emergency rooms as de facto treatment facilities when encountering individuals whom they perceive are experiencing a mental health crisis. However, just as within penal institutions, hospitals are ill-equipped to address the needs of the population. Under New York law, hospitals must provide people in psychiatric units with an array of services, including assistance in obtaining outpatient mental health treatment, appropriate housing, and public benefits.⁹⁷ In New York City, funding for psychiatric inpatient beds in state psychiatric institutions and Article 28 acute care hospitals has steadily declined over the last two decades.⁹⁸ Simultaneously, utilization of hospitals for psychiatric treatment, 911 calls about people with mental health issues, and the percentage of homeless shelter residents with mental health diagnoses have increased.⁹⁹ People in mental health crisis do not receive the level of care they need, as service providers report that hospitals often refuse to admit people to inpatient units even in cases where the person expresses a desire of self-harm.¹⁰⁰

In addition, New York law requires that hospitals provide people in psychiatric units with discharge planning prior to their release.¹⁰¹ Discharge planning has proven to be an effective tool for preventing homelessness, accessing appropriate community-based mental health treatment, and preventing re-hospitalization.^{102 103}

“It's the same stupid discharge plan. That's not what the person needs. You're not meeting the needs of the person. The person actually needs a home to live in. They need a team to work with them and try to engage with them so that they can deal with whatever they need to work on their recovery.”

Public Defender

However, despite the legal requirement for and benefits of discharge planning, hospital staff routinely discharge people as quickly as possible and provide extremely limited discharge planning support, if any. In 2013, 13 percent of people who were psychiatrically hospitalized were re-admitted

within 30 days, and 22 percent were readmitted within 90 days.¹⁰⁴ This phenomenon of people cycling through the hospital, jail, and shelter system is referred to as a “revolving door.”¹⁰⁵

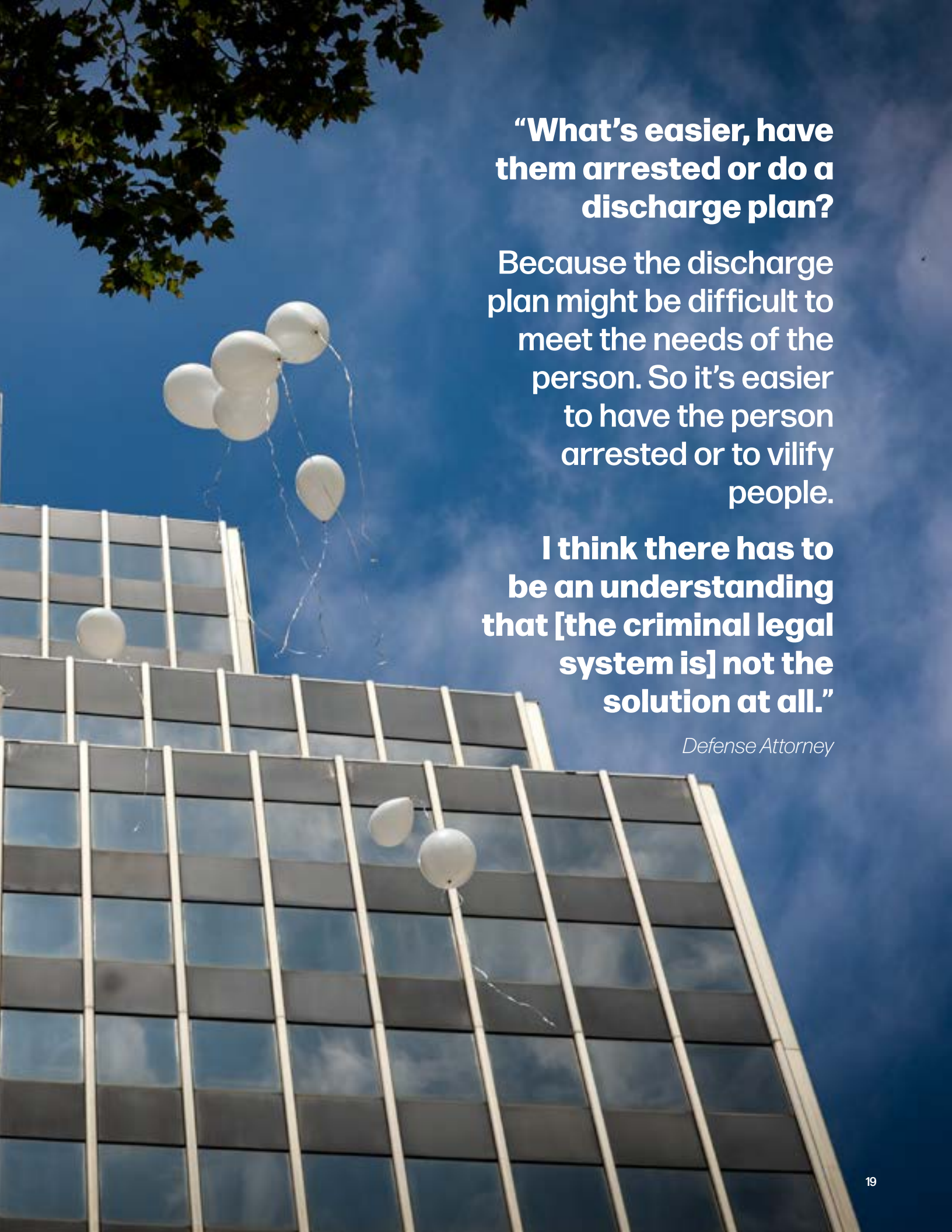
This problem is even more acute for people who are homeless, as they are routinely discharged to the streets and City shelter system, only to return.^{106 107}
108

Unfortunately, the “revolving door” is not new. In 1998, after the New York State law related to discharge planning took effect, the Mental Health Project (MHP) published, “The Revolving Door: Repeated Psychiatric Hospitalizations of the Homeless.” The report details the lack of training social workers in inpatient psychiatric units receive in completing supportive housing applications. Since the report, unfortunately, very little has changed. Hospital social workers and discharge planners are often unwilling or ill-equipped to submit supportive housing applications for homeless people who are hospitalized in acute inpatient psychiatric units.^{109 110 111} MHP staff still communicate continually with hospital social workers and discharge planners who are not trained on completing supportive housing applications and are also under the false impression that they are not required to complete housing applications. In addition, MHP staff repeatedly observe people being discharged into shelters after weeks and even months long stays in hospitals. One *Psychiatric Services* study showed that hospitals in New York City scheduled outpatient mental health appointments for people who had been enrolled in Medicaid and hospitalized for psychiatric care at lower rates than in more rural parts of the State.¹¹² The study also found that people who were homeless and had a substance use issue, who were not already receiving outpatient mental health treatment, were even less likely to receive an outpatient appointment.¹¹³

“We’re tasking folks with very limited means and resources to navigate a healthcare system that is not really set up to serve and provide for them.”

Prosecutor





“What’s easier, have them arrested or do a discharge plan?”

Because the discharge plan might be difficult to meet the needs of the person. So it’s easier to have the person arrested or to vilify people.

I think there has to be an understanding that [the criminal legal system is] not the solution at all.”

Defense Attorney

“

It seems like we're just running around, turning police into psychiatrists and doing all sorts of things to address this problem. But there has to be a serious investment in housing and – even better – the kind of housing that our participants need that might have onsite supports for them.

Service Provider

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Housing Crisis & Shelter System

A severe shortage of affordable housing is the leading cause of homelessness across the United States and in New York City.¹¹⁴ The number of people experiencing homelessness in NYC has soared in recent years. BIPOC, LGBTQ people, people with mental health, substance use concerns, disabilities, and/or with a history of criminal legal involvement are disproportionately affected by housing instability and homelessness.^{115 116 117} In its 2020 State of the Homeless report, Coalition for the Homeless noted that while Black and Latinx people represent 54 percent of NYC's population, they account for 86 percent of the single homeless adult population.¹¹⁸ The same report also notes that more than half of single adults in NYC shelters and two thirds of unsheltered individuals have mental health concerns.¹¹⁹ People with mental health concerns experience homelessness for longer periods of time compared to homeless people who do not have mental health concerns.¹²⁰ A 2022 Corporation for Supportive Housing report found that over 2,500 people incarcerated in City jails in 2021 were homeless and struggling with a mental health or substance use challenges.¹²¹ Between 2015 and 2018, at least 1,900 people who had received mental health treatment in city jails were sent to city shelters, after being released from DOC custody.¹²²

Housing is a known social determinant of health and overall wellbeing. For people with mental health concerns, homelessness and housing insecurity can exacerbate psychiatric symptoms and increase the likelihood of involvement in the criminal legal system.¹²³ Research has found that chronic homelessness exacerbates serious mental health and substance use issues.¹²⁴

“Stop sending us who are getting released from incarceration into the shelter system because you're taking us out of the pot and you're putting us into the fire because there's nothing there for us, nothing at all.”

Directly Affected Individual

The housing support system is abysmal. Most of NYC Department of Homeless Services (DHS) shelters are congregate style and crowded. Many people who have resided in city shelters describe the environment as chaotic and report witnessing and experiencing physical violence and property theft.¹²⁵ Shelters have very strict rules, and there are severe consequences for breaking them, including loss of bed, which can impact housing, healthcare, and stability. These shelter conditions are even more destabilizing for people who have mental health concerns. As a result, many individuals who are homeless and have serious mental health concerns often voluntarily leave the shelter system to live on the streets.¹²⁶ A 2009 research study, based on interviews with sheltered and unsheltered people who are homeless in New York City, found that those who were unsheltered had been homeless for significantly longer periods, struggled more with mental health issues, and were incarcerated at higher rates than those who were sheltered.¹²⁷

People in the shelter system who report or are known to have mental health and/or substance use concerns should be transferred to specialty mental health or substance use shelters.¹²⁸ These shelters are intended to better serve the population with trained, on-site staff to provide housing, behavioral health, and other supports.



A 2022 Audit, by the Office of the New York State Comptroller, found that between January 2018 and January 2022, DHS failed to place 26 percent of people who were identified as having a serious mental health concern and 49 percent of people who were identified as having a substance use concern in specialty shelters.¹²⁹

“And that happened maybe like six times that they called the police on me in the shelter. In the shelter. For complaining. For complaining and arguing with staff.

They will call me in as an EDP [emotionally disturbed person]. So many times the police will come, I will go into ambulance or ask me questions. They’ll let me out.”

Directly Impacted Individual

Those we interviewed who have lived in NYC shelters reported that living in the shelter system led to interactions with police, which otherwise would not have occurred, causing arrests and parole and probation violations. In 2022, alone, the NYPD made 1,600 arrests at DHS shelters.¹³⁰ In its 2023 report, NYC Criminal Justice Agency noted that the percentage of people arrested for summary offenses experiencing homelessness increased from 7.6 percent in 2013 to 9.5 percent in 2021.¹³¹

Safe havens, alternatives to congregate shelters, are smaller facilities with single or double private rooms and have no curfews and a lower staff-

to-resident ratio. Staff are available to assist residents with obtaining public benefits, including housing, accompany them to appointments, and provide on-site treatment.¹³² However, access to safe havens is generally limited. Safe havens require an individual to be unsheltered and “chronically homeless.”¹³³ Most safe havens residents are referred by street outreach teams who have engaged them over several months and determined that they meet the chronic homelessness criteria.¹³⁴ Consequently, safe havens are inaccessible to homeless individuals who are released from jail. Maintaining contact with outreach teams also can be very difficult, as the city frequently conducts encampment sweeps that force unsheltered people to move to other locations.¹³⁵ In addition, there are not enough safe haven beds for the number of chronically homeless unsheltered people with mental health concerns. According to Coalition for the Homeless’ 2022 State of the Homeless Report, there were only 1,000 safe havens beds in NYC in 2022.¹³⁶

Many New York City homeless residents who have mental health and/or substance use concerns eventually move into supportive housing. Since the early 1990s, thousands of supportive housing units and beds for people with mental health concerns have been developed.¹³⁷ Supportive housing combines subsidized housing with supportive services. Placing those who have mental health challenges and are chronically homeless into low-barrier permanent supportive housing has been shown to reduce future psychiatric visits and shelter use and increase retention in outpatient

mental healthcare.¹³⁸ Despite its benefits, there still is not enough supportive housing to meet the need.¹³⁹ The types of supportive housing programs and eligibility criteria vary upon funding type. For example, a large portion of the supportive housing units developed since 2016 were funded under the NY 15/15 initiative and are reserved for single adults with serious mental health concerns who are chronically homeless. To access any NYC supportive housing program, a pre-approved homeless, healthcare, or social services provider must submit a 2010E application, which must include a recent psychosocial assessment and psychiatric evaluation, as well as documentation of homelessness.^{140 141}

Meeting eligibility criteria is particularly difficult for those involved in the criminal legal system. Unfortunately, people who have been incarcerated for 90 days or more, even those who were homeless immediately prior to being incarcerated, are not considered “chronically homeless” and, therefore, are ineligible for thousands of supportive housing units. The number of supportive housing units specifically for people with mental health and substance use concerns who have recently been released from city jails are miniscule.¹⁴² The Justice-Involved Supportive Housing (JISH) program was able to bypass the 2010E application process by determining eligibility through a data match that identified individuals with the highest numbers of jail and shelter stays.¹⁴³ However, only 120 JISH units were established. Although the City sought to expand this model, it failed to offer adequate funding, and no additional units have been developed.¹⁴⁴

Historically, people who are homeless, with mental and behavioral health concerns, leaving incarceration have had two options: the congregate shelter system or the street. In 2020, in response to the COVID-19 pandemic, the Mayor’s Office of Criminal Justice (MOCJ) placed hundreds of people who were released from incarceration into hotels, which would become the Emergency Reentry Hotel program.

“The hotel model has been a godsend during the pandemic. There’s somebody there you can talk to. They have a room. The ACT team can go find them and we can find them. So that’s a good model. I think that should be expanded.”

Judge

“

We had an actual network of [staff in reentry hotels] that we talked to. There were people that had been peers or people that had been through the system...

They were really good because they would say, ‘You gotta go to court.’ ‘You’ve got to do the program, or you’re going to face time like I did.’ They actually had these conversations... They actually attended court. They wrote letters. They supported clients in getting to the ATI program that they had to get to. They had medication compliance onsite.

And those aren’t residential facilities. They were hotels that were set up with services inside.

Public Defender

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The emergency reentry hotels, which contracted with the Mayor’s Office of Criminal Justice (MOCJ), provided people with on-site supportive services.¹⁴⁵ Staff with lived experience of incarceration were critical to the reentry hotels’ success.¹⁴⁶ Individuals who would not be willing to enter the shelter system were willing to stay in the hotels. The reentry hotels did not require a lengthy application process, staff were available to greet new residents 24 hours 7 days a week, and DOC provided transportation to the hotels. These features made the hotels easily accessible to people released from jail.

“Because you had the peers and you had people that were invested in the folks living in these transitional living places. And I think people generally did very well and loved being in Exodus because of that level of commitment. That is kind of like what we need for residential placement.”

Public Defender

Unfortunately, the city has ended the Emergency Reentry Hotel program and shifted funding to transitional housing.^{147 148}

“ I’ve had situations where I’ve tried to tell the police about my mental health to help them help me help us. And they don’t care. They want to do what they want. **And that’s the problem, because then later down the line, if something happens to the police, they blame it on the mental health person.** But what if they warned you before and you still chose to go down the wrong path? That’s like a car, and it’s like, oh, it’s a dead end, but you just still keep driving. ”

Directly Affected Person

Criminal Legal Diversion

Throughout the country, law enforcement is frequently the first response to emergency mental health crisis calls.¹⁴⁹ In New York City, police are first responders to almost all 911 calls seeking help for a person in mental health crisis.¹⁵⁰ Police involvement in these crises can have tragic outcomes with police officers killing the person whom they were supposed to help.¹⁵¹ Even when the consequences are not deadly, police often respond in a way that escalates the situation, injures and retraumatizes the person in crisis, and deters people from seeking help in the future.¹⁵² Providing police with crisis intervention

team training has had little impact.¹⁵³ Moreover, a traditional law enforcement response is not focused on providing care but is limited to the person being transported to an emergency room or placed under arrest.

To address these issues, law enforcement agencies have introduced several strategies, such as crisis intervention teams of specially-trained police officers, co-response teams of mental health clinicians and police, and officer notification systems that alert officers about individuals’ needs.¹⁵⁴ In June 2021, New York City launched

Majority of Mental Health Calls Come Into 911 System & Receive Police Response

170,000+
calls to
911 system

95,000+
calls to
988 system

168,000+
receive police
and ambulance
response

2,000+
receive
EMT/ social
worker response

25,000+
receive
mobile crisis
team response

Source:
Fountain House. *Rebuilding the Mental Health Crisis Response System in New York City a Public Policy Road Map Created by the Members of Fountain House*. Apr. 2023. <https://www.fountainhouse.org/assets/Fountain-House-988-Crisis-Response-Road-Map.pdf>

the Behavioral Health Emergency Assistance Response Division (B-HEARD) pilot, which teams a paramedic and mental health professional to respond to 911 calls in certain precincts.¹⁵⁵ B-HEARD teams now operate 16 hours a day in 25 precincts.¹⁵⁶ But even in precincts where B-HEARD operates, only 22 percent of mental health calls were routed to B-HEARD teams, and the team responded to only 73 percent of those calls.¹⁵⁷ Despite efforts to shift to a mental health response, in 2022, NYPD still answered 99 percent of those calls.¹⁵⁸

To provide the police with an alternative to arrest or hospitalization, NYC established Support and Connection Centers (commonly referred to as diversion centers) to provide short-term stabilization services and linkage to longer-term care.¹⁵⁹ The East Harlem center, opened in 2020, was designed to be a voluntary program where officers in the 25th precinct could take people who had non-emergency mental health, substance use, and health needs.¹⁶⁰ In 2022, the Bronx Support and Connection Center opened to receive referrals from officers in the 47th police precinct, as well as B-HEARD teams in the South Bronx.¹⁶¹ Although the centers were projected to serve 2,400 people annually, in Fiscal Year 2022, individuals were brought to the East Harlem center only 295 times, and there were 459 overnight stays.^{162 163}

Recognizing that law enforcement interventions have not adequately addressed concerns with police involvement in crisis response, local governments have shifted to community-based, health-centered responses.¹⁶⁴ In July 2022, 988, a dedicated suicide prevention and behavioral health crisis line, launched nationwide.¹⁶⁵ Through 988, people in crisis are connected to a mental health professional who can provide crisis counseling and refer callers to mental health services. In NYC, calls to 988 are routed to the NYC Well hotline, which can connect people to ongoing care and dispatch mobile crisis teams to respond.¹⁶⁶ In 2022, 35 percent of NYC mental health crisis calls went through 988 rather than the 911 system.¹⁶⁷ Most callers received crisis counseling and referrals. Only about a quarter of callers received an in-person response from a mobile crisis team. Mobile crisis teams operate from 8 a.m. to 8 p.m., and their response time is

about two hours. Consequently, these teams are not a substitute for contacting 911 when a person needs immediate attention.¹⁶⁸

Despite some progress in shifting crisis calls to the 988 system, the City has included police in other situations that call for a public health response.¹⁶⁹ The Mayor's Involuntary Transport directive, released in November 2022, requires police to remove a person who "appears to have a mental illness and cannot support their basic human needs to an extent that causes them harm for an evaluation."¹⁷⁰ These interactions are likely to result in police violence, unnecessary arrests, and unconstitutional removals, and as budget cuts for mental health and homeless services continue, this policy change will continue to exacerbate bias against homeless people and disproportionately affects people of color.¹⁷¹



While police involvement with people with mental health concerns does little to address underlying issues or promote stability and recovery, there are resources in the community that can help. Moving people away from the criminal legal system and providing support to address underlying issues constitutes diversion.¹⁷² Diversion can occur before the first point of contact with law enforcement or at any other point along the criminal legal system continuum, including court disposition to incarceration all the way through to reentry and community supervision.

Mental health care treatment and support services can function as diversion by preventing criminal legal system contact or serving as part of a diversion strategy after an individual becomes involved in the criminal legal system or upon release from incarceration. New York City has a wide range of mental health care services, such as outpatient mental health and substance use treatment, mobile mental health treatment, crisis respite centers, and psychosocial clubhouses, amongst others. Despite the presence of these services in NYC, there are significant barriers to accessing them, especially for BIPOC, people without insurance, and people who live in high poverty neighborhoods.¹⁷³

“If you’re receiving Medicaid, you know it can take months to get connected, and then, when you do, you’re one of a case load of way too many on a therapist case list, so they can’t actually pay very much attention to you, or support you in a really intentional way. There just aren’t enough resources for community mental health and community substance use treatment.”

Social Worker at Public Defender Office

To support people with mental health concerns who have contact with law enforcement, diversion opportunities may be established along the criminal legal system continuum, such as by funding specific alternative-to-incarceration programs, court liaisons, specialized court parts, or jail discharge planners. New York City has instituted a range of diversion interventions but does not have a system-wide strategy. Existing interventions also have significant limitations.

“Since I’ve been home, I’ve had a bunch of therapists. I’ve lost count. They don’t last long, and then some don’t take your insurance. They’ll take 101-insurance, but you have 102 so they won’t take that insurance. I think it’s stupid to be honest. Especially for people that want the help and need the help. Because I need it, I want it.”

Directly Affected Person

Directly affected people reported challenges accessing and maintaining quality mental health treatment. Finding mental health providers who accept Medicaid, and particularly a specific Medicaid managed care plan, is very difficult.¹⁷⁴ High staff turnover at clinics that accept Medicaid hinders the development of a therapeutic relationship and requires individuals to repeatedly recount oftentimes trauma-laden histories.¹⁷⁵ In addition, providers who do accept Medicaid often do not offer specialized treatment modalities.¹⁷⁶

“Clinics are just hard to run, particularly for populations that are transient. What happens in the model of a lot of clinics in NYC is that there’s a stable base of people that every week are going to psychotherapy and seeing their psychiatrist once a month. When we think about a more active population who are slightly younger, who’ve been on Rikers Island, they need something different.”

Service Provider

People with mental health concerns who have been incarcerated often require multiple forms of support which outpatient mental health clinics often cannot adequately address.¹⁷⁷ The Certified Community Behavioral Health Clinic (CCBHC) model reduces the silos that currently exist between mental health and substance use treatment providers, as they allow for both types of services to be provided on-site and for funds to be used more flexibly.¹⁷⁸ A core component of the CCBHC model is providing crisis response services, so expanding access to CCBHCs has the potential to reduce police involvement in mental health crises.¹⁷⁹ Currently, there are 13 CCBHCs in New York, and the State plans to develop 26 more by July 2025.¹⁸⁰

People who need a higher level of care may qualify for mobile behavioral health treatment, such as Assertive Community Treatment (ACT) or Intensive Mobile Treatment (IMT). IMT, funded by New York City, is designed for people who have been poorly served by traditional treatment models and have frequent contact with criminal legal, shelter, and/or hospital systems and recent “unsafe and escalating” behavior.¹⁸¹ These teams holistically serve people considered the most difficult to engage.¹⁸² ACT, similar to IMT, is provided in the community by a multidisciplinary team to people diagnosed with “serious mental illness” who have not been well-served in traditional clinic settings.¹⁸³ ACT teams are licensed by the NYS Office of Mental Health, and ACT is a service covered by Medicaid Managed Care.¹⁸⁴ ACT has proven very effective in reducing symptom severity and psychiatric hospitalizations and increasing housing stability.^{185 186} However, ACT team engagement has not been shown to reduce rates of incarceration for people who have a history of criminal legal system involvement.¹⁸⁷

Forensic ACT (FACT) was developed to address the particular needs of people with severe mental health concerns who are involved with the criminal legal system.¹⁸⁸ FACT addresses individuals’ risks

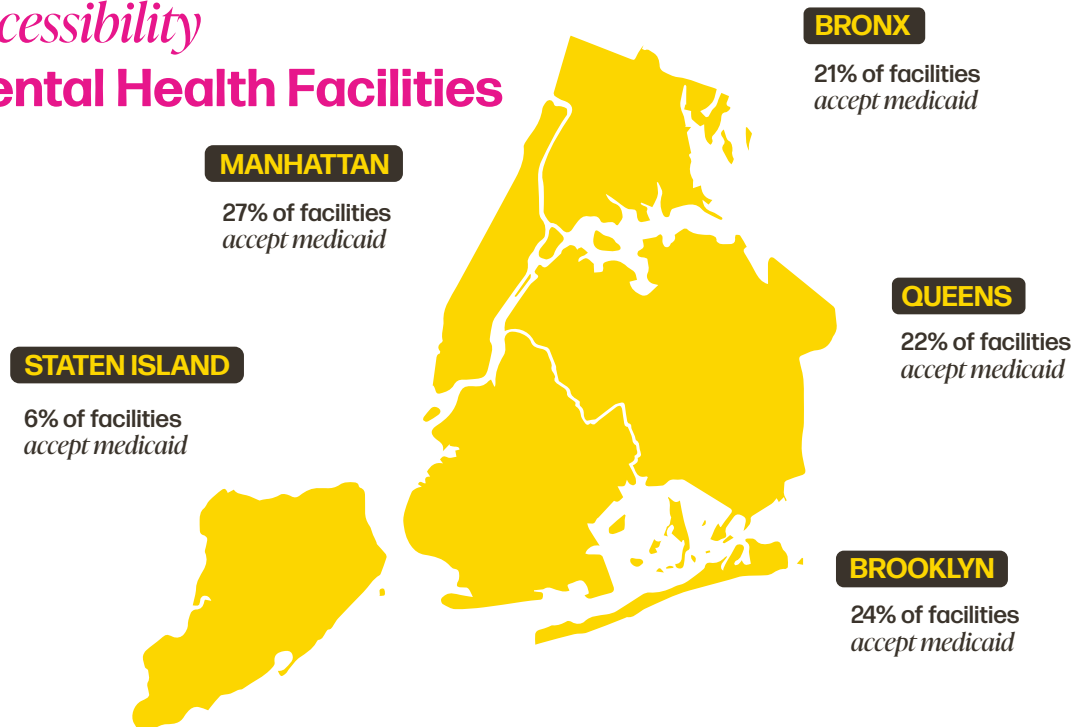
and needs related to the criminal legal system as part of the treatment plan, and FACT teams include staff with criminal legal system expertise, including peer specialists, who engage with court, probation, and parole personnel.¹⁸⁹ Studies examining the impact of FACT team engagement have shown reduced rates of recidivism.¹⁹⁰

“I can’t tell you how many emails every week I got that. Can I refer someone to your Act TEAM, to your IMT team? And I have to sadly write back, no, you have to go through the city centralized system and there’s pros and cons to that.”

Service Provider

To receive ACT, FACT, or IMT, a person must be referred through the city’s Single Point of Access (SPOA) program.¹⁹¹ The application, which requires recent psychiatric and psychosocial evaluations, can be difficult for community providers to complete, and agencies that should assist individuals in obtaining these services often do not. According to a 2022 audit by the New York State Comptroller, DHS did not provide any proof that it utilized SPOA to make ACT/IMT referrals for shelter residents.¹⁹² Although hospitals are best-

Medicaid Accessibility in NYC’s Mental Health Facilities



Source: Breslau, Joshua, Dionne Barnes-Proby, Mallika Bhandarkar, Jonathan H. Cantor, Russell Hanson, Aaron Kofner, Rosemary Li, Nipher Malika, Alexandra Mendoza-Graf, and Harold Alan Pincus, Availability and Accessibility of Mental Health Services in New York City. Santa Monica, CA: RAND Corporation, 2022. https://www.rand.org/pubs/research_reports/RRA1597-1.html

equipped to make ACT, FACT, and IMT referrals, as they have access to patients' psychiatric hospitalization history and records and credentials to access the SPOA portal, they often fail to refer people who are eligible for these services. Even when community providers refer people for ACT or IMT, they often remain on the waitlist for six to twelve months.¹⁹³

“ACT in New York City has never been used effectively to provide that equivalent policy for access to people with serious mental illness who are in Rikers Island. For 22 years we have had one ACT team with capacity for 68 people doing Alternatives to Incarceration in New York City.”

Service Provider

Interviewees from community-based and legal services organizations spoke positively about ACT, FACT, and IMT as an appropriate and effective form of treatment. Interviewees who work within the court system reported that the teams help individuals improve compliance with court appearances and court-mandated ATI programming. However, interviewees did express concern about program funding and capacity issues, which result in people waiting for months to get connected to services. A challenge in diverting people with significant mental health treatment needs from the criminal legal system is that the appropriate level of community care is difficult to access, especially for those who are incarcerated.¹⁹⁴

“They need peers to help them understand their illness and say, hey, you know, I've been there and this is what works for me, like bridging things and treating people in honorable ways, like celebrated way.”

Public Defender

Almost everyone we interviewed spoke about the need for more peer specialists in legal and clinical settings, particularly to help people who are returning from jail to navigate systems. Peer staff have proven to be effective in engaging people in care, reducing hospitalization, and decreasing substance use among people with co-occurring substance use disorders.¹⁹⁵ Peer support has also been found to improve quality of life, increase self-care, and decrease levels of depression

and psychosis.¹⁹⁶ For people with criminal legal system involvement, peer specialists can help lower recidivism risks, increase engagement with treatment, and improve compliance with court obligations.¹⁹⁷

“One other thing I think is great about New York City is the respites... it's an alternative to hospitalization where you go and stay at the respite for like seven days. It's like a crisis respite. So you take a break and they feed you, and it's staffed by peers and they're available twenty-four, seven to talk. And it's just you can come and go, but you have to sleep there every night. And you can come in intoxicated but you can't use anything on site, that sort of thing. Sort of like a harm reduction kind of model, I guess.”

Directly Affected Person

Crisis respite centers provide a more nurturing, supportive environment than hospitals.¹⁹⁸ But, the limited number of respite centers and cumbersome referral process make them inaccessible for most people who are not otherwise connected to treatment.

“A lot of systems have failed folks over and over again before they get to us, and the challenge of solving someone's lifelong behavioral health issues in the court system is just not appropriate or the right place to be doing it.”

Prosecutor

For more than two decades, New York has funded alternatives to incarceration (ATIs) to resolve cases in the criminal legal system through treatment participation.¹⁹⁹ There are drug treatment and mental health courts in all five boroughs of New York City.²⁰⁰ Resolving criminal charges against people with mental health challenges who would otherwise be punished with a jail or prison sentence can be beneficial to the individual and society.²⁰¹ However, the perils of these interventions include sweeping more people into the criminal legal system and focusing reform efforts on the legal system rather than building a comprehensive system of community-based

mental healthcare and services.²⁰² In addition, treatment courts frequently coerce compliance with treatment mandates by requiring a guilty plea and using the threat of incarceration to shape behavior.²⁰³

“We need more residential treatment facilities that can service that population, that doesn’t shy away when someone has a diagnosis like schizophrenia. Also – and this is across the board – there is a terrific gap in the quality of care at some of the residential facilities.”

Prosecutor

Moreover, in some cases instead of relying on clinical professionals to decide treatment mandates, prosecutors and courts substitute their own judgment. For instance, courts may prioritize restricting a person’s freedom by mandating residential treatment, despite a clinical assessment prescribing outpatient treatment as the appropriate level of care. Residential treatment for co-occurring mental health and substance use disorders is often the default – even when it is not the appropriate level of care – because it is more accessible than supportive housing and ACT services. People with serious mental health concerns but no substance use disorder face a significant challenge in having their cases diverted because they are not eligible for residential treatment. Courts also heavily rely on residential treatment for people who are homeless because supportive housing is difficult to obtain, and the dysfunctional shelter system is not considered a suitable place alternative.

“[T]here’s one thing that delays our clients sometimes. So, the DA has agreed that they could have a program instead of jail. We have a plea agreement in place. But there are no beds. I’ve seen people sit in jail an extra month or two while waiting for a bed, and that’s heartbreaking because they can get out. But the DA’s office, especially when someone’s charged with a very violent crime with kind of an unstable history, is not comfortable consenting to them being released to outpatient [treatment].”

Public Defender

Residential treatment, however, is not a long-term housing solution. Without residential treatment programs providing adequate discharge planning, some participants who successfully complete treatment are released to the community without housing at the end of their treatment mandate.

Many people with serious mental health challenges do not have an opportunity to participate in treatment court. Drug treatment courts were created by statute, and any person who fits the eligibility criteria can be considered for judicial diversion.²⁰⁴ However, many people with mental health challenges are not eligible for drug treatment court because either they do not have a substance use disorder, or it is not their primary diagnosis, or the crime with which they are charged makes them ineligible. In mental health courts, which were not established by statute, prosecutors have an outsized role in determining who gets diverted because cases can only be transferred to the court with their approval.²⁰⁵

“In order to get risk assessments done, which are often required, especially for higher level offenses, they have one doctor ... the case has now been adjourned for seven weeks for a risk assessment by the one doctor that is doing them for an agency that oversees courts in both Brooklyn and Staten Island.”

Public Defender

Even the people whose cases are ultimately diverted may spend months, or sometimes a year or more, incarcerated waiting for the case to be resolved. For example, an evaluation of the Manhattan Mental Health Court revealed that the time from arrest to enrollment was almost 11 months on average, with 40 percent of program participants being incarcerated for an average of more than three months pre-enrollment.²⁰⁶ In addition, long waits in the assessment process are common. The result is that people who cannot afford bail are subjected to extended periods of incarceration before their cases can be resolved.

The selection process also is racially biased.²⁰⁷ Assessments are problematic as racial and implicit biases impact screening and diagnosis.²⁰⁸ In addition, BIPOC are more likely to be found noncompliant and terminated from treatment.²⁰⁹

“ They got me in, and apparently it was miraculous that I was let into the mental health court because of the high level of my charges. **And I do think that being a white female might have made the DA let me in. In that way, I think there’s a racist element to me being allowed in, even though I was charged with the violent felony, a major felony charge, which is why I’m part of the Treatment Not Jail coalition, because I don’t think it’s fair.** ”

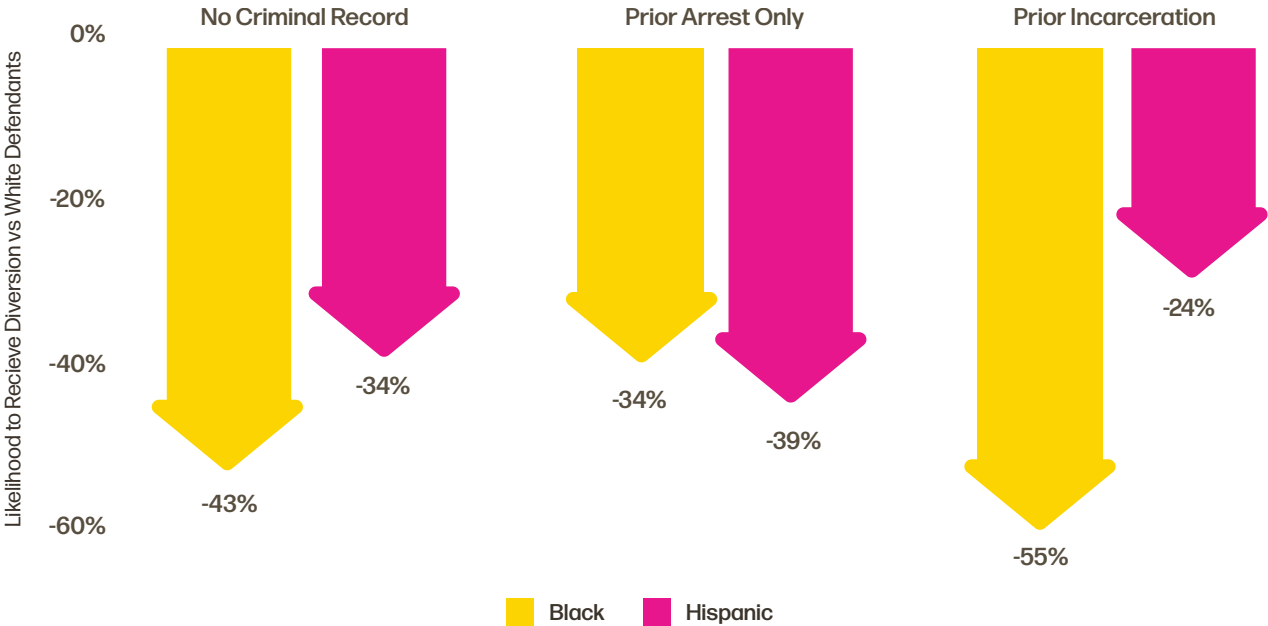
Directly Affected Person

“ **I think there are some real challenges to the way people are diagnosed, the way people are taught about diagnosis, the way the Diagnostic and Statistical Manual, which guides diagnosis in the United States, the way that’s even created.**
For example, the DSM is based on trials that do not involve people who have ever been incarcerated. It largely does not involve people of color. It’s based on a white middle class outpatient clinic model, so that’s a real problem, from my perspective. ”

Anonymous

Black and Hispanic people are less likely to receive pretrial diversion, even after accounting for criminal history.

The chart below shows the likelihood of Black and Hispanic defendants to receive diversion for a drug-related offense compared to white defendants, in a study of nearly 38,000 felony cases filed in 40 urban U.S. counties between 1990 and 2006.



Source: Schlesinger, T. (2013). Racial Disparities in Pretrial Diversion: An Analysis of Outcomes Among Men Charged With Felonies and Processed in State Courts. *Race and Justice* 3(3): 210-238.

“My son’s been in five psychiatric hospitals throughout his life [and had a case manager through the Office for People with Developmental Disabilities]. He needs to go into a place that’s going to focus on his mental health disorder, on his developmental delays, on his autism spectrum disorder.

So I got all those records, paid out of pocket to get them to [the assigned Assistant District Attorney], and basically she said, ‘Oh, I don’t see anything in these files and these records that says he has a mental health disorder. It just seems like he has behavioral issues, you know, tantrums when he doesn’t get his way.’”

Mother, Directly Affected Person

NO MORE
SOLITARY
CONFINEMENT

“

We don't have many [models for supportive housing and services for those with serious mental illness on Rikers] because they're not being funded.

We could create one tomorrow if you give me the money. But the money is just not being put into that. It's only being put into ATI programs, but not with the supportive housing component that should come with it. Housing is a huge need if we really want to reduce this population on Rikers, so I would like to focus on a funding stream for an alternative to incarceration.

This alternative mental health track [with] supportive housing [could be funded at \$35,000 to \$40,000, including paying rent and providing all the services,] versus the \$559,000 being spent on each [person] at Rikers per year.

Service Provider

”

Most Expensive & Least Effective

New York State and City have a long and well-documented history of fiscal irresponsibility when it comes to spending on its carceral systems, particularly when compared to its spending on supportive services.²¹⁰ In 2019, New York State spent \$18.2 billion on policing and corrections, approximately three times more than was cumulatively spent that year on a vast array of supportive services for mental health, youth programs, elder services, recreation, and public health.²¹¹ In fact, New York is the third highest spender on corrections throughout the United States as of 2020.²¹²

“He got a settlement for that, too. So think about all this money to settle this, my son's been there not even two years that could have been a salary for someone with a mental health background helping these young men. But you gave us this because of neglect.”

Mother, Directly Affected Person

Not only does mass incarceration create significant strain on state and local budgets, it also results in catastrophic loss in household earnings for families impacted by the criminal

legal system. It is estimated that a cumulative \$1.9 billion are lost each year in potential earnings for families when a primary earner is incarcerated.²¹³ These losses disproportionately impact Black and Latinx New Yorkers, whose estimated losses make up approximately 80 percent of the total lost earnings.

For Rikers Island alone, the annual cost to detain an individual has more than quadrupled between 2011 and 2022, despite a steady decline in the daily average population of individuals in City jails.²¹⁴ The most recent available data show that the cost to incarcerate one person for one year at Rikers Island is over half a million dollars, or approximately \$1,526 per day.²¹⁵ To put this in perspective, \$1,526 per day would cover the nightly rate at a 5-star hotel in Manhattan with amenities including air conditioning and gym and pool access, with approximately \$300 remaining for food and other personal needs.

In fact, we have already seen the potential economic impacts of a significant reduction in the City jail population. During the COVID-19 pandemic, jail populations throughout New York State were reduced by 36 percent in an effort to reduce over-crowding and prevent the spread of

virus.²¹⁶ If the state were to maintain the average jail populations as they were in June 2020, it would save approximately \$638 million annually, creating the potential to divert significant funds to services that actually benefit those with serious mental health concerns.²¹⁷

“I think the biggest issue is that we’re not effectively funding social services like mental health programs, substance abuse programs, and education.

We fund the NYPD and the DOC with a five-billion-dollar budget for the year, and it’s millions of dollars that pour into the NYPD and the Department of Corrections. But I don’t see anything being changed except for the work that we do. We’re the ones making the change because we’re the ones providing the services.”

Service Provider

While the financial data born of the pandemic is promising, it should be noted that, despite the reduction in jail population, conditions in City jails drastically worsened during this time. Photographs from inside the jails show massive overcrowding, unsanitary conditions, and a complete lack of oversight by DOC staff.²¹⁸ If the City were to

significantly reduce both the jail population and the DOC budget, it would require legislation and oversight to ensure that the millions of dollars saved were channeled into supportive services to keep individuals out of jails, rather than merely exacerbating the already inhumane conditions in City jails.

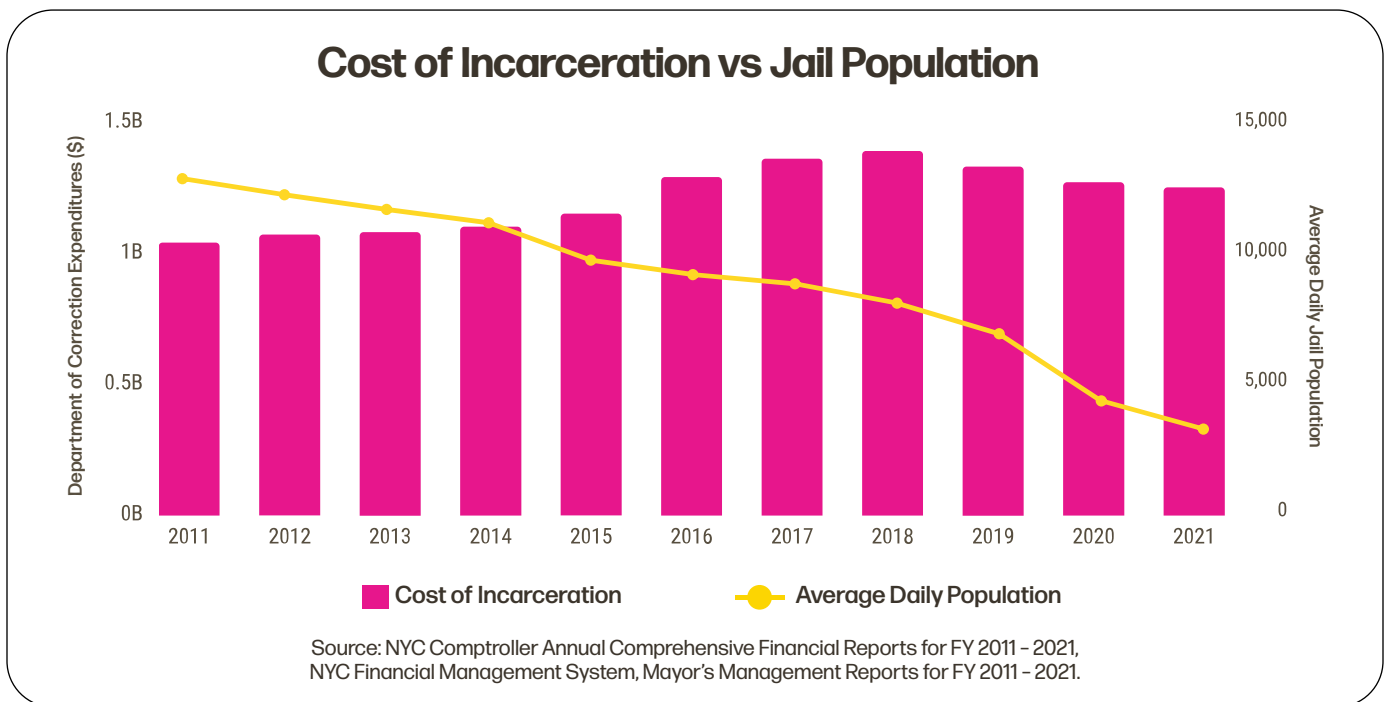
“They want penalization and not rehabilitation.

And it shows in the budgeting, it shows in how they treat people in Rikers, in how they treat people when they come out, and how they transition them out.”

Service Provider

A recent report found that, with the implementation of five major decarceration reforms,²¹⁹ New York State would save an estimated \$1.52 billion annually.²²⁰ These savings, in conjunction with the restoration of potential earnings for released individuals, could provide a significant boost to a struggling state economy, whose budget faces an estimated deficit of \$36 billion over the next three years.²²¹

The following 10 Recommendations provide examples of ways to invest in services that center individual health and well-being, reduce involvement in the criminal legal system, and make New York safer for everyone.



III.

RECOMMENDATIONS TO IMPROVE DIVERSION



1

Invest and Design More Preventative Measures

New York elected officials need to invest in more preventive measures that ideally would help the population avoid ever becoming involved in the criminal legal system.

As shown in the **BARHIL FRAMEWORK**, preventive measures focus on improving the social determinants of health, such as housing, healthcare, and education by addressing social inequities through laws, policies, and procedures. This year, New York State made an historic investment in the mental health system, which included expanding school-based mental health services, increasing the number of CCBHCs, funding additional ACT teams, and investing in peer-based outreach, as well as increasing inpatient treatment capacity.²²²

However, “a universal approach to improving access to care by itself will [not] reduce disparities in behavioral health services.”²²³

The State must intentionally allocate these resources equitably to ensure BIPOC access. Moreover, the needs of people with mental health concerns involved in criminal legal system must be accounted for in the distribution of this funding. When speaking to our interviewees many of them discussed the school system.

“No one told me, . . . [T]his could be a sign of this. Let’s evaluate him for this. Let’s look at this.’ No, it was just either his behaviors were off, or he’s dyslexic, and for me, it’s kind of created that pipeline – that school to prison pipeline, and I would say birth, to school, and then prison pipeline.”

Mother, Directly Affected Person

The New York City school system can play an integral role in preventive measures. More than 65 percent of youth who are arrested every year have mental health conditions, which amounts to more than two-thirds of boys and three-quarter of girls.²²⁴ Often, their needs have gone untreated or lead to involvement in the juvenile legal system - or even worse - the adult criminal legal system.²²⁵ When addressing this population needs, the school system should take an integrated approach, which involves juvenile system stakeholders, particularly families, school administrators, community-based organizations, police officers, defense attorneys, prosecutors, and judges, working together to address the mental health needs of youth.²²⁶

Funding should also focus on “upstream” interventions to reduce continued and further involvement in the criminal legal system. Elected officials should increase funding on programs focused on intercepts 0-2 of the **Sequential Intercept Model**, which avoid incarceration and the criminal legal system. For example, as detailed, below, New York should improve its 988 and other crisis response systems involving the population by completely removing law enforcement from all engagement in situations in which another person’s safety is not at risk. In expanding the number of CCBHCs, the State should not only fund CCBHCs in communities most affected by incarceration but also select providers who have experience serving people with involvement in the criminal legal system.

Prioritize Housing

Housing is essential in both preventing and reducing incarceration. The City and State must develop and fund effective housing models that address the immediate need for permanent supportive housing, in all forms, particularly for people with mental health challenges involved in the criminal legal system. To reduce homelessness, New York City should adopt a Housing First approach, which prioritizes moving people into housing without preconditions, such as sobriety or participation in services. Boston's Way Home, Denver Supportive Housing Social Impact Bond Initiative, and NYC's Frequent Users Services Enhancement (FUSE) initiative demonstrate the effectiveness of adopting a Housing First model.^{227 228 229}

City and State officials, administrative agencies, and policymakers should work to: (1) expand access to housing for people with criminal legal system involvement; (2) improve emergency shelter and transitional housing options; and (3) prevent evictions.

Given the current scarcity of supportive housing units and the way in which vacancies are filled, supportive housing should be funded specifically for this population. For example, the City should increase the number of Justice-Involved Supportive Housing (JISH) units, adequately fund services, and provide coordinated engagement and assessment between the JISH program and CHS, as the Corporation for Supportive Housing recommends.²³⁰ Similarly, residential programs and supportive housing should have some dedicated units for this population, and the funding to provide services should be adequate to meet the needs of this population.²³¹ In addition to developing new

units, the City should maximize use of existing units by preventing supportive housing apartments from sitting empty for months while tenants are screened and required to submit documentation.²³² The City can also increase access to housing for people with mental health concerns who have been involved in the criminal legal system by amending the definition of "chronically homeless" for NYC 15/15 supportive housing to include time spent incarcerated. The City should also pass the Fair Chance for Housing Act, which would prevent housing providers from conducting criminal background checks and denying or taking other adverse action based on an arrest or conviction record.²³³

In addition, the City should improve emergency shelter and temporary housing options. All people with disabling mental health conditions should have access to safe havens, as the Coalition for the Homeless recommends.²³⁴ Safe havens, as with other supportive housing units, should relax or even eliminate ineffective housing requirements. As an alternative to the shelter system rapid reentry housing, with onsite behavioral health services, staff with lived experience of incarceration, access to housing vouchers, and a system for CHS to share health information, similar to the reentry hotels established during the COVID-19 pandemic, should be provided. This is also true for MOCJ funded transitional housing.

Preventing eviction of tenants who have mental health concerns should be a priority. Enabling people to obtain rental assistance vouchers before eviction, as provided for by Local Law 100 is critical.²³⁵ The Center for Justice Innovation's Eviction Intervention Stage Model identifies points at which community supports and legal representation can be provided to enable tenants with mental health concerns to maintain housing.²³⁶



3

Develop Community Crisis Response

New York City must develop a non-police crisis response that is available 24 hours a day, 7 days a week. The city should make 988 a true alternative to 911 for managing mental health crises, with these calls receiving an immediate, in-person response from a peer-led health team as Correct Crisis Intervention Today - NYC (CCIT-NYC) recommends.^{237 238} Similarly, the State should enact Daniel's Law (S.2398/A.2210) to make non-police crisis response teams first responders to mental health crises statewide and limit police involvement to when a person's safety is at risk.²³⁹

Most recently, New York City Council passed Local Law 118, which requires the establishment of at least four new crisis respite centers. New York City Health + Hospital opened two new extended care units at Bellevue and Kings County Hospitals in 2020 and 2023, respectively.²⁴⁰ These types of units and crisis respites centers provide a more nurturing and supportive environment than hospitals. However, more are needed, the referral process needs to be less cumbersome, and people should be allowed to self-refer.

Expand Community Diversion

Given the harms of incarceration, more people with mental health concerns should be diverted from jail, as early as possible. Doing so will require funding additional alternative-to-incarceration options and making emergency and permanent supportive housing more readily available.

“Originally, the Office of Court Administration established the [mental health] court as a nonviolent felony court, so we were not going to take violent felonies. But almost immediately upon us operating, violent felonies began to be referred to us. So, the clinical director at the time ... and I decided that if we were going to do the good that we hoped to do, we would have to accept people that committed violent felonies.”

Judge

The Treatment Not Jail Act (TNJ) (S.1976A/A.1263A) would revise the statutory framework to allow any person impaired by mental illness, developmental or intellectual disability, or substance use disorder to be assessed for participation in judicial diversion.²⁴¹ The offense with which the person is charged would no longer restrict access to treatment court, and the prosecution’s approval would not be required to have a person with mental health challenges considered for diversion. In addition, TNJ would allow people to participate in treatment without requiring them to plead guilty, reducing the coercive aspect of treatment courts.

“Our division’s review of the case on the outset is to look for those things. And if we identify them, we start to do some proactive outreach to the defense attorney to say, are there other things that help mitigate this situation for us to better understand your client and potentially route them to a problem-solving court rather than a traditional prosecution?”

Prosecutor

District Attorneys can expand access to alternatives to incarceration and speed diversion by proactively reviewing cases to determine whether a treatment alternative is advisable, as the Manhattan District Attorney’s Pathways to Public Safety Division does.²⁴² The

newly-launched jail population review program presents an opportunity to prioritize the release of people with mental health challenges, or at a minimum, identify obstacles to diverting this population. The program also elevates racial equity to reduce disparities.^{243 244} Data collected during these reviews should inform ATI development and funding.²⁴⁵

Most recently, the Manhattan District Attorney’s Office announced its new court navigator program awarded to the Fortune Society. Navigators will work inside the Manhattan Criminal Courthouse seven days a week, meeting people, particularly those with serious mental health concerns and/or substance use disorder, after their arraignments to offer immediate and long-term assistance and connecting them with care. Navigators will assist defendants in making it back to court for their next appearance and can offer food, a hygiene kit, and transportation to housing.²⁴⁶ Funding for the program was made available by money seized from banks after criminal investigations.²⁴⁷ Similar programs should be funded, as they could be essential to reduce continued involvement in the criminal legal system.

Additional funding must be allocated for ATIs that effectively support people with serious mental health treatment needs. For instance, more ACT teams should be funded as ATI programs for people charged with a felony and at risk of being sentenced to a state prison sentence. Currently New York City funds only one ACT team – *CASES Nathaniel ACT* – for this purpose.²⁴⁸ In addition, more residential treatment programs for people with serious mental health concerns and co-occurring substance use disorders should be established. Monitoring the quality of care and discharge planning services providers offer is important for successful diversion outcomes.

Easier access to congregate care supportive housing would enable diversion of people with mental health challenges who need the wraparound supports provided by this type of housing. One way to improve access and expedite ATI dispositions is developing new JISH units which are reserved for use by the court system. The availability of rapid reentry housing would speed diversion by enabling individuals who are homeless to be released from jail while pursuing long-term housing.



5

Improve Carceral Quality of Care

The quality of care in jails and prisons throughout the country is abysmal. To mitigate the harms of incarceration for people with mental health concerns in NYC jails, in-custody treatment, discharge planning, competency processes, and conditions of confinement must be addressed. To improve the quality of care provided, Health + Hospitals, CHS, and DOC must expedite opening the promised outposted therapeutic housing units planned for Bellevue, Woodhull, and North Central Bronx Hospitals. All incarcerated individuals who require treatment in specialized mental health units should receive this care outside of Rikers Island.²⁴⁹ In addition to improving care, CHS and DOC must finally come into compliance with their obligations to provide appropriate discharge planning services to people receiving mental health treatment, as the *Brad H.* settlement agreement

requires.²⁵⁰ People who are not competent to stand trial should not languish in jail awaiting transfer to a psychiatric facility. Reducing lengths of stay for this population requires city and state officials to work together. They should expedite competency evaluations and provide for outpatient restoration or create more inpatient beds for this purpose. Finally, the jails should not use practices, such as solitary confinement, which have been proven to cause devastating, even fatal, harm to people's mental health. In 2019, the Jails Action Coalition and #HALT solitary Campaign developed *A Blueprint for Ending Solitary Confinement in NYC Jails*, which sets forth a plan for supporting the mental health of people incarcerated by replacing solitary with an alternative form of separation that provides program-based interventions better suited to reduce and prevent violence.²⁵¹ The City Council should pass Introduction 549-2022, modeled on the Blueprint, to require DOC to improve conditions of confinement for everyone in its custody.²⁵²

6

Enhance Reentry Supports

“I think that particularly when we think about Rikers Island, we have to think about other ways in which people can get wellness and healing that may not be served by psychotherapy.”

Service Provider

Proper discharge planning can have a positive impact on reentry. Social workers who work in jails and prisons should be able to connect people to rapid housing upon release. In addition, parole and probation officers should play a greater role in supporting those transitioning into the community. By collaborating with the Continuum of Care, New York City Housing Authority, and supportive housing providers, the NYC Department of Probation can build partnerships that enable officers to better support people who need housing. Mental health and substance use treatment in the community also needs to be more accessible to people released from jail. Establishing CCBHCs in communities that have few, if any, mental health treatment providers would improve reentry outcomes.²⁵³ In addition, helping people attain some measure of financial stability is critical. More organizations should be funded to assist with Supplemental Security Income (SSI) applications, reinstatements, and appeals, as the Urban Justice Center Mental Health Project (MHP) does.

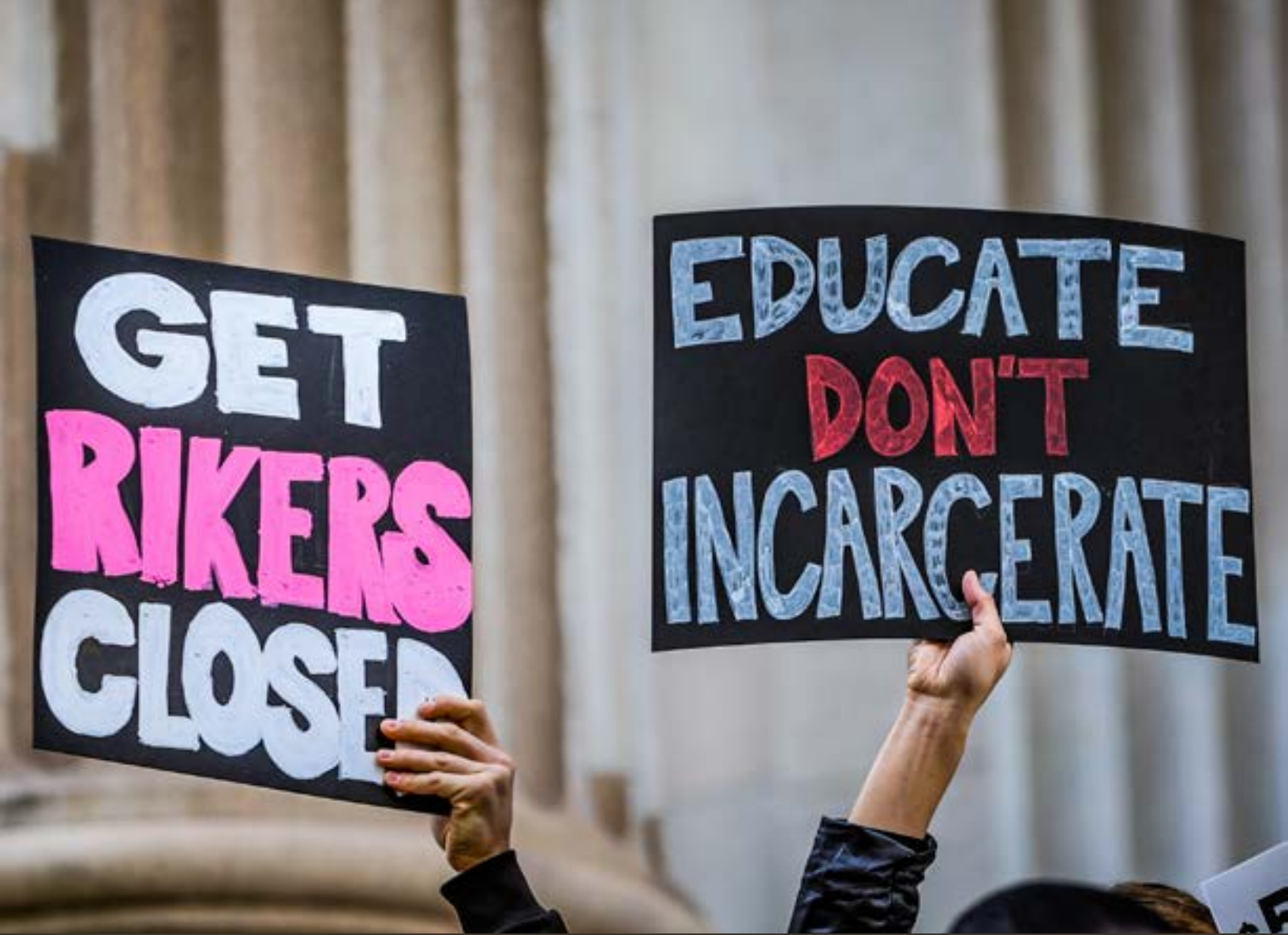
“Sometimes it takes a person like myself, who experienced it already, to really tell the other guys who’s coming out, and then they look at where I’m at today . . . ‘Look at me. If I could do it, you can do it.’ Even though we’re not the same person. We all have our differences, but we all went through the same thing. No one can be you but you. You can’t hide from yourself because everywhere you go, there you are.”

Directly Affected Person

Peer support, amongst other things, is also critical to reentry.²⁵⁴ The NYC Health Justice Network (HJN), which pairs people with a community health worker, who has lived experience, to provide basic social, health, and material support post-release should be expanded and enhanced to prioritize those diagnosed with a serious mental health condition.²⁵⁵ In addition, the NYAPRS Peer Bridger Program, which provides support to individuals with mental health concerns as they transition from psychiatric hospitalization to community, should be adapted and expanded to support people reentering the community.²⁵⁶

“Substance abuse programming needs to be had on Rikers Island, especially since you have city sentenced women. So every day you have women leaving Rikers and there needs to be some type of recovery and wellness program and it needs to incorporate some type of peer support because you won’t have a good recovery and wellness program unless you incorporate lived experiences.”

Directly Affected Person



“

There's a lot of people who do want the support, but that's why we've got to make sure the support and the services are there.

As soon as someone comes out, our organization connects them right away to psychiatrists, so they automatically are getting that A to B - there's no referral. I take care of that for them... That barrier being cut across to see a doctor makes a huge difference. We're addressing the mental health aspect of their treatment.

Service Provider

”



7

Incorporate Racial Equity in All Measures

“We have to think about Black men and Latinx men with serious mental illness. Why do they continue not to get in programs that are supposed to be accessible to all populations?”

Service Provider

Training all stakeholders in the criminal legal and mental health systems about systemic racism and racial trauma is fundamental. To understand the extent of racial and ethnic disparities, all stakeholders must collect data across all stages of the systems.²⁵⁷ City and State legislators must require racial equity evaluations in all criminal and mental health systems legislation and statutes. For example,

the Office of Court Administration should collect racial demographic and other outcome data for all cases involving diversion to identify inequities related to the use of alternatives to incarceration. The court system should also collaborate with prosecutors and defenders to reduce implicit racial bias.²⁵⁸ The use of Prosecutorial Performance Indicators can identify disparities related to prosecutorial discretion.²⁵⁹ In allocating additional mental health funding, the state should conduct a racial equity impact assessment.²⁶⁰ Similarly, all programs should incorporate a racial equity lens into their work and should be assessed for racial equity impact. Program staff performance evaluations also should include racial equity measures.

Improve Cross System Coordination

“...it’s not just about expanding, creating more spots. We have to really look at what’s going on with verifiable data. These programs were created for people that were at risk of incarceration.

How do you identify that someone’s at risk of incarceration? They’re in the jail, literally. That’s how you do it. That’s the science of it. And that’s been researched, and it’s scientifically backed up. But if 70% of the people in ATI programs are in the community, they already were not at risk of incarceration because you’re in the community, you’re walking in for your court dates... They’re not going to send you to prison for two years...

But if you’re in jail already, it’s easier to re-incarcerate. And so there it is. It’s not just about having more resources. We have to dig in a different way.”

Service Provider

To increase diversion of people with mental health concerns from the criminal legal system, the City and State should improve their use of data, and legal system stakeholders should receive more education about ATI models and community mental health resources. The Mayor’s Office of Criminal Justice (MOCJ) compiles and reports on NYPD, DOC, and Office of Court Administration data as well as collecting data about the ATI programs MOCJ funds.²⁶¹ But there are significant gaps in that data, such as a lack of information about mental

health conditions and other demographic data of people in custody and data about all case dispositions involving diversion. In 2015, CHS staff published a report about the needs of those most frequently incarcerated in City jails, which included findings related to the mental health, substance use, homelessness, and criminal charges of the population. Requiring CHS to combine their jail population data with information MOCJ compiles would enable the city to better target ATI funding. Court data related to ATI and mental health court case dispositions could inform the City and State not only about gaps in ATI services and capacity but disparities in ATI dispositions as well. For instance, data sharing regarding Opioid Intervention Courts (OIC) is enabling researchers to identify racial and ethnic disparities in OIC enrollment.²⁶² To ensure that available ATI and mental health resources are used as designed, agencies funding them and contracted providers should educate judges, prosecutors, and defense attorneys on these models and outcomes so that these services are used to reduce incarceration and not extend the reach of the criminal legal system.

“We need to know who’s getting in and who’s not getting in and maybe some basic outcomes. How long are people being supervised for? People are being supervised for a very long time now. I started these services 20 years ago. It takes longer (now) for people to get into these services”

Service Provider

Another thing that sets us apart is our trauma responsiveness. You know the first question we ask folks when they walk in is, 'Have you eaten today?,' and 'Do you have a place to sleep tonight?' That's unique - not everybody thinks about those things right away. **We're always leaning in through a trauma lens and ensuring we're providing holistic care. People appreciate that.** They remember that our first question was 'Have you eaten?' Because before I'm going to sit down and make you do an intake with me for an hour, or however long, I want to make sure that you're comfortable. Because being trauma-responsive is about taking a step back and ensuring the person is all right.

It's hard for a nonprofit. **Being a fully-fledged trauma-responsive facility takes five to seven years of training.** Some people and organizations do one-off trauma training, and they think they know trauma, and no - **it has to be embedded in every commitment.** We don't even use the term 'supervision.' We call them 'strategy sessions' because the word 'supervision' is triggering, whereas 'strategy sessions' focus on professional growth and relationship development."

Service Provider

9

Enhance Staff Training and Support

Hospital social workers and other staff providing supportive services should be trained on discharge planning and completing 2010E housing applications. In addition, hospital staff should be required to utilize and trained on SPOA (Single Point of Access), as they have more access to patients' medical histories and records, as well as better access to the SPOA portal.

"Every system needs better training, not just the police, the shelter systems, the jail systems, all the mental health systems need better training because a lot of people take these jobs because it's easy to get the certification and it's a fast way to get a check."

Directly Affected Person

All staff working throughout the criminal legal and mental health systems should be trained on racial equity and cultural and gender responsiveness. Specifically, court staff should be trained on bias to ensure the screening and diagnosis process for determining diversion

eligibility is not racialized. In addition, staff should be trained on a trauma-informed approach, which requires not only staff training but an organizational commitment to implement policies and practices that align with it. Having staff take a client-centered approach requires more than training alone; there must also be a supervision and support structure within the agency that promotes staff self-care. Organizations that have peer support should ensure that peers receive appropriate compensation, training, and support and that staff assigned to supervise peers are trained in providing effective supervision.²⁶³

"[W]e get really good basic mental health counseling and training. I've had all staff do that CASES training, right across the agency. I don't care if you work in a mental health clinic or not.

Everyone needs to know the basics of identifying when someone is being triggered or struggling with mental health because that's usually the crux of folks walking in off the street that might be disrespectful, belligerent, or violent...It is not just staff that's benefited and gained understanding, but the knowledge trickles down to the participants."

Service Provider



10

Elevate Art in Mental Health Recovery and Diversion

Art can contribute to individual healing, building community, and overcoming stigma. Arts-based practices have proven effective in promoting mental health recovery.²⁶⁴

Creative arts therapy can help people express feelings, increase self-confidence, and build social connections.²⁶⁵ Some community mental health programs in NYC offer creative arts therapy, and CHS provides this treatment modality in City jails.^{266 267} Beyond the clinical context, engaging in the arts allows for self-awareness and reflection and creates a space for a social connection. The Fountain House Gallery and Studio, one component of the clubhouse's services, exists not only to support their members by providing a collaborative workspace and opportunity to exhibit their work but also to connect to the broader arts

community and challenge stigma.²⁶⁸ The Studio Museum in Harlem promotes a therapeutic arts-based practice - separate from art therapy's language of diagnosis and treatment - with the belief that "creativity is more closely aligned to an individual's health than to any disease process."²⁶⁹

Art can also be a vehicle for educating audiences about mental health symptoms and recovery tools and overcoming stigma. For instance, Rha Goddess' Hip Hop Mental Health Project engaged young people of color through theater to spark dialogue and shift attitudes about mental health.²⁷⁰ The role of art in healing should be prominent in efforts to divert people with mental health concerns from the criminal legal system. We need interventions beyond psychotropic medication and traditional therapy to engage people in recovery in new ways.

Art enables individuals to be seen - the opposite of the dehumanizing effect of institutionalization and criminalization.

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REIMAGINING PATHS TO HEALING & JUSTICE

Perspectives on Community Diversion

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