MENTAL HEALTH ADVISORY BOARD REPORT
A BLUEPRINT FOR CHANGE

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August 4, 2015

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CRIMINAL JUSTICE MENTAL HEALTH ADVISORY BOARD REPORT

STATEMENT OF PURPOSE

In Los Angeles County, mentally ill offenders may be incarcerated in the county jail for significant periods of time. Many of these offenders also suffer from co-occurring substance abuse disorders and chronic homelessness. For lower-level crimes, when mental health treatment can appropriately take place somewhere other than the jail while preserving the safety of the public, continued incarceration may not serve the interests of justice. The jail environment is not conducive to the treatment of mental illness.

As stated in this Board's Motion, dated May 6, 2014, ***"Diversion can address the untreated mental illness and substance abuse that is often the root cause of crime. By providing appropriate mental health services, substance abuse treatment, and job readiness training, as well as permanent supportive housing when it is needed, the mentally ill are stabilized and less likely to commit future crimes."*** Such positive interventions can not only change the lives of mentally ill offenders but also others, including family members, victims whose future harms can be prevented and the community as a whole.

In addition to the ethical implications of incarcerating mentally ill offenders, there are also fiscal ones. Our jail is a scarce resource which must be used wisely to house those who pose a danger to public safety, or for whom incarceration is otherwise necessary and appropriate.

Our jail should not be used to house people whose behavior arose out of an acute mental health crisis merely because it is believed—whether correctly or otherwise—that there is no place else to take that person to receive treatment instead. Indeed, even in instances in which it could arguably cost more to divert such mentally ill persons from the jail, it is still the right thing to do.

Mental health diversion is not a jail reduction plan. Although a successful mental health diversion program could result in some reduced need for jail beds in years to come, there will always be a need for mental health treatment to take place within the jail. That is because offenders at all levels of the criminal justice continuum can find themselves afflicted by mental illness, including those charged with serious and violent crimes including the ultimate crime of murder. Due to the nature of charges pending and their level of dangerousness, violent offenders may need to be housed at the county jail while they receive mental health treatment. Indeed, under current jail conditions, those mentally ill offenders must be carefully handled and monitored to prevent them from posing a danger to themselves and other inmates while they are incarcerated.

Mental health diversion also must not come at the price of victims' rights. It is not just a priority, but a given, that the rights of victims will be preserved while efforts are being made to enhance mental health diversion.

Should any future reduction in the jail population occur as a result of the mental health diversion project, it would enable serious and violent felony offenders who are not mentally ill to serve a

longer percentage of their sentences. Such a result would enhance public safety, but would not reduce the need for jail beds.

In the criminal justice system, the term "diversion" is often used as a legal term of art to describe alternative programs which prevent someone from suffering a criminal conviction. This report uses the term "diversion" more broadly. As used in this report, diversion includes all circumstances ranging from pre-arrest to post-conviction, in which mentally ill persons can be prevented from entering the jail at all, can be redirected from the jail into treatment, or can receive linkage to services (during and after incarceration) to help prevent them from returning to custody.

Viewed through this lens, mental health diversion is not new, but is alive and well in Los Angeles County. For some years, various key individuals, public entities, and community based organizations have planned, developed, and implemented programs that prevent mentally ill individuals from being incarcerated and instead divert them into community-based mental health treatment. However, these efforts have often gone unrecognized, due to a lack of general knowledge. What is new is the current active collaboration and commitment to this project which is shared by all of the stakeholders. A spirit of communication, innovation, and enthusiasm exists for this project which is unprecedented. With the allocation of additional resources, our County will be able to improve upon what is already being done.

Progress is being made on the issue of how to most effectively divert mentally ill offenders from the jail, but it is a large task that will not happen overnight. The experiences of other large jurisdictions which have faced this problem have taught us that steady, incremental progress can and will work over time.

The District Attorney's Office provides the following report regarding the continuing work of the Criminal Justice Mental Health Advisory Board, as directed by this Board's Motion dated May 6, 2014. This report will discuss existing efforts, identify gaps in services and suggest priorities for how to improve mental health diversion efforts on an ongoing basis.

EXECUTIVE SUMMARY

Statement of Purpose

The Criminal Justice Mental Health Advisory Board was convened to safely divert non-violent mentally ill offenders from the jail, into community treatment options. This is an ambitious, long-term goal which will take time and fiscal resources to fully effectuate.

Mental health diversion is not a jail reduction plan. There will always be the need for mental health treatment to take place in the jail, since offenders at all levels of the criminal justice continuum can find themselves afflicted by mental illness, including those charged with serious crimes, violent crimes and even the ultimate crime of murder.

Criminal Justice Mental Health Advisory Board and Working Groups

Over the past year, the Advisory Board has made significant progress in assessing mental health resources and identifying strengths, weaknesses and priorities for improvement. Local stakeholders participated in a "Summit" and a "Mini-Summit" which introduced them to the "sequential intercept model" of mental health diversion planning. The sequential intercept model identifies all "intercept points" along the criminal justice continuum where contact with those who suffer from mental illness occurs and appropriate intervention can take place. The five intercepts are: (1) Law Enforcement/Emergency Services First Contact; (2) Post-Arrest/Arraignment; (3) Courts/Post-Arraignment/Alternatives to Incarceration; (4) Community Reentry; (5) Community Support.

Using the sequential intercept model as an aid to discussion, the Advisory Board has met regularly over the past year. Most recently, the Advisory Board has begun to create and deploy Working Groups, which are designed as active problem solvers for subject areas deemed worthy of further study. The Working Groups are dynamic in nature and will evolve over time as current problems are solved and new ones are identified. The current Working Groups are: (1) Law Enforcement Working Group; (2) Community Based Restoration Working Group; (3) Criminal Justice Working Group; (4) Treatment Options and Supportive Services Working Group; (5) Pre-Booking Diversion Working Group; (6) Data and Systems Connectivity Working Group; (7) Long Beach Mental Health Diversion Working Group.

Data Collection and Sharing

Data collection and data sharing must be made a priority. It will also be necessary to establish metrics so that the efficacy of mental health diversion can be evaluated on an ongoing basis. These issues will be addressed in the Data and Systems Connectivity Working Group from an inter-departmental perspective.

Crisis Intervention Team ("CIT") Training

Training is the most important priority for mental health diversion, because change cannot be effectuated without it. The first opportunity to divert a mentally ill person is when first responders encounter a person at the scene. At that point, law enforcement officers can take the person to a

community treatment option instead of the jail, but how the situation unfolds and whether the mentally ill person is arrested can be highly dependent upon how the first responders are trained.

The original Crisis Intervention Team ("CIT") training was a 40 hour model, which is fully endorsed by the Advisory Board and by the District Attorney. CIT training will help to raise awareness of and sensitivity to mental health issues and provide law enforcement officers with the tools necessary to interact more effectively and compassionately with mentally ill persons in the field. Educating law enforcement officers about community based treatment options will encourage them to use those options in lieu of arrest and booking. Skills training to defuse potentially violent situations will make those encounters safer for both law enforcement and mentally ill persons alike and help to prevent encounters from turning violent or even fatal. In addition, CIT training will lead to decreased litigation and judgment costs.

Over the next six years, the LASD has created an ambitious plan to have 5,355 patrol deputies complete the full 40 hour CIT training. For smaller law enforcement agencies, an alternative 16 hour model will be available under the auspices of the District Attorney and Criminal Justice Institute, commencing in January, 2016.

Co-Deployed Law Enforcement Teams

The Department of Mental Health has paired with a total of seventeen different law enforcement agencies in the field, to provide crisis intervention services. The co-response model pairs a licensed mental health clinician with a law enforcement officer. Together, they jointly respond to patrol service requests where it is suspected that a person might have a mental illness, so that appropriate referrals to treatment facilities can be made. These teams have been universally praised by mentally ill persons who have interacted with them, and family members who have seen their loved ones treated with compassion and understanding.

These specially trained co-deployed teams are known as Mental Evaluation Teams ("MET") by the LASD and as the System-wide Mental Assessment Response Team ("SMART") by the LAPD. Regardless of the name, the demand for services is so great that there are not enough teams to provide sufficient coverage. Therefore, the Advisory Board recommends both expanding the MET and SMART teams, as well as providing CIT training for all officers whenever possible.

Mental Health Urgent Care Centers: The First 24 Hours After a Mental Health Crisis

When a law enforcement officer encounters a mentally ill person in the field, the choice is to either take the person to a crowded emergency room and possibly wait for an average of 6 to 8 hours, or arrest the person, book the person into the county jail, and return to their duties within the hour.

Mental health Urgent Care Centers ("UCCs") provide another option. UCCs are acute care mental health facilities where mentally ill persons can be taken for specialized evaluation, but their stay must be less than 24 hours. Investing in UCCs takes the pressure off County hospitals by freeing up emergency rooms to deal with medical health crises as they arise, thus enhancing care for both medical and mental health patients. DMH currently has underway a plan to add three additional

UCCs to be located near Harbor UCLA, the San Gabriel Valley and the Antelope Valley. The Advisory Board endorses this plan.

Other Treatment Options: After the First 24 Hours

After a law enforcement officer has transported a mentally ill person to an Urgent Care Center, the person should then be linked to appropriate inpatient or outpatient mental health treatment options. Los Angeles needs the right combination of treatment services to serve the mentally ill population, and good linkage to those services. Current treatment options include law enforcement hospital beds, Institutions for Mental Diseases ("IMD" beds), Crisis Residential programs, Full Service Partnerships ("FSPs"), Field Capable Clinical Services, Wellness Centers and the Assisted Outpatient Treatment program.

In order for mentally ill persons to be diverted from the jail into community based treatment options, those treatment resources must be adequate to address a mental health crisis both during and after the first 24 hours. Therefore, the Advisory Board recommends increased mental health treatment resources in each of these categories.

Permanent Supportive Housing and Other Housing Options

Mentally ill individuals who are homeless are significantly more likely to become involved in the criminal justice system, and to remain incarcerated, than those who have a stable housing environment. It is also more difficult to engage homeless mentally ill individuals with treatment, resulting in high-cost utilization of medical, emergency and mental health care systems which could have been avoided by providing permanent supportive housing.

There are a variety of housing options and programs available, such as bridge housing, Shelter Plus Care, federal housing vouchers, Rapid Re-Housing and the Mental Health Services Act ("MHSA") Housing Program. However, there are clearly insufficient resources in the area of permanent supportive housing.

The Department of Health Services has created an innovative rent subsidy program called the Flexible Housing Subsidy Pool, which provides permanent supportive housing. The Flexible Housing Subsidy Pool allows a provider to contract for housing, providing a range of options that include intensive case management, wrap-around services and move-in assistance. To fund the program, DHS has partnered with private foundations, which provides maximum flexibility because participants are not restricted based on criminal history, and the restrictive federal definition of homelessness does not apply.

The Advisory Board recommends a significant investment in a variety of permanent supportive housing beds to be dedicated to mentally ill offenders, both through the Flexible Housing Subsidy Pool and through the Department of Mental Health Specialized Housing Program. It is also recommended that a Mental Health Diversion County Housing Director position be created to administer these beds and generally oversee housing issues related to mentally ill offenders.

Co-Occurring Substance Abuse Disorders

Up to 80 percent of mentally ill offenders also suffer from co-occurring substance abuse disorders. As a practical matter, someone who is actively high on drugs or alcohol may be violent and combative, and will not immediately be amenable to mental health treatment or able to be received at an Urgent Care Center.

Therefore, an increased investment in services to help stabilize mentally ill offenders is recommended. In particular, Sobering Centers which would be able to be accessed by first responders should be pursued by the County. In addition to Sobering Centers, there is also a need for Residential Detoxification Services.

Additional investment in residential drug treatment services is also recommended, to provide substance abuse treatment for up to 90 days.

Finally, for the most acutely mentally ill offenders, there is currently an insufficient supply of IMD beds for individuals with serious mental illness and co-occurring disorders, so 40 additional beds are recommended.

Current Jail Programs and Resources

This report catalogues and describes the existing jail programs which are most relevant to mental health diversion. Of particular interest is the proposed expansion of the Public Defender and Alternate Public Defender Jail Mental Health Team. This innovative jail program is aimed at a broader, more holistic representation of mentally ill offenders who are housed at the county jail.

The Advisory Board supports this request for psychiatric social workers and clinical supervisors. Clients are much more likely to be forthcoming and cooperative with a psychiatric social worker assigned to their own legal team than with a clinician who is not. Enhancing this relationship could greatly assist in the evaluation of appropriate placement options outside of the jail.

Current Court Programs and Resources

Next, this report catalogues and describes the existing court programs which are most relevant to mental health diversion. One such program is the Department of Mental Health Court Linkage/Court Liaison Program, a collaboration between DMH and the Superior Court in which clinicians are co-located at 22 courts countywide. This recovery based program serves adults with mental illness or co-occurring substance abuse disorders who are involved with the criminal justice system. Last year's figures show that the Court Linkage Program helped to divert a total of 1,053 persons out of 1,997 referrals. This group of about a thousand mentally ill offenders annually is placed across the spectrum of available treatment options. The Advisory Board endorses the expansion of this program.

Expansion of Mental Health Diversion Related Staffing and Services

The Advisory Board also proposes the creation of a new, permanent planning committee. Based on the experiences of other jurisdictions, mental health diversion will be a long-term project for years to come. Therefore, a permanent leadership structure will be necessary.

The Advisory Board recommends a small, workable Permanent Planning Committee, to be comprised of one representative from each of the following County Departments: District Attorney, Public Defender, Sheriff's Department, Department of Mental Health, Department of Public Health, Department of Health Services, proposed new Mental Health Diversion County Housing Director, and others appointed by the District Attorney on an as-needed basis. These personnel would be management-level employees, with significant operational experience, who could bridge the gap between high-level policy recommendations and actual implementation decisions.

Recommendations

Based on this report, the Advisory Board recommends the following actions:

1. **Fund CIT Training.**

2. **Expand Primary Mental Health Treatment Resources. (Urgent Care Centers; Crisis Residential Treatment Programs; "Forensic" or "Justice Involved" versions of Full Service Partnerships; Field Capable Clinical Services and Wellness Centers; IMD beds for co-occurring disorders; DMH administrative staffing items; Court Linkage expansion).**

3. **Establish the Permanent Mental Health Diversion Planning Committee.**

4. **Expand Public Health/Health Services Treatment Resources. (Sobering Centers and Residential Substance Abuse Treatment facilities).**

5. **Enhance Housing Services. (Create Mental Health Diversion County Housing Director; fund permanent supportive housing beds both within the Department of Health Services Flexible Housing Subsidy Pool and within the Department of Mental Health Specialized Housing Program).**

6. **Expand Co-Deployed Teams.**

7. **Prioritize Data Improvements to Enhance Data Collection, Data Sharing and Performance Metrics.**

8. **Establish the Public Defender and Alternate Public Defender Jail Mental Health Team.**

9. **Expand Secondary Mental Health Treatment Resources. (Men's Integrated Reentry Services and Education Center; Co-deployed DMH personnel at Probation Offices on a pilot project basis).**

10. **Fund the LASD Mental Health Evaluation Bureau. (Fiscal Year 2016-2017).**

LOCAL STAKEHOLDER DISCUSSIONS AND THE SEQUENTIAL INTERCEPT MODEL

On May 28, 2014, a Countywide Mental Health Summit *(hereafter the "Summit")* was convened. Policy Research Associates was employed as a consultant to assess existing mental health resources in Los Angeles County, identify strengths and weaknesses, and help identify priorities for improvement.

Initial funding for the Summit was provided by the California Endowment and by the Aileen Getty Foundation, and it was hosted by the USC Gould School of Law. The Summit was attended by a myriad of stakeholders, including the District Attorney's Office, the Department of Mental Health ("DMH"), the Sheriff's Department ("LASD"), the Superior Court, the Public Defender's Office, the Alternate Public Defender's Office, the Probation Department, the Executive Director of the CCJCC, the Chief Executive Office, the Los Angeles Fire Department, the Los Angeles Public Health Department, the Los Angeles City Attorney's Office, the United States Attorney's Office, the Los Angeles County Mental Health Commission, the National Alliance on Mental Illness ("NAMI") and dozens of others.

On July 8 and 9, 2014, a smaller series of local stakeholder meetings took place (hereafter, the "Mini-Summit"). The Mini-Summit was convened so that further evaluation of existing mental health resources and recommendations for improvements to services could take place in a more focused setting.

During both the Summit and Mini-Summit, participants were introduced to the *"sequential intercept model"* of mental health diversion planning which has been successfully utilized in other jurisdictions, including Miami-Dade County, Florida. The sequential intercept model identifies all places or *"intercept points"* along the criminal justice continuum where contact with those who suffer from mental illness occurs and appropriate intervention can take place.

Because our system is so large and complex, there has necessarily been a high degree of specialization by individuals whose work takes place at completely different intercept points of this model. The sequential intercept model has clarified and focused local discussion and helped flush out interplay between the different decision points. *For example, a decision made regarding the length of custody imposed as part of a criminal sentence (such as 90 days versus 120 days in the county jail)* can legally foreclose certain public healthcare and housing benefits from being available to a person later upon their release, solely as a result of the length of time spent in custody. Learning more about this type of systemic interplay will help inform policy decisions made in the criminal justice system. The following is an introduction to the sequential intercept model.

❖ *Intercept One: Law Enforcement/Emergency Services*

Intercept One is the first justice system contact with an offender, before an arrest. First contact may include a call to a 911 operator by a family member, an on-site evaluation by a paramedic, or a law enforcement response to a crime in progress. Pre-booking diversion is essentially an evaluation of whether a situation is truly criminal or non-criminal in nature,

and it occurs at Intercept One. If a person is diverted to treatment instead of jail at this intercept, there will be no arrest and no case will be presented to a prosecutor for consideration.

❖ ***Intercept Two: Post-Arrest/Arraignment***

After first contact, an offender is typically taken to the county jail. Next, the prosecuting agency decides whether to file criminal charges or decline charges. The period of time between an offender's arrest and their first appearance in court at arraignment is locally referred to as "second chance" diversion, because regardless of the original determination in the field, a prosecutor independently reevaluates whether an incident should be handled criminally or non-criminally.

If a prosecutor declines to file a criminal case, the person will be released, possibly without services. This lack of services is problematic, and possible solutions are being explored during ongoing discussions. If criminal charges are brought, the mentally ill offender appears in court at an arraignment, a criminal defense attorney is appointed or retained and a judge will either release a person on their own recognizance or set bail. Diversion at Intercept Two minimizes custody time, because it takes place early in the process, and may or may not include a criminal conviction. Not all offenders are suitable for diversion at Intercept Two, because less information is known at arraignment than later, and some decisions must be made more deliberatively.

❖ ***Intercept Three: Courts/Post-Arraignment/Alternatives to Incarceration***

If a criminal case is not resolved at arraignment, other court proceedings take place. Ultimately, a criminal case may resolve either by a dismissal, a guilty plea or a trial. A sentence may include a combination of custody and supervision.

Depending on the mental health and criminogenic factors involved, some offenders will need the structure provided by formal supervision in order to be successfully diverted from custody. Thus, a dismissal will not be suitable in every case. Instead, diversion efforts at this intercept can also employ alternatives to incarceration as a sentencing choice upon conviction. Within Intercept Three, there is also a special class of offenders who are so acutely mentally ill that they are declared incompetent to stand trial. When that happens, criminal proceedings are suspended and jurisdiction transfers to the Mental Health Court, Department 95. Offenders who are incompetent to stand trial present unique issues which are distinct from other mentally ill offenders.

❖ ***Intercept Four: Community Reentry***

Whether a person is criminally convicted or not, if they are taken into custody, at some point they will be released back into the community. Appropriate discharge planning, including jail "in-reach" efforts, can greatly assist in successful reentry.

Intercept Four issues include where a person will live, whether they will be able to support themselves, what access to mental health and other health services they will have, whether

or not they will be supervised by the criminal justice system and the like. For example, if a person is receiving medication, a plan should be put into place so that they are linked with mental health services and their course of medication can continue uninterrupted.

❖ ***Intercept Five: Community Support***

This Intercept focuses on the person's continued and permanent access to resources, after the transition from jail to the community. Ongoing peer and family support are important.

The need for permanent supportive housing is another significant policy issue, which will be discussed separately in this report. Although transitional housing can help get a person back on his or her feet, some mentally ill offenders will need more assistance than transitional services can provide. Appropriate needs evaluations can assist in determining the need for more permanent resources.

Using the sequential intercept model, existing programs and priority needs were incorporated into the Policy Research Associates report, which is attached as Attachment 1. Those priorities have continued to inform further discussion during Criminal Justice Mental Health Advisory Board meetings, which have addressed issues relating to each of the intercept points.

CRIMINAL JUSTICE MENTAL HEALTH ADVISORY BOARD AND WORKING GROUPS

Since the District Attorney provided her interim report to this Board on November 12, 2014, she has led the Criminal Justice Mental Health Advisory Board *("Advisory Board")* as the chair of monthly stakeholder meetings. The Advisory Board collaboration has produced significant early successes.

First, a new court diversion pilot project was created at the San Fernando and Van Nuys courts, the Third District Diversion and Alternative Sentencing Pilot Project *("Third District" project)*. The Third District project can assist up to 50 criminal defendants at a time who are chronically homeless and suffer from a serious mental illness. This program is based on the "Housing First" model, which provides supportive housing first, thereby creating an environment conducive to treatment for individuals to combat their mental illnesses and co-occurring substance use disorders. The Housing First model motivates offenders to succeed, because they want to keep the housing provided through the program rather than return to the streets.

Eligible crimes for the Third District program include both misdemeanors and felonies. Defendants charged with misdemeanors earn a full dismissal of their charges following successful completion of a 90 day diversion program, without having to plead guilty. For felony crimes, a defendant must initially enter a plea of guilty or no contest and complete an 18-month program; upon successful completion, an offender earns early termination of probation and dismissal of charges. This ongoing pilot project was a collaboration between the Department of Mental Health, District Attorney, Public Defender, Alternate Public Defender, Indigent Criminal Defense Appointments Program, Los Angeles City Attorney's Office, Superior Court, Probation Department, Department of Public Health, LASD, San Fernando Valley Community Mental Health Center and Department of Veteran's Affairs. In June, 2015, the stakeholders met once again to refine the selection criteria for the program in order to serve more participants.

Also in June, 2015, Los Angeles County was awarded a competitive Mentally Ill Offender Crime Reduction ("MIOCR") grant for $1.8 million dollars. This grant will address the problem of "offender tri-morbidity" by diverting these at-risk offenders from custody. Tri-morbid offenders have three factors which can lead to their early demise: They are mentally ill, suffer from substance abuse and are medically fragile.

The MIOCR grant proposal submitted by Los Angeles was ranked first among all of the jurisdictions which competed for funding. Perhaps the greatest strength of the Los Angeles County grant proposal was the extensive collaboration which went into it. The District Attorney's Office applied for the grant as the lead department on behalf of the collaborative team. The Board of State and Community Corrections ("BSCC") has provided a contract which was received and executed by the District Attorney's Office in accordance with the July 1, 2015 implementation date.

The Advisory Board is currently meeting every other month in order to more effectively deploy and support specialized Working Groups. These Working Groups are practical problem-solvers whose subject areas were deemed worthy of further study in detail. The Working Groups are dynamic in nature, and will evolve over time as current problems are solved and new ones are identified.

❖ *Law Enforcement Working Group. (Intercept One)*

This group is chaired by Chief Jim Smith of the Monterey Park Police Department. The Law Enforcement Working Group has developed training for first responders, who include law enforcement officers, dispatch employees, fire department personnel and others. The training is modeled after the Crisis Intervention Team Training ("CIT") model which originated in Memphis, Tennessee. The Law Enforcement Working Group has made substantial progress on CIT training over the past year, which will be discussed separately in this report.

❖ *Community Based Restoration Working Group. (Intercept Three)*

The Community Based Restoration Working Group ("Restoration Working Group") is chaired by Judge James Bianco, who is the bench officer assigned to Department 95, Mental Health Court. The Restoration Working Group convened to consider treatment options for offenders who are mentally incompetent to stand trial. These offenders are often actively psychotic, cannot care for themselves, and have been found incompetent to stand trial because their mental illness is so acute that they cannot understand the nature of the criminal charges against them or rationally assist their defense attorneys.

In particular, the Restoration Working Group has focused on the population of misdemeanor incompetent to stand trial ("MIST") defendants. There are currently a total of about 130 MIST defendants in the county jail. The MIST population is a priority because these offenders are being held on misdemeanor charges and but for their mental illnesses, would likely have already completed their criminal cases and been released. On the other hand, criminal charges cannot simply be dismissed for a variety of legal and practical reasons.

The Restoration Working Group is piloting an ambitious project to divert up to 100 MIST defendants from the jail for treatment in the community. At this time, appropriate residential treatment beds are being identified and an individualized plan is being created for each MIST offender, depending on their needs. However, due to the nature of this population, there may not be an appropriate treatment setting for each of these offenders, who require extensive care and monitoring.

The Restoration Working Group will explore whether it would be feasible to place some of these MIST defendants into a skilled part nursing facility, which is a facility akin to a nursing home, but for persons who are anticipated to recover. Los Angeles County does not currently have any skilled part nursing facilities. At this time, it is not yet known if there is a sufficient population which would need such a facility to justify the creation of one in our County.

❖ *Criminal Justice Working Group. (Intercepts Two and Three)*

The Criminal Justice Working Group is chaired by Judge Scott Gordon, who is the Assistant Supervising Judge of the Criminal Division. The Criminal Justice Working Group was formed to address court and jail-related issues.

Initially, the group will design a pilot project to divert up to 100 defendants from the county jail into community based treatment options as alternative sentencing. In contrast to the MIST defendants, who are under the jurisdiction of the Mental Health Court, the Criminal Justice Working Group will focus on defendants who remain under the direct jurisdiction of the criminal courts.

The Criminal Justice Working Group will also address justice stakeholder training for prosecutors, defense attorneys and others in the justice system— even judges. These training recommendations will educate stakeholders regarding the benefits of mental health diversion, legal issues, available resources and the like. The Criminal Justice Working Group will also consider related issues such as victims' rights. It is anticipated that the Criminal Justice Working Group will provide a ready forum to address any local procedural or policy issues regarding case processing which will arise during all phases of the mental health diversion project on an ongoing basis.

❖ ***Treatment Options and Supportive Services Working Group. (Intercepts One through Five)***

The Treatment Options Working Group is chaired by Flora Gil Krisiloff, Department of Mental Health. It will seek to maximize the use of existing treatment resources and to develop new options in the future.

Available treatment resources are a universal need which is critical for successful diversion efforts at every intercept point. Los Angeles County does not simply need "more beds" but rather, the right kind of beds in the right combination to serve a mentally ill offender population which is very diverse in its needs. Notwithstanding that diversity, the Treatment Options Working Group will identify common problems which are amenable to solution.

The Treatment Options Working Group will consider treatment options broadly, both in the jail as well as upon reentry. This discussion will include the intersection of mental health, substance abuse and the need for supportive housing. One idea to be explored is the development of multi-disciplinary teams to ensure the delivery of integrated services to homeless and mentally ill clients. The Treatment Options Working Group will be empowered to generate recommendations for best practices.

❖ ***Pre-Booking Diversion Working Group. (Intercept One)***

The Chair of this group is to be determined. The Pre-Booking Diversion Working Group will address practical issues regarding how offenders can appropriately be selected for pre-booking diversion rather than brought to jail. The Pre-Booking Diversion Working Group will also examine the "second chance" time period for diversion after booking, but before criminal charges have been filed.

This discussion will be more nuanced than merely creating a list of criminal offenses that are either included or excluded for diversion, even if that could be definitively done. Some individualized evaluation of each offender must necessarily take place, such as what circumstances brought them to the attention of law enforcement, the severity of their mental

illness, whether they have housing and available support persons, and the like. The Pre-Booking Diversion Working Group will generate protocol recommendations and discuss strategies for success based on all of the relevant factors.

The Pre-Booking Diversion Group will also critically examine how and why welfare related calls which are initially non-criminal in nature can transform, resulting in a county jail booking and criminal case. Successfully preventing entry into the jail at this intercept point could reduce the incompetent to stand trial population in the jail, and in particular, the MIST population who are booked on misdemeanor charges and can remain in the jail for some time.

- ***Data and Systems Connectivity Working Group. (Intercepts One through Four)***

This group is chaired by Todd Pelkey, who is the Chief of the District Attorney Systems Division. The Systems Working Group will discuss data collection and data sharing issues, including appropriately maintaining privacy and patients' rights.

Systems solutions can help create better linkage to available services. "Linkage" means more than simply making an appointment. For example, after incarceration, the treatment provider who receives the client needs information about the treatments which were provided to the client while incarcerated, in order to avoid unnecessary duplication and give the person what they need. Equally important, upon return to jail, knowledge about a client's recent clinical history can potentially reduce risk and speed the delivery of services.

In our County, the Sheriff's Department, Probation Department and Department of Health Services all use Cerner Health Information Systems. The Cerner Hub is software which can facilitate transparent exchange of clinical information between participating implementation sites. Netsmart, the health information vendor for the Department of Mental Health, is currently involved in discussions with Cerner to enable Netsmart systems to participate in health information exchange through the Cerner Hub. If successfully deployed, Los Angeles would be among the first sites to use this approach in production. Adding DMH to the Cerner Hub community would greatly simplify the task of coordinating care for clients shared among the participating departments.

By early 2016, the Department of Health Services will complete its implementation of the Online Read-time Centralized Health Information Database ("ORCHID"). ORCHID is an electronic health record system which provides a unique identifier for each patient to track his or her services throughout the clinical specialties and patient care venues. ORCHID is built on a platform that will also be used by the Sheriff's Department Medical Services Bureau and the Probation Department's Juvenile Health Services, to enable real-time access to patient records for their shared patients. In a separately pending motion, this Board is considering whether it would be better to pursue system linkage solutions or to integrate all electronic health record systems into a single platform.

The Systems Working Group will also consider possible use of the Justice Automated Information Management System ("JAIMS"), which was developed after the enactment of AB 109, to possibly store or share anonymized data related to mental health diversion.

Perhaps the most important topic to be discussed by the Systems Working Group will be how data collection and data sharing will inform evidence-based practices. Over the long term, data regarding mental health diversion will be crucial, in order to record what is being done here and preserve it for analysis by outside experts. Indeed, our ongoing mental health diversion efforts must be data driven so that we can quantify our successes, identify trends and learn from our experiences. It is anticipated that in the future, the Systems Working Group will be able to identify systems related gaps which could be remedied by additional fiscal resources.

- ***Long Beach Mental Health Diversion Working Group. (Intercepts One through Five)***

This group is chaired by Kelly Colopy, who is the Director of the Long Beach Department of Health and Human Services. The Long Beach Working Group was convened to discuss issues specific to Long Beach, which is the second largest city in the County. The group will create and launch a Long Beach pilot project, which is especially appropriate because Long Beach has its own Police Department, City Prosecutor, and Health and Human Services Department. There are 88 municipalities within the County of Los Angeles, and each of these locations feeds mentally ill offenders into the county jail. Therefore, the experiences of cities such as Long Beach are important to the overall mental health diversion project.

CRISIS INTERVENTION TEAM ("CIT") TRAINING

Training is currently the single most important priority, because change cannot be effectuated without it. Law enforcement training will raise awareness of and sensitivity to mental health issues, and provide law enforcement officers with concrete tools to interact more effectively and compassionately with mentally ill persons in the field.

There are several benefits to Crisis Intervention Team training ("CIT" training). First, educating law enforcement officers about community based treatment options will encourage them to use those options instead of booking mentally ill persons into the jail. Skills training in field interactions—in particular, how to defuse potentially violent situations—makes these encounters safer for both law enforcement and mentally ill persons alike, and helps to prevent encounters from turning violent or even fatal.

This is not only a more enlightened approach, but it is also a fiscally wise one. CIT training means that law enforcement officers will be less likely to suffer from workplace related injuries and disabilities. Based on the experiences of other jurisdictions, CIT training will also pay for itself over time, in reduced litigation and judgment costs. The LASD has estimated that up to 40 percent of use of force incidents may involve mentally ill persons.

The original, highly successful CIT training was based on a 40 hour model. However, this can impose a heavy burden on law enforcement agencies. Logistically, CIT training requires law enforcement agencies not only to send personnel to the training for a week, but also to provide backfill coverage while those officers are gone. Indeed, that can be the largest cost involved. This can be quite challenging for law enforcement agencies, whether they are large or small.

The District Attorney fully endorses the full 40 hour CIT training model whenever it can be employed, but recognizes the practical realities involved and the need for flexibility. Accordingly, the Law Enforcement Working Group has developed an alternative 16 hour CIT training program for local implementation in Los Angeles County. In developing the 16 hour CIT training model, the District Attorney's Office contributed technical and resource assistance through the Criminal Justice Institute, which is a training entity administered through the District Attorney's Office. The Law Enforcement Working Group has identified key training priorities, developed a proposed curriculum, and recruited trainers.

On June 3, 2015, the Law Enforcement Working Group staged a successful half day "Train the Trainers" event at the Burbank Fire Department Training Center. Once fully online, local CIT training will be scheduled as two 16 hour training sessions per month, serving a maximum of 25 participants per training session, for a minimum of one year, and is currently planned to continue indefinitely. Due to the sheer scope of this training effort, these sessions will require a multitude of trainers from a variety of agencies and backgrounds, some of whom will work as teams and others who will rotate in and out of service. These trainers will include representatives from DMH, the LAPD, and the National Alliance on Mental Illness ("NAMI") whose family members, close friends, and themselves have been impacted by mental illness.

Also due to the magnitude of this training effort and ancillary issues associated with it, the District Attorney has identified an immediate need for a Training Liaison who would be hired

as a District Attorney employee. Because CIT training is at its heart a law enforcement concern, the Training Liaison would ideally be either a current or retired high-level managerial law enforcement officer. The District Attorney is currently considering candidates for this position. In addition, the District Attorney requests funding for a Management Assistant position. The Management Assistant position is necessary in addition to the Training Liaison to assist with administrative tasks related to scheduling and organizing the training. In addition to the law enforcement aspect of the anticipated training burden, there will also be significant training needs on an ongoing basis for stakeholders such as attorneys and even judges.

The District Attorney's Office is also working directly with the state Peace Officer Standards and Training Commission ("POST") to seek approval of the 16 hour CIT training curriculum. POST approval is anticipated and if granted, actual CIT training programs may be presented as soon as January, 2016.

The value of CIT training is universally recognized by the law enforcement community. In fact, the larger local law enforcement agencies are each already planning to satisfy their own training needs. For example, the District Attorney is informed that the LAPD, which has embraced CIT-type training for some time, plans to present additional training sessions at least once a month during the next year. The CHP already has underway its own plan to provide a 12 hour block of CIT training to each of its officers statewide.

The Sheriff's Department has proposed a comprehensive six-year plan to incrementally train each of its 5,355 patrol deputies in the full 40 hour CIT training. Although deputies receive six hours of mental health training as new recruits in the Academy, this is not adequate to prepare them for the numerous contacts with mentally ill persons that actually occur once they are deployed as deputies. The Sheriff's Department has created a three-part plan to better train its deputies.

First, the Sheriff's Department is currently providing Baseline Training (3 hours) and Intermediate Training (8 hours) to deputies. As of June 8, 2015, more than 1,200 patrol deputies have received the Baseline Training, which provides an overview of mental health issues that first responders encounter in the field and strategies which may apply to specific situations. The Intermediate Training is a mental health awareness class, which provides students with the tools to better recognize symptoms and behaviors associated with mental illness and fundamentally, to understand that behavior engaged in by a mentally ill person relates to a medical condition that the person has not chosen to have. Students are also taught how to better communicate with mentally ill persons. As of June 8, 2015, more than 700 personnel have attended the Intermediate Training. Finally, the Sheriff's Department plans to provide a 40 hour Advanced Training, to be conducted 40 weeks per year with a class size of 24 students. The Advanced Training is true CIT training. Topics covered will include: Mental health signs and symptoms, appropriate medications and their side effects, use of verbal de-escalation techniques, active listening skills, and improved police tactics using safe restraint techniques that result in reduced use of force. During Fiscal Year 2015-2016, the LASD will send 480 patrol personnel to CIT Training. Deputies who complete the training will return to their patrol areas and be available to respond to and assist with incidents involving mentally ill persons when co-deployed Mental Evaluation Teams (discussed in the next section) are not available. The value of this ambitious plan cannot be overstated.

Because each of the larger law enforcement agencies are already planning their own independent CIT training programs, the participants in the 16 hour CIT training sessions sponsored by the District Attorney and Criminal Justice Institute will largely be drawn from the 48 smaller police agencies in the County.

Simply stated, CIT training is a good idea whose time has finally come, one which is worthy of the full support of this Board.

CO-DEPLOYED LAW ENFORCEMENT TEAMS

The Department of Mental Health's Emergency Outreach Bureau has teamed with law enforcement agencies in the field, to provide crisis intervention services throughout Los Angeles, various municipalities, and the unincorporated areas of the County. This co-response model pairs a licensed mental healthcare clinician with a law enforcement officer. Together, they jointly respond to 911 calls and patrol service requests where it is suspected that a person might have a mental illness, make appropriate referrals to treatment facilities, and facilitate hospitalization when necessary.

These specially trained, co-deployed field teams are known as Mental Evaluation Teams ("MET") by the Sheriff's Department and as the System-wide Mental Assessment Response Team ("SMART") by the LAPD. Regardless of the name by which the co-deployed teams are known, the mission and partnership with the Department of Mental Health remain the same. DMH has estimated that these teams may contact over 6,500 mentally ill persons per year.

In addition to partnering with the LASD and LAPD to deploy the MET and SMART teams, DMH has also partnered with a total of fifteen other law enforcement agencies which also employ co-deployed teams: Alhambra Police Department; Bell Gardens Police Department; Burbank Police Department; City of Bell Police Department; City of Vernon Police Department; Downey Police Department; Gardena Police Department; Hawthorne Police Department; Huntington Park Police Department; Long Beach Police Department; Pasadena Police Department; Santa Monica Police Department; Signal Hill Police Department; South Gate Police Department; Torrance Police Department. Also, the Metropolitan Transit Authority ("MTA") contracts with the LASD for four Crisis Response Teams, funded by the MTA. These four teams primarily serve homeless individuals and respond to critical incidents involving mentally ill persons on public transportation such as buses and trains. DMH also has plans underway to partner with six additional law enforcement agencies on co-deployed teams, once appropriate memoranda of understanding are approved and executed.

Co-deployed teams roll out in the field and use their specialized training and experiences to help to defuse potentially violent situations. The teams respond to persons in crisis, barricaded suspects, suicides in progress such as jumpers, and a variety of other volatile situations. The MET teams are praised by both mentally ill persons who have interacted with them, and family members who are grateful to have seen their loved ones appropriately treated with compassion and understanding. Co-deployed teams are a bright spot in the ongoing relationship between law enforcement and the communities that they police.

Unfortunately, the demand for services is so great in Los Angeles that there are never enough co-deployed teams to respond. Because the team coverage areas currently occupy such a large geographic area of the County, there is often a lengthy response time. The co-deployed teams certainly cannot respond to every call which involves a possible mental health issue. That is why, in addition to adding new MET teams, the LASD has also focused on improving mental health training for all of its deputies, a wise investment in the future.

The Sheriff's Department currently has only eight MET teams to cover the entire County, and would need at least a total of twenty-three to provide sufficient coverage and services for the vast

geographic area and population involved. Both the Department of Mental Health and LASD propose the expansion of these teams.

In addition, plans are currently underway for the LAPD to add one additional SMART team per shift per Bureau, for a total of sixteen additional teams. The Department of Mental Health will provide clinicians for each of these teams.

MENTAL HEALTH URGENT CARE CENTERS: THE FIRST 24 HOURS AFTER A MENTAL HEALTH CRISIS

The following problem is presented every day in Los Angeles County. Upon encountering a mentally ill offender in the field, a law enforcement officer faces a choice. The officer could take the person to a crowded hospital emergency room, and possibly wait for an average of 6 to 8 hours there, during which time their assigned patrol area would lack coverage. Or, the officer could take the person to jail, book them there, and be back out on patrol within the hour.

In order to successfully divert mentally ill offenders from the jail, there must be places to take them where they can receive treatment instead. In addition, sufficient resources must be invested into those alternative treatment locations so that they are not overloaded by demand.

Mental Health Urgent Care Centers ("UCCs") are the logical resource to fill this gap. Urgent Care Centers are acute care provider locations, where a mentally ill person can be taken so that their needs can be evaluated. Urgent Care Centers are not residential facilities. In fact, a person can only remain at an Urgent Care Center for a maximum time period which is less than 24 hours.

During that initial 24 hour window of time, a crisis can be averted. A person can be stabilized and allowed to go home, if they have housing and a support system. On the other hand, a person might be unable to care for themselves and need to be civilly committed on a 72 hour hold (commonly called a "5150 hold" since it is authorized by Section 5150 of the Welfare and Institutions Code). Or, the person's mental health needs could fall somewhere in the middle, and they can be linked to other services such as recovery-oriented community-based resources.

Because these UCCs specialize in mental health care, they are capable of making mental health determinations promptly and professionally. Investing in adequate mental health UCCs takes pressure off County hospitals by freeing up emergency rooms to deal with medical health crises as they arise, thus enhancing care for both medical and mental health patients. The mental health UCCs provide integrated services, including treatment for co-occurring substance abuse disorders. The Department of Mental Health currently has four UCCs, and a fifth is already slated to be reopened in November, 2015. Of these, two are currently designated under the Lanterman-Petris-Short Act ("LPS designation") and operate twenty-four hours a day, seven days a week. A facility must be designated under the LPS in order for 5150 holds to be made. DMH already has plans in place to have all of the mental health UCCs in the County, both current and future, designated under the LPS. Each of these UCCs are located in close proximity to hospitals.

The Department of Mental Health is planning to add three additional UCCs to be located near Harbor UCLA, the San Gabriel Valley, and the Antelope Valley, which will serve an additional 54 individuals at any given time. These UCCs will operate twenty-four hours a day, seven days a week. It is anticipated by DMH that these three new UCCs will serve approximately 49,275 persons per year. It is estimated that between 15 and 20 percent of those individuals would have otherwise been incarcerated. These three additional UCCs will primarily be used as assessment and staging facilities for the Assisted Outpatient Treatment program (discussed in the following section) and proposed pre-booking diversion.

The mental health UCCs are a prudent and necessary investment of resources, but cannot be used in every situation. For example, mentally ill persons who are actively under the influence may not

appropriately be taken directly to UCCs. Therefore, there is also a significant separate need for stabilization and detoxification services to be offered at Sobering Centers and Residential Detoxification Centers, as well as longer term Residential Drug Treatment, as discussed later in this report in the section entitled, "Impact of Co-Occurring Substance Abuse Disorders."

OTHER TREATMENT OPTIONS: AFTER THE FIRST 24 HOURS

After a law enforcement officer has transported a mentally ill person to a mental health Urgent Care Center, what happens next—after the first 24 hours—is also important. Ideally, the person would be linked to appropriate mental health treatment, whether inpatient or outpatient. On the other hand, if a gap in services occurs, law enforcement could receive another call about the same person. Clearly, this would increase the likelihood that upon a second or subsequent call, the person might then be transported to the jail instead.

Los Angeles needs the right combination of treatment options to serve the mentally ill population, and good linkage to those services. There are several different types of mental health treatment services currently available, as follows.

Law Enforcement Hospital Beds The Department of Mental Health provides some dedicated acute psychiatric inpatient services, specifically for uninsured individuals who are brought in by law enforcement. These facilities are located at Aurora Charter Oak Hospital in Covina and College Hospital in Cerritos. The law enforcement bed program serves approximately 300 mentally ill individuals per year.

Institutions for Mental Diseases ("IMD" beds) Institutions for Mental Diseases are licensed long term care psychiatric facilities which may be locked, and are similar to hospital beds. The Department of Mental Health contracts with these IMD facilities to provide care for persons who no longer meet the criteria for acute care but are not clinically ready to live in a board and care facility or other less restrictive treatment settings. Most IMD residents have received services in the past, have had failed board and care placements, and have been in and out of County hospitals, jails, or other IMD beds. They include the most severely mentally ill persons who typically may be the subject of conservatorships.

Crisis Residential Treatment Programs Crisis Residential Treatment Programs have been nationally recognized for over 25 years as an effective model for diversion from psychiatric emergency rooms and as a "step-down" from inpatient hospital and jail care. Mentally ill persons can stay at adult crisis residential treatment programs for up to thirty days, but the usual expected stay is ten to fourteen days. These facilities are not locked, but offer augmented supervision and intensive mental health services.

The County currently has only three Crisis Residential Treatment Programs with a total of 34 beds that provide housing and very intensive mental health services and support for those mentally ill individuals who can benefit from additional stabilization and linkage to ongoing community-based services.

The Department of Mental Health is currently using SB 82 funds to develop and implement 35 additional Crisis Residential Treatment Programs for a total increase of 560 beds. DMH estimates that these additional beds will serve an estimated 17,030 additional people per year, based on an average 12 day length of stay.

Full Service Partnerships ("FSP") The Full Service Partnership Program serves individuals with mental illness who need intensive, integrated wrap-around services. These are individuals whose criminal justice and psychiatric histories place them at risk of institutionalization, frequent psychiatric hospitalizations, homelessness and incarceration. FSP services support individuals as they transition to lower levels of care and participants engage in the development of their treatment plan which is focused on wellness and recovery. The treatment team is available to provide crisis services to a client twenty four hours a day, seven days a week. FSP providers may be community based organizations or others who contract with the Department of Mental Health. Though comprehensive, these services cannot be used for everyone due to cost issues.

Field Capable Clinical Services ("FCCS") The Field Capable Clinical Services program is a field-based service program, which assists persons who are either graduating from Full Service Partnerships or were never in need of that level of intensive support and individualized case management. The treatment team is available twenty-four hours a day, seven days a week by telephone to provide crisis services to the client.

Wellness Centers The Wellness Center Program is an outpatient clinical service, for persons who are either graduating from Full Service Partnerships or Field Capable Clinical Services, or were never in need of that level of support. Wellness Center services support individuals in the community.

Assisted Outpatient Treatment Program ("AOT") Assembly Bill 1421 established the Assisted Outpatient Treatment Demonstration Project Act of 2002 ("Laura's Law"). Laura's Law created a process for the courts, probation, and the mental health systems to order supervised outpatient treatment of mentally ill adults who would otherwise resist treatment. The Assisted Outpatient Treatment Program can also be used on a voluntary basis by participants who are engaged in their own treatment.

In May 2015, the Department of Mental Health fully implemented an Assisted Outpatient Treatment program and expanded its intensive Full Service Partnership network by 300 slots and its enriched residential services network by 60 slots. The Assisted Outpatient Treatment Team screens requests, conducts extensive outreach to engage patients, develops petitions and manages the court processes to connect Assisted Outpatient Team enrollees with Full Service Partnerships or enriched residential services that have dedicated funding for these persons.

PERMANENT SUPPORTIVE HOUSING AND OTHER HOUSING OPTIONS

Mentally ill individuals who are homeless are significantly more likely to become involved in the criminal justice system than those who have a stable housing environment. In addition, once they do come into the justice system, they are much more likely to remain in custody than be released on bail or their own recognizance. Because they lack a stable residence, officers are more likely to take them to jail than issue a citation, and judges are more likely to conclude that they will fail to appear for a future court date and order them to remain in custody.

It is also more challenging to consistently engage homeless individuals in treatment services, and too often, their connections with the County's system of care are precipitated by crisis situations and law enforcement contacts rather than being guided by an established treatment plan. The result is high-cost utilization of medical, emergency, and mental health care systems by homeless mentally ill individuals, as well as their increased likelihood of cycling in and out of the criminal justice system.

As such, a discussion of appropriate housing models for mentally ill, justice-involved populations is integral to any mental health diversion and re-entry effort. In particular, the availability of permanent supportive housing is critical to stem the tide of recidivism. The provision of safe, stable, and affordable housing—with necessary supportive services—has been found to be one of the most effective strategies for reducing recidivism.

In response to the direction of this Board's May 6, 2014 motion, the following sections provide an inventory of currently available permanent supportive housing in the County, an assessment of housing service gaps identified for people with severe mental illness, and recommendations for addressing permanent supportive housing needs.

Permanent Supportive Housing Permanent supportive housing is affordable housing with indefinite leasing or rental assistance, combined with supportive services designed to assist homeless persons who suffer from disabling conditions to achieve housing stability. Permanent supportive housing service providers proactively engage tenants and offer treatment plans. The supportive services made available are voluntary and participation is not a requirement of maintaining eligibility for the permanent housing.

The premise of permanent supportive housing is that the effectiveness of mental health, substance abuse disorder, and other treatment interventions is significantly limited when individuals are homeless and in unstable living environments. In contrast, providing homeless, mentally ill individuals with stable, supportive housing promotes better outcomes with regard to health, public safety, and personal dignity among the housed individuals.

There are three types of permanent supportive housing models: Single-site based, mixed-population, and scattered-site models.

A. **Single-Site Model Permanent Supportive Housing** This is traditionally a single multi-family apartment building with all units occupied by supportive housing residents and with the benefit of on-site supportive services.

B. **Mixed-Population Model Permanent Supportive Housing** This is traditionally a single multi-family apartment building where a portion of the units are set aside for supportive housing residents and may include on-sitesupportive services. Both single site and mixed population models of permanent supportive housing are traditionally produced using community development or affordable housing financing.

C. **Scattered-Site Model Permanent Supportive Housing** This is financial rental assistance funds provided directly to residents who then secure rental housing from private landlords in the community. The most common program which provides this form of supportive housing is the federal Housing Choice Voucher ("Section 8" program). Supportive services are then provided directly to tenants through mobile teams in the community.

To provide an inventory of available permanent supportive housing, this report relied upon data reported by the Los Angeles Homeless Services Authority (LAHSA). LAHSA is an independent Joint Powers Authority which was created in 1993 by the City and County of Los Angeles. LAHSA operates as the lead agency for the Los Angeles Continuum of Care and is responsible for collecting an annual Housing Inventory Count information of all beds and units in the Continuum of Care's eight Service Planning Areas.
The 2015 Housing Inventory Count has been completed, but has not yet broken down the data into a detailed analysis. Therefore, this report relies upon both 2014 and 2015 data, as identified below:

- 17,172 total permanent supportive housing beds of varying type (2015 Housing Inventory Count);
- 3,606 permanent supportive housing beds which are expressly set aside for individuals who are chronically homeless, mentally ill, returning from jail, or multi-diagnosed (2014 Housing Inventory Count);
- 4,285 permanent supportive housing beds which are uncategorized, so it is unclear whether or not they would be available to the criminal justice mentally ill offender population (2014 Housing Inventory Count);
- 1,903 "other permanent housing" beds, which do not include supportive services, and are thus not actually considered to be permanent supportive housing in the total count (2014 Housing Inventory Count).

Notwithstanding these figures, there remains a significant gap between the available housing and the demand for housing options for the homeless and mentally ill population. In addition to permanent supportive housing, there are other kinds of housing as well, which are described as follows. However, substituting temporary or transitional housing for permanent housing, when permanent housing is truly necessary, does not solve the ultimate problem and can result in more transition points where people can fall between the cracks.

Bridge Housing Bridge housing is temporary housing for people in need while a housing navigation team works with clients to secure appropriate permanent supportive housing once it becomes available. Bridge housing has no set maximum stay and is generally provided through local, accessible service organizations within the Continuum of Care. By minimizing barriers to participate, clients are encouraged to move from the streets into a safe bed. Having a stable location greatly assists clients to keep meetings and appointments.

Shelter Plus Care Shelter Plus Care provides federally subsidized housing through a services-match grant for individuals and families who meet the Department of Housing and Urban Development's ("HUD") definition of homelessness. The supportive services match must be equal to or greater than the rental assistance award. These grants allow a variety of housing rental situations. To be eligible, a person must be homeless, with a mental illness, substance abuse problem, HIV/AIDS, or a dual diagnosis. Shelter Plus Care does not require a background check.

Department of Mental Health Shelter Plus Care This is similar to Shelter Plus Care housing, but participants must be Department of Mental Health clients. DMH contracts with the Housing Authority of the City of Los Angeles ("HACLA") and the Housing Authority of the County of Los Angeles ("HACoLA"), to provide Shelter Plus Care certificates to eligible clients. To be eligible, individuals must be at least 18 years of age, meet the HUD criteria for homelessness, have a diagnosis of severe and persistent mental illness, including a co-occurring substance use disorder, and agree to maintain active contact with DMH for case management and other mental health services for as long as the certification is valid (at least five years).

HUD-VASH Vouchers This is a veteran's housing program, which combines Section 8 rental assistance vouchers with case management and clinical services, which are provided by the Los Angeles Veterans Affairs Medical Center ("Medical Center"). Clients must be Veterans Affairs Supportive Housing ("VASH") eligible veterans. The Medical Center determines whether homeless veterans and families are eligible for VASH benefits. The local housing authority determines eligibility for the rental subsidy. As a condition of the program, participants must receive case management services from the Medical Center.

Rapid Re-Housing This program is designed to help persons who recently became homeless, not the chronically homeless. It quickly provides housing, so recipients may pursue employment, health and social service needs and get back on their feet.

Mental Health Services Act ("MHSA") Housing Program There are a total of 976 Mental Health Services Act funded units which are an option for some homeless mentally ill offenders returning to the community from custody, but some offenders will not qualify based on their criminal history. If an offender is enrolled in a Full Service Partnership program, they are eligible to receive assistance with their housing needs, and in these situations the Department of Mental Health can provide a subsidy by using MHSA funds to rent a unit from a private property owner. Under this program, DMH requires that the tenant be engaged in mental health treatment, and the housing developments must provide onsite supportive services.

In addition to permanent supportive housing, there are various short term stay beds in the County such as emergency shelters. However, they cannot effectively be used for mental health diversion from the jail since they are too uncertain and short term in nature—since they are usually first-come, first-served, a spot is not certain even on a day-to-day basis.

There are several significant efforts currently in progress within the County, regarding housing services.

Coordinated Entry System The Coordinated Entry System is an effort to capture and electronically input data from clients and landlords to create a real-time list of individuals experiencing homelessness in our communities, and to quickly triage and efficiently match these individuals to available housing resources and services that best fit their needs. Clients are surveyed using an assessment tool known as the "VI-SPDAT," which provides a survey score. Clients identified with the greatest need of a particular housing type are referred to eligible housing opportunities as they become available. The Coordinated Entry System relies on the Homeless Management Information System, which is a federally mandated database used to collect information on homelessness. Housing providers that receive any federal HUD funding are required to input their available units by type, subsidy, eligibility criteria and number of units into the system, to ensure an accurate inventory of beds available for potentially qualifying tenants. All homeless service providers are encouraged to participate even if they do not receive federal funding. As of September 2014, LAHSA reported a participation rate of 65% for emergency shelter programs, 67% for transitional housing programs and 83% for permanent housing programs.

Department of Health Services - Flexible Housing Subsidy Pool The Flexible Housing Subsidy Pool is a rental subsidy program which currently provides permanent supportive housing to patients who are homeless and have experienced two or more hospital visits in one year. This program allows the provider to contract for housing, providing a range of options that include intensive case management, wrap-around services, and move-in assistance. To fund the program, DHS has partnered with private foundations, which provides maximum flexibility because participants are not restricted based on criminal history and the restrictive federal definition of homelessness does not apply. DHS has established a goal of securing 10,000 permanent supportive housing units for this program.

Breaking Barriers Program Breaking Barriers was jointly launched by the Probation Department and the Department of Health Services in June, 2015. It is a two-year pilot program to provide rapid re-housing and case management services for eligible offenders supervised by the Probation Department. These offenders are homeless, have been identified as moderate to high risk of re-offending, and have expressed a desire to seek full-time employment. Each client is provided intensive case management, employment services, a housing unit and a rental subsidy, with the client contributing a percentage of their monthly income towards the rent. Once stabilized, participants work to successfully "transition in place," eventually taking over the full rental payment amount so that they can continue to reside in their unit once participation in the program expires. The maximum length of program participation is 24 months, with case management aftercare services continuing for 3 months after program completion.

Just In Reach Program This Sheriff's Department program was developed to improve custody discharge planning for homeless individuals who repeatedly cycle through the jail, primarily due to their homelessness. Just In Reach targets individuals who are either currently homeless or at risk of homelessness, repeat offenders, and those who are charged with lower level offenses; specifically, offenders who have been in jail three times in the last three years and who have been homeless three times in the last five years. The program offers participants comprehensive assessments, case plans, and linkage to community services to assist participants to secure permanent supportive housing and remain self-sufficient.

Notwithstanding each of these resources and programs which are currently underway, significant gaps in services remain: Los Angeles County currently has no permanent supportive housing dedicated to the justice-involved population with mental illness.

Permanent supportive housing beds are needed to serve this specific population, who currently face many barriers to successful re-entry, such as housing restrictions based on their history of incarceration and long housing wait lists. This population currently must independently apply for supportive housing through the standard homeless service delivery system.

Even with an investment into additional permanent supportive housing, it is clear that some homeless mentally ill offenders exiting custody would not have immediate access to a permanent supportive housing placement until a spot becomes available in the system that could be matched to meet their individualized service needs.

This is particularly true because there are a myriad of legal definitions and requirements which may apply, especially for federally funded housing programs, which often restrict participation based upon criminal background checks and make it difficult for the justice involved homeless population reentering the community to stabilize.

For example, for programs funded under federal HUD guidelines, the federal definition of homelessness applies. Under that definition, inmates who serve 90 days or more of custody in the county jail do not qualify as homeless, even if they were homeless before they entered the jail. Instead, they would have to reestablish homelessness, such as by going to an emergency shelter, before being processed onto a list for appropriate housing.

There is also a federal housing restriction which would prevent a person who is being released from jail from returning to live at their original home, if it would mean cohabiting with a family member who holds a Section 8 voucher. This means that even when there is a family member of a mentally ill person who is willing to have them, it would prevent them from being welcomed back into the home. Instead, the mentally ill offender would have to compete for their own permanent supportive housing or face homelessness.

To address these gaps, the County should also secure additional bridge housing capacity for this specific population. Bridge housing would provide a safe bed for the population of justice involved homeless individuals exiting custody until appropriate permanent supportive housing can be secured.

Additional investment should also be made into subsidized housing through the Flexible Housing Subsidy Pool, Shelter Plus Care and DMH Shelter Plus Care programs to provide the County with the flexibility to quickly and strategically invest in housing and services based on need and availability. Focusing on connecting these resources to the most difficult to house population would help to break the cycle of returns to custody.

The following housing-related recommendations are made to this Board:

1. Allocate sufficient funding to the Flexible Housing Subsidy Pool for 200 permanent supportive housing scattered site units for a five-year period. These will provide immediate access to housing for the mentally ill population leaving custody;
2. Allocate sufficient funding to the Flexible Housing Subsidy Pool for rapid re-housing rental assistance for 200 people for a five-year period;
3. Allocate sufficient funding to contract for 200 units to be subsidized by the federal Rental Assistance Program that are prioritized for qualifying mentally ill offenders exiting custody in need of permanent supportive housing;
4. Allocate sufficient funding for 400 supportive housing units to be provided through new construction or rehabilitation of single site or mixed population developments;
5. Allocate sufficient funding within the Department of Mental Health Specialized Housing Program to add housing subsidies for approximately 300 individuals to be housed in permanent supportive housing and 200 individuals to be placed in bridge housing while participating in Full Service Partnership, Field Capable Clinical Services and Wellness Center treatment services. It is anticipated that this funding would allow DMH staff to negotiate with private housing providers on behalf of inmates to pay for move-in costs and provide rental assistance.

It is recommended that a Mental Health Diversion County Housing Director position be created to generally oversee housing issues related to mentally ill offenders who are justice involved. Housing issues are often fragmented due to the different entities involved at the city, county, state and federal level; for example, the Housing Authority of the City of Los Angeles ("HACLA"); Housing Authority of the County of Los Angeles ("HACoLA") and the Los Angeles Homeless Services Authority ("LAHSA"). If appointed, the proposed Mental Health County Housing Director would serve as a member of the Permanent Mental Health Diversion Planning Committee, discussed more fully in this report in the section entitled "Proposed Expansion of Mental Health Diversion Related Staffing and Services."

CO-OCCURRING SUBSTANCE ABUSE DISORDERS

As instructed by this Board's motion dated May 6, 2014, the stakeholders have assumed as a goal the diversion of a total of 1,000 mentally ill offenders from the jail into community based treatment options, although that certainly will not happen overnight. According to the Department of Public Health and the Department of Mental Health, approximately 80 percent of those persons may have a co-occurring substance abuse disorder involving drugs, alcohol or both. This would require planning for the appropriate service referrals and placement of approximately 800 additional mentally ill offenders also suffering from substance abuse problems.

The Department of Public Health, the Department of Mental Health and the Sheriff's Department all agree that mental illness with co-occurring substance abuse disorder is a priority problem among this offender population which presents specialized treatment challenges. For example, mentally ill offenders who suffer from substance abuse disorders may need stabilization and/or medically managed care in a Sobering Center, Residential Detoxification or Residential Drug Treatment Program before accessing appropriate mental health treatment. Mentally ill persons suffering from untreated substance abuse disorders are less likely to accept available mental health resources and engage in their own mental health treatment.

The following current programs and resources relate specifically to co-occurring substance abuse disorders:

Alcohol and Drug Free Living Center Services Currently, the Department of Public Health offers alcohol and drug free living center ("ADFLC") services in limited capacity for clients who are enrolled in outpatient substance abuse disorder outpatient services. These are housing facilities where clients recovering from alcohol and drug problems reside, and the presence of and use of alcohol or drugs, other than prescribed drugs, is forbidden. This type of housing environment is suitable for individuals with a stable co-occurring disorder condition.

Co-Occurring Integrated Care Network ("COIN") This court-based program is a collaboration between the Department of Public Health, the Department of Mental Health and the Superior Court. The COIN program serves the needs of AB 109 offenders who have a co-occurring chronic substance abuse disorder coupled with a severe and persistent mental illness, by making intensive, inpatient services available. The Probation Department and the Parole Revocation Court identify offenders who are at a high risk for relapse and would benefit from integrated substance abuse and mental health treatment. The COIN program was established in 2013, but recently expanded in early 2015 to serve clients in an additional two service areas. Twenty beds are reserved specifically for AB 109 supervised persons with co-occurring disorder.

Probation Department Co-Occurring Caseloads The Probation Department has developed Co-Occurring Caseloads. Persons with mental health issues and co-occurring substance abuse disorders who are under court supervision are identified, and provided with a Deputy Probation Officer who specializes in these issues. The Deputy Probation Officers assigned to this caseload are provided additional training in order to build a knowledge base of what services are available in the community for these supervised persons, and how to

more effectively supervise them. The Probation Department developed a 20 hour course on this subject entitled "Case Management of AB 109 Clients with Co-Occurring Disorders" which was available to both Deputy Probation Officers and Supervising Deputy Probation Officers.

Co-Occurring Disorders Court ("CODC") Co-Occurring Disorders court is an option for offenders who have failed at previous attempts at substance abuse treatment and who have a severe or persistent mental illness. Specified low-level felony charges are eligible for this program. The court requires a guilty plea, followed by 90 days at the Antelope Valley Rehabilitation Center and then placement into a full service partnership which includes medication, housing, benefits evaluation, and educational and vocational assistance.

Women's Community Reintegration Services and Education Center ("Women's Center") The Women's Center is a jail in-reach program for women with mental health needs who are being released from jail at the Century Regional Detention Facility. These women struggle with histories of repeated arrests and incarcerations, persistent mental illness and co-occurring substance abuse disorder, domestic and community violence, unemployment, financial instability and children in out-of–home placement. Through the Department of Mental Health, the Women's Reintegration Center provides release planning groups, one-to-one interviews, and outpatient services upon release to equip these women with the life skills necessary to succeed outside of jail.

There currently does not exist an analogous men's program. However, the Department of Mental Health already has a plan underway to add one as follows:

Men's Integrated Reentry Services and Education Center ("Men's Center") The Men's Center will serve men with mental illnesses and co-occurring substance abuse disorders being released from Men's Central Jail or Twin Towers Correctional Facility. The Men's Center will be able to serve up to 40 clients at a time, assuming an average length of stay in the community for 59 1/2 days. The Men's Center will not only provide an innovative model of care for men who struggle with their mental illnesses and other life issues, but will also serve as an education and training center for a variety of integrated care providers and interns.

Four key gaps in services have been identified relating to the co-occurring disorder population, for which additional resources are recommended:

1. **Sobering Centers** Los Angeles County currently does not have any Sobering Centers, which would provide a place for first responders to take mentally ill persons who are not suitable to be brought to an Urgent Care Center, as an alternative option to jail. The typical model for a Sobering Center would be an 8 hour stay before being referred to other services.

2. **Residential Medical Detoxification Services** These residential facilities are directed toward the care and treatment of persons in active withdrawal from alcohol and/or opiate dependence, for up to 14 days.

3. **Residential Treatment Services** Residential treatment facilities provide a structured, 24 hour a day environment which are non-institutional and non-medical, but provide rehabilitation services to clients suffering from substance abuse disorders. Clients can stay for up to 90 days, and more days may be required with clinical justification.

4. **IMD Beds Designated for Co-Occurring Disorders** For the most acutely mentally ill offenders, there is currently an insufficient supply of IMD beds for individuals with serious mental illness and co-occurring substance abuse disorder, who are in need of treatment in a secure setting. The Department of Mental Health is requesting funding for 40 additional IMD beds for individuals with co-occurring disorders rather than have them remain in the jail. These beds could serve individuals with criminal justice histories who are placed on conservatorships.

IMPACT OF PROPOSITION 47

On November 5, 2014, Prop. 47 was enacted by the voters of California. Prop. 47 reduced common felony theft and drug possession offenses to misdemeanors. Although the long-term impact of Prop. 47 on the jail population and mental health diversion efforts cannot completely be known at this time, two observations can be made.

First, Prop. 47 did not result in any immediate reduction in the mentally ill population in the jail even though the total jail population has dropped. To the contrary, the mentally ill population has gradually increased. According to the Sheriff's Department, the average jail population mental health count in 2013 was 3,081 total inmates; in 2014, it was 3,467 total inmates; and as of June 16, 2015, it was 3,614 total inmates. This could be the result of an overall increase in the mentally ill population in the County, but may also be a result of more diagnoses being made due to increased attention and sensitivity to this issue. Regardless of the reasons for this increase in the mental health population, the numbers are certainly not any lower after Prop. 47.

Second, Prop. 47 crimes by definition are non-violent and lower-level. Presumably, this could make it more difficult to identify offenders for mental health diversion, since there would be fewer non-violent felony offenders in the county jail to choose from for diversion. It is difficult to reconcile these competing observations. Further analysis of the mentally ill jail population may shed light upon these issue and guide further discussion regarding diversion.

On June 9, 2015, this Board instructed the interim CEO to provide an independent analysis of the actual number of treatment beds and other beds needed at the new Consolidated Correctional Treatment Facility ("CCTF") and to conduct a capacity assessment of all community-based alternative options for treatment including, but not limited to, mental health and substance abuse treatment.

CURRENT JAIL PROGRAMS AND RESOURCES

There are currently a variety of jail programs which provide mental health treatment for those who are currently incarcerated, seek to link them to services upon their release, or are alternative custody programs. In particular, the following current efforts are noteworthy.

LASD Population Management Bureau The Sheriff's Department has enhanced its transitional services systems through collaboration with the Department of Mental Health and Jail Mental Health Services. The LASD works with Jail Mental Health case managers to process vital records such as birth certificates and California ID cards. This is a preliminary step to completing Affordable Care Act (Medi-Cal) enrollment. With the assistance of the Department of Public Social Services, benefits are effective the day of release from custody.

If a mentally ill inmate is entitled to Homeless General Relief, a coordinated release is conducted and the client is driven to the Department of Public Social Services immediately following release to receive their General Relief benefits. Additionally, through a collaborative effort with Jail Mental Health Services, the inmate is linked with services such as emergency shelter before their discharge date, so that they will have someplace to live when they are released.

In fact, the Sheriff's Department has consistently provided transportation assistance to take offenders from the jail directly to a myriad of services, including mental health services, residential substance abuse programs, transitional housing, emergency shelters, employment services, social services, mother-infant residential programs, veteran-specific programs, parolee substance abuse service, HIV services, temporary financial assistance and food benefits to families and individuals. This transportation service has filled a gap to greatly assist offenders to connect with needed services upon their release.

Affordable Care Act Program On July 1, 2014, the Sheriff's Department began the Affordable Care Act ("ACA") Project. This is a two-year grant program in collaboration with the Departments of Mental Health, Public Health, Health Services and Public Social Services. All sentenced inmates who are within 60 days of their release date are contacted and assisted to complete and submit Medi-Cal applications, which are processed within 45 days of their release. Inmates who require hospitalization outside of the custody environment, or who are in community treatment with electronic monitoring, can use their benefits as a source of payment for care. As of May, 2015, a total of 8,175 applications were taken and 1,766 inmates received benefits upon their release from custody.

Jail Mental Evaluation Teams ("JMETs") The JMETs are co-deployed teams where DMH clinicians are paired with Sheriff's personnel within the jail, just as the MET teams are co-deployed teams in the field. The JMETs oversee care of inmates in the general population who are on psychiatric medications but are not severely mentally ill and do not require specialized mental health housing. The JMETs also regularly go through the jail to promptly identify inmates who were not identified as having mental health problems upon their initial intake at the jail, or who have decompensated while incarcerated, so that they can receive services.

AB 109 Mental Health Alternative Custody Pilot Program The Sheriff's Department is currently working with the Department of Mental Health on a new alternative to custody program, which will have a 42 bed capacity. The location, Normandie Village East, is a licensed adult care residential facility which is a "step-down" from higher levels of care.

AB 109 offenders who have been incarcerated for low-level and non-violent offenses that appear to be a result of their mental illnesses will be eligible. Referrals to the program will be accepted from various sources including Jail Mental Health Services, the Department of Mental Health Court Linkage Program and the LASD. Admissions will be authorized through the DMH Countywide Resource Management Center. Program participants will be electronically monitored. Criteria are currently being developed to select participants, and discussions are ongoing regarding appropriate mental health programming. There is a October, 2015 goal for implementation.

LASD Inmate Services Bureau, Education Based Incarceration Unit ("EBI") The Sheriff's Department has expanded its mental health programming services to both the male and female population. Currently, the LASD provides mental health programming to over 200 mentally ill inmates a week. This includes specific life skills classes taught by the Five Keys Charter School and by other outside volunteers. Exploratory discussions are underway regarding how to better organize and present material to optimize time and access to sub-groups within the mentally ill population. The LASD is also deploying "comfort dogs" to visit the mental health floors on a regular basis.

Restoration of Competency "ROC" Program Ordinarily, felony offenders who are mentally incompetent to stand trial receive mental health treatment at a state hospital, to restore them to competency. However, there are so few state hospital beds that there is a waiting list for treatment, resulting in lengthy delays while these persons remain in custody, awaiting treatment. At any given time, Los Angeles may have up to two hundred felony inmates who are incompetent to stand trial. In response to this problem, the LASD has entered into a contract with the San Bernardino County Sheriff's Department and Liberty Healthcare regarding services to restore these defendants to mental competency.

The Restoration of Competency "ROC" Program has a 76 bed capacity and is anticipated to be implemented this summer. The ROC program is an intensive, individualized treatment program comparable to restoration services at a state hospital. Treatment is provided by an array of mental health professionals. The sooner offenders can be restored to mental competency, the sooner they can move through the justice system and complete their criminal cases. This program is entirely funded by the state.

Jail Linkage Program Inmates with mental illness require specialized assistance with release planning. The Department of Mental Health Jail Linkage Program works throughout the jail system with clients who require all levels of release planning assistance, from minimal to comprehensive. Jail Linkage personnel coordinate with Jail Mental Health Services, with Department of Mental Health Countywide Resource Management for AB 109 clients, and with the LASD Community Reentry Resource Center, which was created by the Sheriff's Population Management Bureau in 2014 as an information source for all inmates being released.

Mental Health Forensic Outreach Teams ("FOT") Many inmates with mental illness do not successfully transition to treatment and services in the community, which increases the possibility of recidivism. Forensic Outreach Teams under contract with the Department of Mental Health assist approximately 1,260 inmates annually who are released from county jails upon the completion of AB 109 sentences.

Forensic Outreach Teams can provide both jail in-reach and intensive short-term case management for up to 60 days after release, for persons referred to contracted AB 109 providers. Jail in-reach efforts help to build relationships with inmates before they re-enter the community. Building trust in providers and the health care system can help offenders comply with treatment recommendations regarding health, mental health, and/or substance abuse issues. After release, the Forensic Outreach Teams provide additional assistance for successful linkage to community services.

Public Defender and Alternate Public Defender Jail Mental Health Team The Public Defender has conceived and proposed an innovative new jail program aimed at a broader, more holistic legal representation of detained mentally ill offenders who are housed at the county jail. Public Defender clients would be referred through their existing attorney of record, by the existing Public Defender Mental Health Unit, or otherwise. Once referred, the clients would be evaluated by in-house psychiatric social workers, so that the Public Defender's Office could begin to engage proactively with their clients at the earliest possible stage of the criminal justice process. This type of expert assistance would enable the Public Defender's Office to actively collaborate with other justice stakeholders such as the Sheriff's Department and Department of Mental Health.

The Public Defender has also requested the addition of psychiatric social workers to be housed at their branch offices throughout the County. Both the jail social workers and the branch social workers would be well-placed to efficiently communicate "real-time" information about their clients' mental state to assigned attorneys in courts and therefore address longstanding gaps in communication from county jail to courtroom personnel, including judges and attorneys. This increased communication will reduce case continuances, expedite case processing, better facilitate the delivery of mental health services, reduce jail overcrowding, and improve the overall administration of justice.

The Advisory Board supports this proposed new program not only for Public Defender clients, but also for offenders who are represented by the Alternate Public Defender as well. Clients who suffer from mental illnesses and are interviewed in the jail are much more likely to be willing to be frank and forthcoming with a psychiatric social worker who is assigned to their own legal team, than with a clinician who is not. Indeed, mentally ill clients commonly fail to fully cooperate with Department of Mental Health personnel or admit their active symptoms, such as visual and auditory hallucinations, due to the nature of the jail environment and their own concerns that making such admissions could be used against them and possibly result in additional incarceration.

Therefore, the Advisory Board believes that this proposal has merit and should be supported by this Board.

CURRENT COURT PROGRAMS AND RESOURCES

Department of Mental Health Court Linkage/Court Liaison Program The Court Linkage program is a collaboration between the Department of Mental Health and the Los Angeles County Superior Court. Court Linkage is staffed by a team of 21 mental health clinicians who are co-located at 22 courts countywide. This recovery based program serves adults with mental illness or co-occurring substance abuse disorders who are involved with the criminal justice system.

Through the Court Linkage Program, there is a specialized program by which offenders can be placed in licensed, long term psychiatric care ("IMD") beds. The specialized Court Linkage IMD bed program serves 50 individuals at any given time who are pre-adjudicated and agree to receive treatment in lieu of sentencing. The program served 112 individuals in Fiscal Year 2013-2014.
Although full figures for Fiscal Year 2013-2014 are not yet available, last year's figures show that the Court Linkage Program helped to divert a total of 1,053 persons out of 1,997 possible referrals. This group of about a thousand mentally ill offenders annually is placed across the spectrum of available treatment options, which were discussed in detail in the preceding section entitled, "Other Treatment Options: After the First 24 Hours."

There are several reasons why not every offender who is contacted by the Court Linkage Program can actually be diverted: Some refuse services; some are sentenced by the court to state prison or otherwise in a way that would foreclose treatment; some may not have an available treatment option which matches their mental health needs; some may have an available treatment option from a mental health perspective, but one which is not acceptable to the court and counsel from a public safety perspective. Again, it bears emphasis that not every mentally ill offender can safely be removed from a custodial setting.

However, the fact that more than half of the offenders contacted by the Court Linkage Program are able to be diverted is a significant success, which is worthy of attention. The Court Linkage Program is a resource which may benefit from additional expansion of assigned personnel in future years. The District Attorney's Office is currently preparing a new office policy memorandum to ensure that each of the office's deputies is aware of the efforts made by the Court Linkage Program and appropriately coordinates with the Department of Mental Health so that they can evaluate mentally ill offenders for potential diversion opportunities.
The Court Liaison Program provides ongoing support to families and educates the court and the community at large regarding the specific needs of mentally ill individuals. Mental Health Court Liaison services include on-site courthouse outreach to defendants, individual service needs assessments, providing information to individuals and the court about appropriate treatment options, development of post-release plans, linkage of individuals to treatment programs, expedited mental health referrals, and providing support and assistance to defendants and families in navigating the court system.

Mental Health Court/Department 95 The Los Angeles County Mental Health Court handles matters which are referred from criminal courts throughout the County. The court is staffed with lawyers from the District Attorney's Office, Public Defender and Alternate Public Defender. Department 95 handles a wide range of proceedings, including issues relating to mental incompetence to stand trial, post-conviction defendants who were adjudicated as not guilty by

reason of insanity, or alleged to be a mentally disordered offender ("MDO") and are the subject of a petition for restoration or an extension of a parole commitment.

The 2014 Superior Court Annual Statistics Report provides a snapshot example of the volume of matters handled in Department 95. In 2014, an average of 198 new cases per month were sent to Department 95 upon the issue of incompetence to stand trial; this does not include the cases carried over from 2013. The total number of cases under the supervision of the Mental Health Court during 2014 was 118,551.

Veteran's Court Veteran's Court is a diversion program for veterans charged with felonies who suffer from post-traumatic stress disorder or traumatic brain injury. Most of the veterans in this court have alcohol or drug addiction problems and if these problems were caused or exacerbated by military service, the veteran will be considered for the program. Veterans from all areas of the county are eligible to participate. A guilty plea is required and a dismissal is the usual result for successfully completing the program. All costs of housing, transportation and treatment are borne by the Veterans' Administration.

Santa Monica Homeless Court Program This program, operated by the Santa Monica City Attorney's Office in coordination with the Superior Court, is available to homeless individuals who have quality of life or other minor misdemeanor charges pending. Following the successful completion of a 90 day program, charges are dismissed. Services such as mental health treatment, substance abuse assistance, job placement, and assistance in finding permanent supportive housing are provided through the City of Santa Monica and are largely funded through annual grants.

Homeless Court Clinic This program, operated by the Los Angeles City Attorney in coordination with the Superior Court, serves adults who are either homeless or at risk of homelessness, who may also suffer from mental illness, substance/alcohol addiction, co-occurring disorders, or are veterans. The program helps to resolve legal barriers to care and connect them with appropriate service providers to address the challenges that they face on the road to recovery, including permanent supportive housing. In exchange for community obligation hours worked by participants, certain traffic and quality of life offenses, such as low-level misdemeanor charges, warrants and fines can be resolved. These clinics operate as mobile one-day events where participants are assisted by a myriad of stakeholder representatives and service providers.

EXPANSION OF MENTAL HEALTH DIVERSION RELATED STAFFING AND SERVICES

In addition to the need for additional resources earmarked for CIT training and co-deployed MET teams, as well as expansion of the mental health Urgent Care Centers, Crisis Residential beds and other available treatment services, the following improvements are also proposed.

Criminal Justice Mental Health Diversion Permanent Planning Committee Based upon the experiences of other large jurisdictions, it is anticipated that mental health diversion will be a long-term project for some years to come. The Advisory Board and Working Group participants are committed to the project, but cannot reasonably devote full-time attention to it, since each has other primary job duties which are also important. The District Attorney fully and personally supports this effort and is committed to leading it indefinitely.

It will be necessary to dedicate additional permanent employee positions to fully implement mental health diversion. This cannot be accomplished by any one person given the nature and magnitude of the anticipated workload, and the need for collaborative input. Therefore, the Advisory Board recommends a small, workable Permanent Planning Committee, to be comprised of one representative from each of the following County Departments: District Attorney, Public Defender, Sheriff's Department, Department of Mental Health, Department of Public Health, Department of Health Services, proposed new Mental Health Diversion County Housing Director, and others appointed by the District Attorney on an as needed basis. These personnel would be management-level employees, with significant operational experience, to be able to bridge the gap between high-level policy recommendations and actual implementation decisions.

In addition to the employee needs related to the Permanent Planning Committee, both the Sheriff's Department and the Department of Mental Health are requesting additional funding for employees and other costs, as follows:

Sheriff's Department Mental Evaluation Bureau In future years, the Sheriff's Department proposes to establish a new Mental Evaluation Bureau in order to enhance current services to mentally ill persons. For example, a serious problem exists involving mentally ill persons who are the subject of repeated calls for service, which cost the County millions of dollars in emergency resources without positive outcomes.

The new Mental Evaluation Bureau would operate 24 hours a day, seven days a week. Upon encountering a mentally ill person in crisis, patrol deputies could communicate with Desk Operations Triage to coordinate service calls and determine whether the co-deployed MET teams would roll out. If the Triage Desk determined that a call involves a person who was the subject of frequent calls for intervention, a referral to a Consolidated Case Management Team would be made.

The Sheriff's Consolidated Case Management Team would help manage cases that involve persons with a history of violent criminal activity caused by mental illness, and cases that involve persons whose mental illness has caused numerous responses by law enforcement or the deployment of substantial resources. The Consolidated Case Management Team would be the liaison point with the Homicide Bureau-Missing Persons Unit to determine whether a missing

person had been placed on a 5150 hold. The Consolidated Case Management Team would also manage a database to track and update contacts with mentally ill persons and other data which would help to evaluate and improve departmental crisis responses. Finally, the Consolidated Case Management Team would attempt to link mentally ill offenders with available resources.

The Mental Evaluation Bureau would also include a Crisis Negotiations Team, Training Unit and Community Relations Unit. The Crisis Negotiations Team would handle situations involving hostage takers, barricaded suspects, and other persons who pose an immediate, violent threat to themselves or the community.

The Training Division would create and maintain a Mental Health Training Manual, review use of force incidents involving mentally ill persons, review and revise office policies regarding contacts with mentally ill persons, and conduct both basic mental health training and CIT training. The Community Relations Unit would act as a liaison with the Department of Mental Health, other stakeholders and the community in implementing jail diversion programs.

The Mental Evaluation Bureau would be co-supported by the Department of Mental Health. The total staffing request for the Mental Evaluation Bureau is currently estimated at 68 Sheriff's Department personnel and 32 Department of Mental Health personnel. However, funding will be requested from the County no sooner than Fiscal Year 2016-2017.

Countywide Adult Justice Planning and Development Program The Department of Mental Health also requests four additional administrative staffing items to help conceptualize, develop and implement the jail diversion plan. This program infrastructure would help ensure that a wide range of mental health programs are made available at all intercepts in the criminal justice system, and to oversee the existing Mental Health Jail Linkage Program and Court Linkage Programs, which have been discussed separately in preceding sections of this report.

Forensic Additions to Existing Mental Health Programs As previously described, the Department of Mental Health already has services which were designed for the non-criminal population, but proposes to expand with separate "Forensic" or "Justice Involved" versions of the same programs, which would permit a specialized focus on the criminal justice population: Full Service Partnership, Field Capable Clinical Services and Wellness Centers.

Reentry Referral and Linkage Network of Care This proposal is a computer systems network solution designed for the Department of Mental Health, building on existing Jail Linkage and Countywide Resource Management Programs. Ideally, this would be an easily accessible online resource which could: (1) capture and store the assessments of post-release needs of mentally ill inmates; (2) identify service providers to meet the needs; (3) consolidate referral information for each inmate in a format that can be easily printed and shared with an inmate; (4) communicate electronically with service providers to make the referrals; (5) receive electronic responses back from service providers regarding referrals, such as acknowledgement of receipt and confirmation of placement; (6) allow electronic communication with the clients upon their release.

RECOMMENDATIONS

Based on this report, the Advisory Board recommends the following:

1. CIT Training

- Train 5,355 patrol deputies in the full 40 hour CIT Training over the next six years;
- Support the 16 hour CIT training program under the auspices of the District Attorney and Criminal Justice Institute;
- District Attorney Training Liaison and District Attorney Management Assistant.

2. Mental Health Treatment Resource Expansion, Priority

- Add three new Department of Mental Health Urgent Care Centers;
- Add 35 new Crisis Residential Treatment Programs;
- Add "Forensic" or "Justice Involved" versions of Full Service Partnerships, Field Capable Clinical Services and Wellness Centers; in the alternative, increase the staffing of current programs to support anticipated pre-booking diversion of mentally ill offenders;
- 40 additional IMD beds designated for co-occurring disorders;
- Four Additional DMH administrative staffing items;
- Additional Court Linkage personnel.

3. Permanent Mental Health Diversion Planning Committee

- Create and maintain the Permanent Planning Committee.

4. Public Health/Health Services Treatment Resource Expansion

- Sobering Centers;
- Residential Medical Detoxification Services;
- Residential Substance Abuse Treatment Facilities.

5. Housing Services Enhancements

- Create Mental Health Diversion County Housing Director position.
- 200 permanent supportive housing beds through Flexible Housing Subsidy Pool for five years;
- 200 rapid re-housing beds through Flexible Housing Subsidy Pool for five years;
- 200 units to be subsidized by federal monies;
- 400 supportive housing units through new construction or rehabilitation;
- Fund within the Department of Mental Health Specialized Housing Program, 300 housing subsidies for permanent supportive housing and 200 housing subsidies for bridge housing.

6. Co-deployed teams

- MET team expansion of 15 additional teams to a minimum total of 23 teams.
- SMART team expansion of 16 additional teams, to a minimum total of 34 teams.

7. Data improvements

- Development of Cerner Hub inter-departmental interface or other solution to data sharing problems;
- Department of Mental Health Reentry Referral and Linkage Network of Care.
- Based upon these data sharing solutions, set aside funds for a consultant to be employed which can assist the County with metrics which will allow management by outcomes to take place.

8. Public Defender and Alternate Public Defender Jail Mental Health Teams

- Jail based psychiatric social workers and supervisors;
- Branch based psychiatric social workers and supervisors.

9. Mental Health Treatment Resource Expansion, Lower Priority

- Men's Integrated Reentry Services and Education Center;
- Co-deployed Department of Mental Health personnel at Probation offices, to be commenced on a pilot project basis at five offices which span the geographic boundaries of the county.

10. LASD Mental Health Bureau

- Establish the new Mental Health Bureau. (Fiscal Year 2016 - 2017)

CONCLUSION

Various counties, municipalities, and metropolitan areas across the country have commenced the journey towards improving the interface between the low level mentally ill criminal offender and the criminal justice system. The keys to their success have been making modest, pragmatic first steps to improve systemic responses to the problem; the "all in" collaboration of the pertinent criminal justice system partners; and the willingness to make a long term commitment to the goal of improving the plight of mentally ill offenders in the criminal justice system.

Through the work of the Criminal Justice Mental Health Advisory Board, unprecedented collaboration has been demonstrated by the criminal justice system partners. Further, the many efforts to date by public and private entities to treat mentally ill persons in Los Angeles County has been laudable. What is needed at this critical juncture is the integration, coordination, and expansion to scale of these resources. This report represents a plan for going forward. Being ever mindful of public safety and victims' rights, it is time to take the next steps in the long journey.

Los Angeles County District Attorney's Office

Sequential Intercept Mapping Report – LA County, CA

Executive Summary

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The Los Angeles County District Attorney's Office contracted with Policy Research Associates, Inc. (PRA) to develop behavioral health and criminal justice system maps focusing on the existing connections between behavioral health and criminal justice programs to identify resources, gaps and priorities in Los Angeles County, CA. On May 28, 2014, approximately 100 participants attended a county-wide summit/kickoff held to begin this process and address the significant issue of persons with behavioral health disorders involved in the criminal justice system. Additionally, there were 46 cross-systems partners from mental health, substance abuse treatment, health care, human services, corrections, advocates, consumers, law enforcement, health care (emergency department and inpatient acute psychiatric care), and the courts that participated in the Los Angeles County Sequential Intercept Mapping and priority planning on July 8, 2014.

There is a longstanding recognition that persons with behavioral health disorders are over-represented in the criminal justice system. The Sequential Intercept Mapping workshop has three primary objectives:

1. Development of a comprehensive picture of how people with mental illness and co-occurring disorders flow through the criminal justice system along five distinct intercept points: Law Enforcement and Emergency Services, Initial Detention and Initial Court Hearings, Jails and Courts, Re-entry, and Community Corrections/Community Support.

2. Identification of gaps, resources, and opportunities at each intercept for individuals in the target population.

3. Development of priorities for activities designed to improve system and service level responses for individuals in the target population.

The recommendations that follow are informed by the work of PRA over the last 18 months in Chicago, Illinois; New Orleans, Louisiana; New York City, New York; as well as Miami, Florida. In addition, PRA has provided training and technical assistance to over 100 jurisdictions, Tribes, and states across the United States. The recommendations stemming from the Los Angeles County Sequential Intercept Mapping are timely, as they also support many of the recommendations set forth in the 2011 Administrative Office of the Courts Task Force for Criminal Justice Collaboration on Mental Health Issues: Final Report. Additionally, the California Mental Health Wellness Act of 2013 supports the work and recommendations of the cross-systems Sequential Intercept Mapping group in that it ensures key behavioral health and criminal justice collaborators are involved in the planning and implementation of key strategic initiatives needed to improve the lives and outcomes of justice involved individuals with behavioral health disorders.

The products of the Sequential Intercept Model workgroup culminated with the recommendation of formalizing a county wide planning body to address the needs of justice involved persons with co-occurring mental health and substance use disorders being the number one priority. PRA concurs with this as the top priority, as formalized planning bodies promote the needed communication, collaboration and coordination which must be present in order for quality diversion programs and efforts to occur. Los Angeles County currently has a number of mental health and criminal justice initiatives that already involve criminal justice partners and can either directly support the work of the county wide planning body or that can be integrated with the work of the planning body. Existing efforts include, but are not limited to: Integrated Behavioral Health Information Systems (IBHIS); The Corporation for Supportive Housing (CSH) Mental Health, Jail Diversion and Supportive Housing Proposal; CSH/Department of Mental Health (DMH) funded Emergency Room diversion programs; and Advancing Safe and Healthy Homes Initiatives/DMH Healthy Homes Initiative. It will be critical for this county wide planning body to not only consider how it will relate to these on-going planning efforts, but also how it will influence the planning and implementation of future efforts.

The quality and growth of this formalized planning body is strongly supported by the second priority, which calls for the utilization of data analysis and data matching to better inform decisions regarding diversion opportunities for justice involved persons with behavioral health disorders. Additionally, the second priority recommends the creation of a criminal justice/mental health technical assistance/resource center. PRA concurs with the priority level of this recommendation and has extensive experience working with Centers of Excellence, including those in Ohio, Illinois, Florida and Pennsylvania. Los Angeles currently has a number of key experts county-wide who can be utilized to implement its specialized center for communication, coordination and collaboration.

At the conclusion of the Los Angeles County systemwide summit and Sequential Intercept Mapping workshop, PRA took note that there are several on-going initiatives, some of which have been identified above, that currently address identified gaps or can increase access to care for justice involved individuals with behavioral health disorders if awareness is raised and needs identified. Rather than taking a heavy focus on the development of new initiatives and resources, PRA is instead utilizing an "adapt and expand" approach to the priorities and recommendations stemming out of the gaps identified during the Sequential Intercept Mapping workshop. This "adapt and expand" approach is designed to not only improve county-wide system response to justice involved persons with behavioral health disorders, but also to create additional capacity to better reach and engage this underserved population of individuals in Los Angeles County.

At **Intercept 1**, PRA recommends that Los Angeles County enhance/expand law enforcement's specialized response and mental health crisis response, such as Systemwide Mental Assessment Response Teams (SMART), Mental Evaluation Teams (MET), and Crisis Intervention Teams

(CIT). There are also insufficient resources available for Los Angeles County's Psychiatric Mobile Response Teams (PMRT). Participants in the Summit Workshop and Mapping Workshop were satisfied with the quality of these law enforcement specialized response and mental health crisis response teams; however, multiple participants cited examples noting the need for additional resources and expansion to better serve and have a broader impact for justice involved individuals with behavioral health disorders. PRA makes this recommendation based upon our extensive nationwide work with specialized law enforcement and mental health crisis response systems such as CIT, as well as our current work with Intercept 1 Early Diversion Substance Abuse and Mental Health Services Administration (SAMHSA) grantees in Colorado, Tennessee and Connecticut. It will be important for Los Angeles County to include criminal justice/behavioral health partners such as law enforcement, crisis stabilization centers, and psychiatric emergency departments in these enhancement/expansion planning meetings.

At **Intercept 2**, PRA recommends the expansion of diversion opportunities at arraignment and the improvement of screening efforts for diversion at later stages. The DMH Mental Health Court Linkage Program is an innovative resource that Los Angeles County has operated for 10 years. Mapping workshop participants reported that the program's capacity to serve persons has not increased during that same period. Utilization of this program was uneven across the county and there was a lack of alignment between the judiciary, prosecutors and the Court Linkage Program regarding diversion philosophy. It is also recommended at Intercept 2, that Los Angeles County implement a Probation Pre-Trial Release program. There is a notable absence of Intercept 2 diversion opportunities present for justice involved persons with behavioral health disorders in Los Angeles County. PRA has seen the value of diversion efforts at this Intercept based upon our work over the last dozen years with just under 20 SAMHSA grantees from across the United States engaged in Targeted Capacity Expansion (TCE) jail diversion efforts.

At **Intercept 3**, PRA recommends the expansion of post-arraignment diversion opportunities for defendants with behavioral health disorders who are charged not only with misdemeanors, but also low level felony offenses. Strategies listed above in Intercept 2 also apply for this Intercept. Expanding capacity for the DMH Court Linkage Program, improving stakeholder alignment regarding diversion and implementing a pre-trial supervision program can increase potential diversion opportunities at Intercept 3. In addition, adding a jail diversion screening component at the jail can increase identification of potential diversion candidates. Jail diversion staff can work with the Court Linkage Program and defense counsel to present a diversion plan to the courts. Diversion strategies at this Intercept should seek to minimize collateral sanctions, such as the housing and employment barriers which are often present for individuals post-incarceration. For justice involved persons with behavioral health disorders, these collateral sanctions also impede recovery. Specialty courts are not required for Intercept 3 diversion. Pre-trial supervision or periodic status updates by providers to the court for proscribed time frames can be very effective as well. For more serious felony level charges, persons can be sentenced to probation with conditions tailored to mental health treatment if appropriate.

At **Intercept 4**, PRA recommends expanding the capacity of the DMH Jail Navigator program as well as the capacity of existing reentry programs found through providers such as: Just In Reach, the Los Angeles City Attorney's Office HALO Program, Women's Reentry Court, and the Los Angeles Sheriff Department's Community Reentry Center. Both the Summit and Mapping workshop participants identified extensive resources devoted to reentry planning. Many of these programs reported being able to service additional individuals with additional funding. The DMH Jail Navigators in particular were identified as needing more resources to keep pace with the high volume of referrals and short time frames with which to link individuals to needed services at the point of reentry, including behavioral health and support services.

At **Intercept 5**, PRA recommends the provision of training on the Risk, Need, Responsivity (RNR) and Cognitive Behavioral Health Interventions. Other than housing, which was a gap across all Intercepts, there were not any specific gaps or priorities identified in this Intercept. There are many Best Practices and innovative programs operating within Los Angeles County at this Intercept, including specialized mental health Probation Department caseloads, co-location of mental health staff in Probation Department offices and peer-run programs for Probation clients. The Probation Department performs risk assessments to determine supervision and program needs utilizing RNR principles to manage caseloads. It is important to uniformly share risk assessment information with behavioral health providers and to expand RNR training and Cognitive Behavioral Training to include behavioral health providers in order to insure that criminogenic needs are addressed in behavioral health settings.

The prevalence of individuals with behavioral health disorders in jails and prisons is higher than in the general population. PRA has seen that, on a national level, alternatives to incarceration have gained momentum as a humane and cost effective strategy to reduce criminal justice costs and improve access to needed services and supports without compromising public safety. The early identification of individuals with behavioral health needs at each level or Intercept of contact with the criminal justice system can improve not only their access to care, but also long-term treatment outcomes. The effects of these types of interventions are increasingly showing promise with benefits to society and the potential for long term cost savings.

Los Angeles County District Attorney's Office

Sequential Intercept Mapping Report – LA County, CA

Prepared by: Policy Research Associates, Inc.
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Travis Parker, M.S., L.I.M.H.P., C.P.C

Acknowledgement

PRA wishes to thank the Los Angeles County District Attorney's Office for the assistance with the coordination of this event.

Introduction:

The Los Angeles County District Attorney's Office contracted with Policy Research Associates (PRA) to develop behavioral health and criminal justice system maps focusing on the existing connections between behavioral health and criminal justice programs to identify resources, gaps and priorities in Los Angeles County, CA.

Background:

The *Sequential Intercept Mapping workshop* has three primary objectives:

1. Development of a comprehensive picture of how people with mental illness and co-occurring disorders flow through the criminal justice system along five distinct intercept points: Law Enforcement and Emergency Services, Initial Detention and Initial Court Hearings, Jails and Courts, Re-entry, and Community Corrections/Community Support.

2. Identification of gaps, resources, and opportunities at each intercept for individuals in the target population.

3. Development of priorities for activities designed to improve system and service level responses for individuals in the target population.

The participants in the workshops represented multiple stakeholder systems including mental health, substance abuse treatment, health care, human services, corrections, advocates, individuals, law enforcement, health care (emergency department and inpatient acute psychiatric care), and the courts. Dan Abreu, M.S., C.R.C., L.M.H.C., and Travis Parker, M.S., L.I.M.H.P., C.P.C., Senior Project Associates for SAMHSA's GAINS Center for Behavioral Health and Justice Transformation and Policy Research Associates, Inc., facilitated the workshop session.

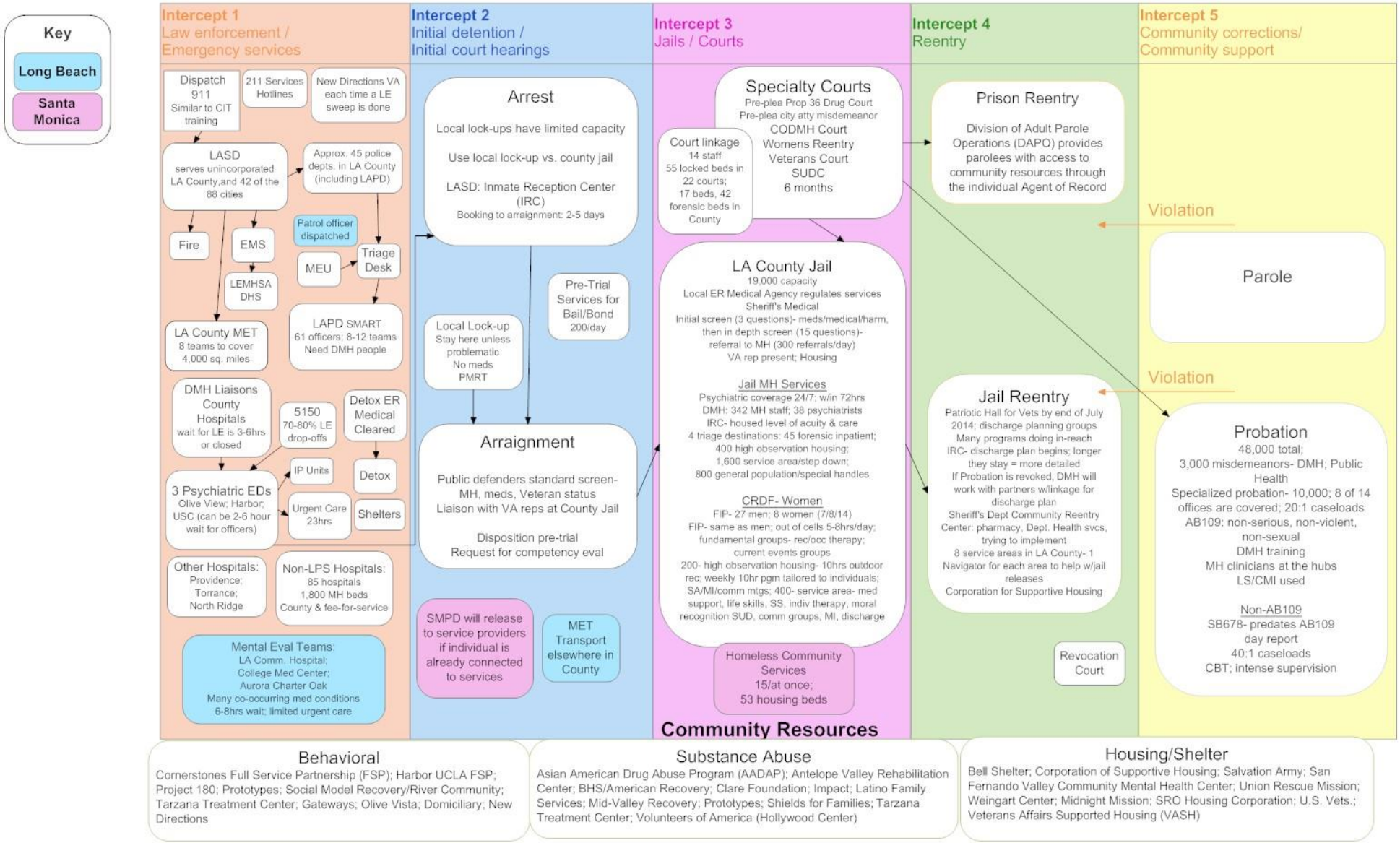
Forty-six (46) people were recorded present at the LA County SIM.

Follow-Up to Mental Health Summit
Sequential Intercept Mapping and Action Planning Workshop
Los Angeles County District Attorney's Office
July 8, 2014

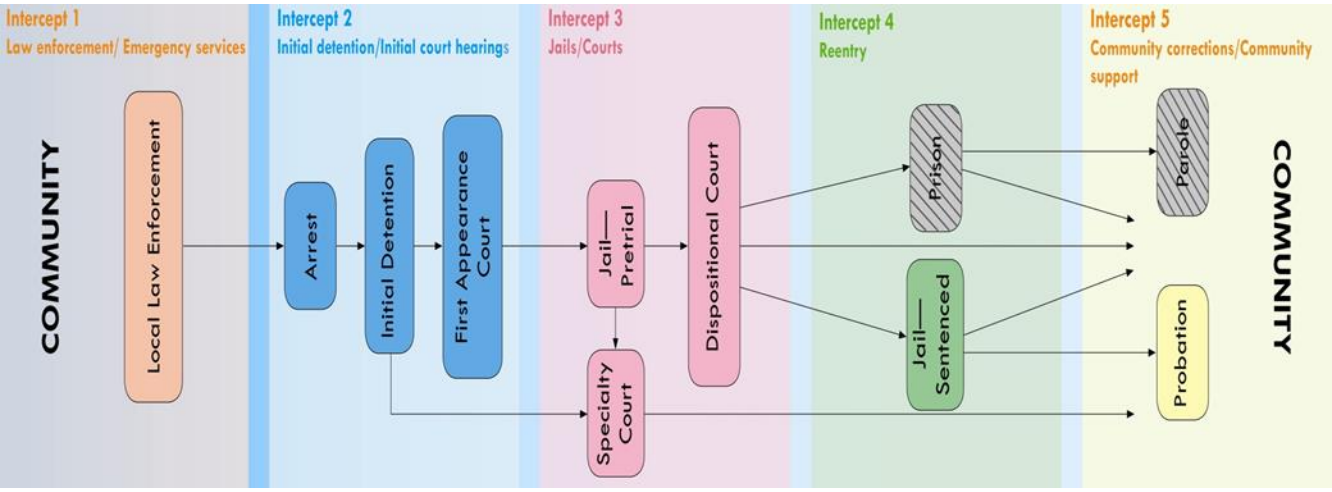
8:00- 8:30a.m.	**REGISTRATION AND CONTINENTAL BREAKFAST**
8:30 – 8:45 a.m.	**WELCOME BY DISTRICT ATTORNEY JACKIE LACEY**
8:45 – 9:45 a.m.	**REVIEW SUMMIT BREAKOUT GROUP PRIORITIES**
9:45 – 10:00 a.m.	**BREAK**
10:00 a.m. – 12:00 p.m.	**MAPPING L . A . EXCERCISE FOR INTERCEPTS I, II/III, AND IV/V**
12:00- 1:00 p.m.	**LUNCH**
1:00- 2:30 p.m.	**MAPPING L . A . (Cont.)**
2:30 – 2:45 p.m.	**BREAK**
2:45 – 3:15 p.m.	**REFINE AND VOTE ON PRIORITIES**
3:15- 4:00 p.m.	**ACTION PLANNING IN INTERCEPT GROUPS**
4:00 – 4:30 p.m.	**REPORT-OUTS TO FULL GROUP**

Special thanks to the California Endowment and the Aileen Getty Foundation for their generous support.

Los Angeles County Sequential Intercept Map



Intercept 1



Resources

- Long Beach Police Department has one Mental Evaluation Team (MET) available per day (usually for one shift between 7 a.m. and 1 a.m. depending upon the day of the week).
- Local police departments or the Sheriff's Department will "triage" calls as they come in and determine if the fire department, Emergency Medical Services, etc. is needed for a response as well.
- LA County: 23 Sheriff's stations to serve 42 out of the 88 cities in LA County. Eight (8) MET teams, but only 2-3 on at any given time
- The LAPD dispatcher received Critical Incident Team-like training course. Thirty (30) or more are on duty in the San Fernando Valley.
    - SMART Team can be dispatched upon patrol's request; 8-12 teams per day; 61 staff members.
    - Patrol must contact EMS for direction.
- There are 99 hospitals scattered throughout LA County.
- Long Beach has hospitals; however they have limited psychiatric capacity.
- The Urgent Care Center is a possible alternative to the Emergency Department, although there are capacity issues.
- Private hospitals (Providence) cannot release individuals, which is easier for law enforcement.

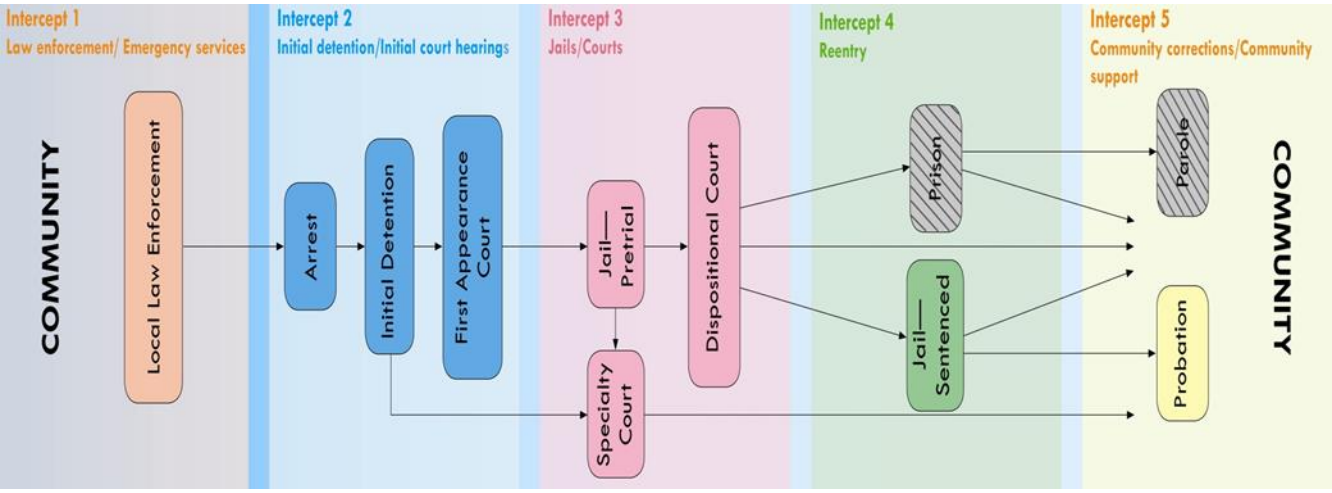
- Aurora Charter Oak and College Hospital-Cerritos have 6 law enforcement beds each, as well as 3 for youth.
- Psychiatric Emergency Departments offer some system decompression and serve as a valuable resource for law enforcement.
- County-wide resource management
- Department of Mental Health liaisons are available/working in inpatient units and Emergency Departments for linkage, as well as linkage/referrals for those without insurance.
- The Corporation for Supportive Housing and the Department of Health Services co-fund an emergency room diversion program.
    - CSH funds 15 hospitals
    - DHS funds 3 hospitals
- County hospital has DMH/DHS databases. A new Integrated Behavioral Health Information Systems data system is on the way.
- AB 1424- Family Form: "You shall take family information about mental illness"
- Street to Home (FUSE): housing voucher and mental health services
- The University of Southern California has an integrated urgent care facility.
- Santa Monica has mental health staff within the police precinct.
- West LA (Skid Row) has a clinician within the police precinct.

Gaps

- Long Beach PD patrol officers have limited training.
- Once the Long Beach MET has been activated, patrol officers are on their own if a psychiatric crisis arises in the meantime.
- The LAPD SMART Teams function 20 hours per day. During the remaining 4 hours each day, the triage of psychiatric crisis calls transitions to the command post.
- It is often more time efficient for law enforcement to book an individual into jail on a minor charge in order to get back into service more quickly, rather than spend many hours waiting in a psychiatric emergency department for the individual to be seen.
- While there are approximately 1,800 hospital beds throughout LA County for psychiatric purposes, only a small percentage of those beds can actually be accessed by individuals who are uninsured or who most frequently come into contact with law enforcement.
- 70-80% of law enforcement drop offs are at the Emergency Department.

- The police can wait up to 3-5 hours in psychiatric emergency departments due to capacity issues. Law enforcement cannot go back into service until the individual is seen by a psychiatrist. Long Beach does not have the resources for a 6-8 hour wait, as staff are working 10 hour shifts.
- Capacity issues at the emergency department cause delays/waits for law enforcement.
- The Volunteers of America Center had a detox program which lost funding.
- Long Beach does not have a practical and available detox facility.
- There are a lack of emergency department and inpatient hospital discharge planning options. Some are referred to urgent care, while others are referred to inpatient treatment or rehabilitation beds.
- There is not a service capacity priority given to persons who are discharging from emergency departments or hospitals for community based treatment.
- There is often a “communication gap” between social workers, community agencies and family members in assisting an individual during their transition from hospital-based to community-based care. If the individual does not sign a release of information form, the social worker will typically not speak with anyone, even in instances of care transitions, coordination, etc. This frequently causes stress and poor outcomes for individuals who already cycle in and out of the criminal justice system, as well as costly, more intense behavioral health treatment settings.
- There is a lack of state support for Crisis Intervention Teams (CIT).
- Private facilities have difficulty with discharge planning and poor family access.
- Law enforcement/crisis response is needed for Veterans.
- Long Beach Urgent Care is not designated to evaluate and treat persons involuntarily detained for mental health reasons under the Lanterman-Petris-Short (LPS) Act.
- Urgent care facilities are needed throughout LA County.
- Centralized drop off locations for law enforcement are needed throughout LA County in an effort to make early diversion a reality.
- Long Beach brings inebriates to jail instead of to a detox center/facility.

Intercepts 2 & 3



Resources

- Psychiatric Mobile Response Teams consist of Department of Mental Health licensed clinical staff assigned to a specific Service Area in Los Angeles County. These licensed clinical staff have the authority to initiate applications for evaluation of involuntary detention.
- The LAPD has access to 21 local lock up facilities throughout the county.
- The Long Beach- MET team can provide reach-in services when individuals are already in lockup and state that they feel like harming or killing themselves.
- Santa Monica- the individuals can be released from local lock-up to a known provider.
    - Ocean Pacific Community Center
    - St. Joseph Center
- LASD Inmate Reception Center (IRC)
    - A 15 question screen is utilized
    - 1,000 booked daily; 1/3 are referred
    - 342 mental health staff (of which 38 are psychiatrists)
    - 24/7 psychiatric coverage
- The Public Defender screens for mental health/veteran status.
- Veterans resources
    - Long Beach/LA for resources
- The LA County Jail has psychiatric coverage 24/7/365, either in person or over the telephone.

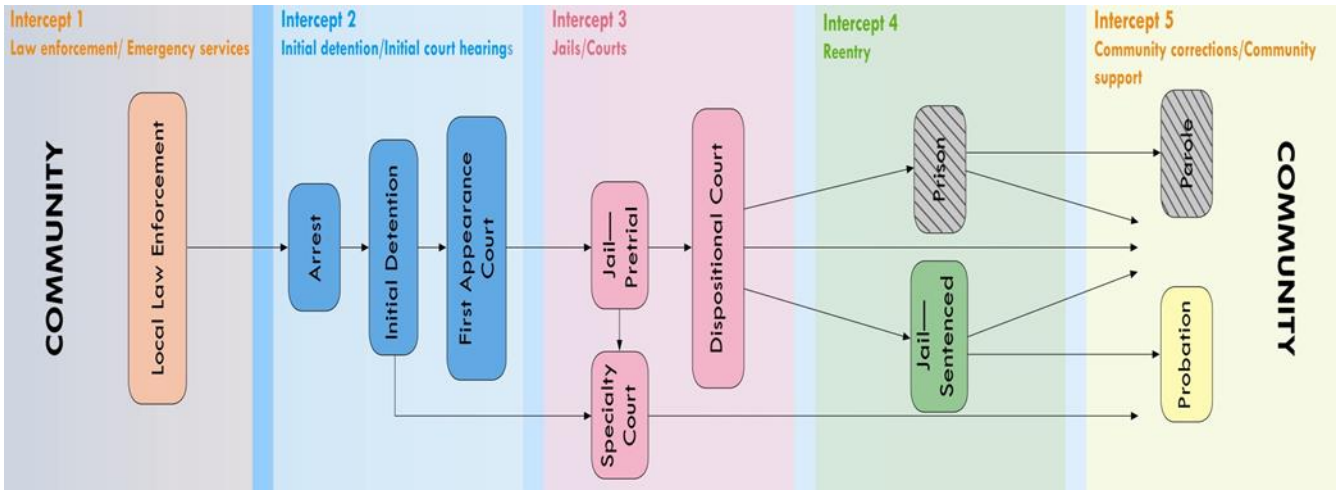
- Co-occurring disorders court diversion is available.
- Mental Health Court Linkage Program has 14 staff members serving 22 courts in LA County to assist with diversion and release to services.
- Sentenced offenders Drug Court- Homeless Community Court- Santa Monica; last created specialty court in 2006-2007 (felonies, generally nonviolent)
- Co-occurring Drug Court- Proposition 36- LA countywide post-conviction
- Specialty courts: Women's Reentry, Veteran's Court, Mental Health Court
    - All generally accept non-violent felonies.
- AB 109
- Revocation
- Department 95
- Mobile crisis with housing vouchers
- Integrated clinics
- Institutes of Mental Disease (IMD) step down programs- residential treatment and living situations
- Abandoned property could be used for housing.
- Shared/congregate housing
- Innovative locally-funded (non-HUD) housing models
- Funding is available to match with people who meet criteria.
- Co-located probation and treatment or peer support groups

Gaps

- There is no medication in lockup; this poses problems, particularly on weekends.
- At the LA County Jail, it can take up to 72 hours for an individual to be seen for needed psychiatric medications.
- Long Beach- no assessment or clinical presence
- Develop strategies for multi-disciplinary and collaborative approaches.
- No formalized Intercept 2 diversion exists at the current time.
- It is extremely rare for the Mental Health Court Linkage Program to get someone into services at the point of arraignment court.
- At the time of lockup, there is a heavy reliance primarily upon the individual to self-report key health information.
- No supervised Pretrial Release Program

- No pre-plea diversion
- Specialty courts have very limited capacity and only address a small fraction of cases which could go to specialty courts.
    - Funding is needed to expand capacity.
    - Very restrictive criteria to get into specialty courts
    - Lack of service providers to work with/be dedicated to specialty court participants
- Specialty courts are post-conviction courts; this allows the person to penetrate the criminal justice system even farther.
- Jail-based diversion via non-specialty courts is needed.
- Additional funding for court linkages is needed.
- The capacity of courts and treatment services has remained the same for the last 10-15 years.
- Small numbers of Supportive Housing slots
- Housing requirements are very restrictive for persons with mental health issues and criminal histories.
- The housing demand is much greater than the supply.
- “Not in my backyard” (NIMBY) housing issues throughout LA County

Intercepts 4 & 5



Resources

- 211 services hotline
- Patriot Hall Veterans
- 30-45 days of notice from jail release- can get on the medical list to make certain they leave the jail with a paper MediCal card
- Families are part of the solution.
- Track recidivism rates
- Jail and court linkages work together.
- The LA Sheriff's Department has a Community Reentry Center that has been open since July 2014.
    - Referrals to job centers, substance abuse treatment, assistance with benefits, mental health services and health insurance
- The LA County Jail can keep persons for up to 16 hours after their scheduled release date for further discharge planning/transitioning.
- Productive programs are now in place at the jail for mental health.
- Mental health clinicians are embedded within the Probation Department.
    - Receive information from the prison/jail; transfer information to providers

  - 35% are rearrested
- Area offices in multiple locations
- Probation has assumed parole functions with AB 109- Specialized probation- 10,000; 8 of 14 offices are covered with specialized probation; 20:1 caseloads
- Mental health is co-located at Probation Department hubs.
- AB 109 funds the services.
  - Not for the other 48,000 on supervision
  - Work with the Department of Mental Health to establish training on recognizing mental health
- Day Reporting Centers- the state allocated funding to counties for evidence-based practices for adults.
- Probation uses the Level of Service/Case Management Inventory to determine needs and risk assessment.
- Probation is exploring the utilization of SB 678 funds (which predates AB 109) to develop services for the probation population which has served time in state prison and is not AB 109 eligible.
- The National Alliance on Mental Illness could be better utilized to connect individuals discharging from incarceration with their families or other key supports who will be critical to their success and increased community tenure.

Gaps

- Lack of immediate/emergency housing
- Prison release: family connections need to be made sooner; a warm handoff to the families is needed at discharge.
- Little lead time for the jail navigator to put services in place
- Each Service Area has a jail navigator, but oftentimes they are overwhelmed. For example, San Fernando only has one jail navigator for the entire area.
- The LA Sheriff's Department Community Reentry Center is only able to be open 5 days per week.
- The jail has many services, but many inmates have not heard of reentry services.
- With so many inmates incarcerated at the LA County Jail, it is often difficult for good discharge planning and handoffs to occur.
- Probation is generally not available for misdemeanor offenders. Misdemeanor diversion is strongly needed.

- Dr. Frank Pratt (Medical Director for the LA County Fire Department) discussed how being on MediCal offers fewer physical and behavioral health treatment options than having no insurance coverage in some instances.
- There is a need for more Integrated Health Homes. Existing Integrated Health Homes are underdeveloped at this time.

Priorities for Change as Determined by Mapping Participants

- Training for all criminal justice professionals in the system- multi-disciplinary and holistic (17 votes)
- Expand capacity for treatment- continuum of care- for justice-involved persons (16 votes)
    - How much is needed?
    - What is the population?
- Data study to examine services needed, capacity needed, populations most in need, etc. (12 votes)
- Better communication/coordination between all system partners/data system/remove silos; develop policies and procedures to guide capacity utilization; develop resource database (10 votes)
- Crisis Alternative Centers/Crisis Stabilization Centers- law enforcement, families, individuals (9 votes)
- Expand housing for justice-involved persons (8 votes)
- Funding for initiatives and sustainability (4 votes)
- Define future configuration of Mental Health Court/Court Diversion (3 votes)
- Implement a pre-booking diversion program. Shorter drop-off times for law enforcement (3 votes)
- Creation/re-creation of an Intercept 2 diversion point (2 votes)
- Public education about behavioral health, homelessness, stigma, etc. (1 vote)
- Expand/enhance co-response models Psychiatric Mobile Response Teams, SMART, etc. (1 vote)

RECOMMENDATIONS:

Participants in the Summit and Sequential Intercept Mapping Workshop (SIMW) showed genuine interest and commitment to improve the continuum of resources available to justice involved persons with behavioral health disorders. Los Angeles County has many exemplary programs and strategies on which to build. As noted below, there are several on-going initiatives that currently address gaps identified in the report (e.g., SB 82) or can increase access to care for justice involved individuals with behavioral health disorders if awareness is raised and needs identified.

Rather than focusing on the development of new initiatives and resources, the focus of the 11 recommendations listed below is to "Adapt and Expand."

1. *Formalize a County Wide Planning Body to address the needs of justice involved persons with co-occurring mental health and substance use disorders.*

This recommendation is consistent with Recommendation 5 (p.19) of the Task Force for Criminal Justice Collaboration on Mental Health Issues: Final Report (April 2011). http://www.courts.ca.gov/documents/Mental_Health_Task_Force_Report_042011.pdf

The first and fifth ranked priorities from the SIMW, as voted on by the participants, identified the need for improved cross system training, communication and planning. Workshop participants expressed the need for on-going dialogue, joint planning and increasing awareness regarding system resources. Implementation of initiatives to increase diversion opportunities will require involvement of a broad group of stakeholders with sufficient authority to impact state, county and municipal level change. An LA County planning body should coordinate activities with the Task Force for Criminal Justice Collaboration on Mental Health Issues, which is prepared to implement recommendations from its 2011 report.

Bexar County (Texas), Memphis (Tennessee), New Orleans Parish (Louisiana), and Pima County (Arizona) are examples of counties and municipalities that have developed Criminal Justice Mental Health Planning Committees.

Los Angeles County has 88 cities, 7 of which have over 100,000 residents. As a result, Criminal Justice/Mental Health resources, needs and strategies across the county vary widely. Development of additional localized planning structures to coincide with Department of Mental Health (DMH) Service Areas, judicial districts or municipal regions may facilitate planning, development and the implementation

of programs. Existing DMH Systems Flow Charts can also prove useful in supporting some of this work (Appendix 1).

2. Data Analysis/Matching; Add a County CJ/MH Technical Assistance/Resource Center.

The fourth highest priority identified during the SIMW was to utilize data to inform decisions. Across Intercepts there has been limited data collection and sharing of existing data regarding persons with mental illness in the justice system. Without adequate screening and data collection, it is difficult to identify and prioritize service needs, plan interventions, and target resources for the highest need and highest risk populations.

Participants acknowledged having data on existing programs, but data is not routinely analyzed to inform planning priorities, often due to a lack of resources and data not being strategically disseminated to interested stakeholders.

Resources to address data collection/analysis strategies include:

- The Urban Justice Institute published "Justice Reinvestment at the Local Level Planning and Implementation Guide" http://www.urban.org/publications/412233.html

  The guide offers an excellent overview of planning, data collection and justice reinvestment strategies across the criminal justice system.

- The "Mental Health Report Card" used by the King County, Washington Mental Health, Chemical Abuse and Dependency Services to document progress in meeting relevant client outcomes http://www.kingcounty.gov/healthservices/MentalHealth/Reports.aspx

- Data matching between jail admission data bases and community provider databases, as is done in Maricopa County, AZ as described in, *"Using Management Information Systems to Locate Persons with Serious Mental Illnesses and Co-occurring Disorders in the Criminal Justice System for Diversion"* http://gainscenter.samhsa.gov/pdfs/jail_diversion/using_mis.pdf and in the Illinois Jail Data Link Program, (Appendix 2).
- In 2013, the LA County DMH Jail Team developed a Pre-booking Diversion Proposal, "An Open Door to Recovery" which included a prevalence study of potentially divertible individuals

in Antelope Valley and Long Beach. The study's conclusion was that 72 individuals per day were potentially divertible from jail. This analysis is an excellent example of how data can confirm need and focus system resources. (Appendix 3)

The first and fifth ranked priorities by the participants identified the need for better cross system training, communication and planning. Recommendation 1 focuses on the need for a criminal justice/mental health planning structure.

With a county as large and complex as Los Angeles, there is a need for a resource center where criminal justice/mental health resources, events, and Initiatives can be centralized to:

- Disseminate information
- Track diversion activity
- Publish performance outcome measures
- Aid in planning
- Provide published resources
- Provide Technical Assistance and Training

Such a center can be modeled after technical assistance centers (Centers of Excellence - CoE) in the following states:

- Ohio Coordinating Center of Excellence (CCOE) http://www.neomed.edu/academics/criminal-justice-coordinating-center-of-excellence
- Illinois Center of Excellence for Behavioral Health and Justice
  University of Illinois Rockford
  http://www.illinoiscenterofexcellence.org/
- University of South Florida, Criminal Justice Mental Health Reinvestment Technical Assistance Center http://www.floridatac.com/
- Pennsylvania Mental Health and Justice CoE

  http://www.pacenterofexcellence.pitt.edu/

3. Integrate Task Force Activities with system wide initiatives.

LA County has a number of mental health and criminal justice initiatives that can either directly support the work of the Task Force or that can be integrated with the work of the Task Force. Some of these initiatives already involve criminal justice partners. It will be critical for this Task Force to not only consider how it will relate to on-going planning efforts, but also how it will influence the planning and implementation of future efforts. Existing efforts include, but are not limited to:

- Healthy Way LA
- Integrated Behavioral Health Information Systems (IBHIS)
- Mental Health and Wellness Act of 2013
- AB 109 Funding
- Corporation for Supportive Housing (CSH) Mental Health, Jail Diversion and Supportive Housing Proposal (Appendix 4)
- CSH/DMH funded Emergency room diversion programs
- Policy Research Associates through its SAMHSA GAINS Technical Assistance Center recently provided a Train the Trainer event: *How Being Trauma-Informed Improves Criminal Justice System Responses*. The lead agency for the event was Tarzana Treatment Centers, which provides Seeking Safety Training as part of the Healthy Way LA initiative and provides outreach recruitment services into the jail for transitional housing programs. For a list of trainees at the recent event see Appendix 5.
- Program planning for LA County's new jail
- Advancing Safe and Healthy Homes Initiative/DMH Healthy Home Initiatives

4. Integrate Peer Programs and Peer Support Staff into planning and service delivery.

This recommendation is consistent with Recommendation 73 (p.42) of the Task Force for Criminal Justice Collaboration on Mental Health Issues: Final Report. The California Health Report recently published an article regarding Peer Respite Centers (Appendix 6). The programs described are excellent examples of utilization of peer models and an opportunity to adapt and expand existing programs.

Participants reported peer involvement in service delivery at various Intercept points.

Peer involvement in the Summit and Mapping Workshop was minimal. It is recommended that peers be formally involved in planning efforts moving forward. Depending on whether or not peers are currently employed, they may need stipends to travel to meetings, for meals and/or be paid for their time.

5. Expand screening for Veterans across Intercepts. Allow early diversion and misdemeanor alternatives for Veterans.

There is currently a felony, post-conviction Veterans Court in LA County. While this program is an important component of diversion alternatives for Veterans, providing diversion for misdemeanors, as well as lesser felony offenses earlier in the court process will allow for earlier intervention and likely better outcomes for Veterans. [It should be noted here, as well as throughout this document, "diversion" means diversion from jail or prison, as opposed to the more narrowly circumscribed statutory authorized diversion set forth in California Penal Code section 1000 et seq.]

Using the "Adapt and Expand" philosophy, LA County already has substantial resources for Veterans. Aside from the Department of Veterans Affairs services, the following programs, for example could be adapted, expanded or linked to diversion activities:

- Los Angeles City Attorney's Office HALO program
- Los Angeles City Attorney's Office VALOR program
- Patriotic Hall

In addition, the Department of Mental Health has Veteran specific mental health programs which could service Veterans who are not eligible for VA services or who do not wish to utilize VA services.

6. Consider broad approaches to improving accessible housing for justice involved individuals.

This recommendation is consistent with Housing Recommendations (pp.43 and 44) of the Task Force for Criminal Justice Collaboration on Mental Health Issues: Final Report.

Both Summit Participants and Mapping Workshop participants identified housing as a critical gap across Intercepts.

LA County is fortunate to have the Corporation for Supportive Housing as a stakeholder and they have already proposed housing strategies for justice involved individuals (Appendix 4).

INTERCEPT SPECIFIC RECOMMENDATIONS:

Intercept 1

7. Enhance/Expand Police Specialized Response and Mental Health Crisis Response, such as Systemwide Mental Assessment Response Teams (SMART), Mental Evaluation Teams (MET), and Crisis Intervention Teams (CIT).

This recommendation is consistent with Recommendations 7 and 8 (pp.19 and 20) of the Task Force for Criminal Justice Collaboration on Mental Health Issues: Final Report.

Expansion of specialized police response (e.g., SMART, MET, CIT) and improved crisis response was the third highest ranked priority identified in the SIM Mapping Workshop. In addition, participants in the Mental Health Summit, Intercept 1 Workgroup also identified insufficient resources for Psychiatric Mobile Mental Response Teams (PMRT) and crisis response options as gaps.

Participants in both the Summit Workshop and Mapping Workshop were satisfied with police specialized response teams, but noted that the LAPD SMART Team responds to approximately 35% of all calls. Elsewhere in the County, specialized police response is available in Long Beach and Santa Monica, as well as through the Los Angeles Sheriff's Department, which has 8 MET teams.

Participants in the Summit Workshop and the Mapping Workshop identified lack of crisis response options, especially crisis stabilization units as a significant gap. The Long Beach Police Department in particular identified long wait times (up to 6-8 hours) in area emergency departments as a significant issue. Participants noted that waiting for an available psychiatrist in the psychiatric emergency departments often accounted for delays. Lengthy delays for these types of important diversionary services often leave law enforcement with the difficult decision of whether to spend several hours "out of service" with a person while he or she waits to be seen in an emergency department or a psychiatric emergency department or, in the alternative, to take the person into custody, book him or her into a local jail, and return to service. The Psychiatric Mobile Mental Response Teams were also seen as valuable partners, but participants noted that there were insufficient resources to meet demands.

The Department of Mental Health has several initiatives underway to address this recommendation (Appendix 7).

Representatives from the City of Long Beach also identified a lack of a detoxification (sobering) facility, which has resulted in serial inebriates being incarcerated. San Diego has had a successful Serial Inebriate Program for several years and information about their program can be found at: http://www.sandiego.gov/sip/index.htm

Intercept 2

8. Expand diversion opportunities at arraignment and improve screening for diversion at later stages:

- *Bring the Department of Mental Health Court Liaison Teams to scale.*
- *Improve alignment regarding diversion at this intercept among stakeholders.*
- *Implement a Probation Pre-Trial Release Program*

This recommendation is consistent with Recommendations 12,15,16,17 and 18 (pp. 23-24) of the Task Force for Criminal Justice Collaboration on Mental Health Issues: Final Report.

Systemic screening for mental health issues and Veteran status is not present at the first court appearance or arraignment. Key mental health screening partners at this diversion point are defense counsel and the Probation Department. Resources may have to be added to these agencies to enhance screening and referral.

The DMH Mental Health Court Linkage Program is an innovative resource that LA County has operated for 10 years. Participants reported that the program's capacity to serve persons has not increased during that same period. Utilization of the DMH Court Liaison Program, a component of the Mental Health Court Linkage Program, was uneven across the county and there was a lack of alignment between the judiciary, prosecutors and Court Liaison Program regarding diversion philosophy.

Participants also expressed the opinion that housing was a barrier to diversion at this Intercept. While housing would likely improve successful diversion, diversion can be successful with individuals who are homeless, as demonstrated by the New York City CASES Transitional Case Management Program (Appendix 8). Reports from the Court Liaison Program also indicate that successful diversion can be accomplished with individuals who are homeless.

Diversion programs which emphasize engagement strategies, direct linkage, focus on immediate needs, and prompt access to community services can be successful even when there are not significant court sanctions available.

People with mental illness have more bail risk factors and are more likely to be remanded to jail. Pre-trial supervision programs allow for greater access to pre-trial release for persons with mental illness.

When additional court leverage is preferred, implementation of a Probation Department pre-trial supervision program can reassure the court that individuals are appropriately monitored and held accountable for adhering to release conditions.

Intercept 3

9. Expand post-arraignment diversion opportunities for defendants charged not only with misdemeanors but also felonies.

This recommendation is consistent with Recommendations 12,15,16,17 and 18 (pp. 23-24) of the Task Force for Criminal Justice Collaboration on Mental Health Issues: Final Report.

Strategies listed above in Intercept 2 also apply for this Intercept. Expanding capacity for the Court Liaison Teams, improving stakeholder alignment regarding diversion and implementing a pre-trial supervision program can increase diversion opportunities.

In addition, adding a jail diversion screening component at the jail can increase identification of potential diversion candidates. Jail diversion staff can work with the Court Liaison Team and defense counsel to present a diversion plan to the courts.

Diversion strategies at this Intercept should seek to minimize collateral sanctions, such as barriers to employment, housing, court fines, access to public benefits and voting rights. The Legal Action Center's ***After Prison: Roadblocks to Reentry*** (http://www.lac.org/roadblocks-to-reentry/) is an excellent review of sanctions which create employment and housing barriers and impede recovery.

Specialty Courts are not required for Intercept 3 diversion. Pre-trial supervision or periodic status updates by providers to the court for proscribed time frames can be effective. For more serious charges, persons can be sentenced to Probation with appropriate conditions.

Court Self-Help Centers could help address the unplanned releases from courts (see "Task Force for Criminal Justice Collaboration on Mental Health Issues: Final Report" Recommendation 39, p.30).

Intercept 4

10. Expand DMH Jail Navigator capacity and capacity of existing reentry programs.

Both the Summit and Mapping Workshop participants identified extensive resources devoted to reentry planning. Many of these programs reported being able to service additional individuals with additional funding. The DMH Jail Navigators in particular were identified as needing more resources to keep pace with the high volume of referrals and short time-frames with which to link individuals to services. Other providers include, but are not limited to:

- Just In Reach
- HALO Program
- Women's Reentry Court
- LASD Community Reentry Center

Intercept 5

11. Provide training on the Risk, Need, Responsivity (RNR) and Cognitive Behavioral Interventions.

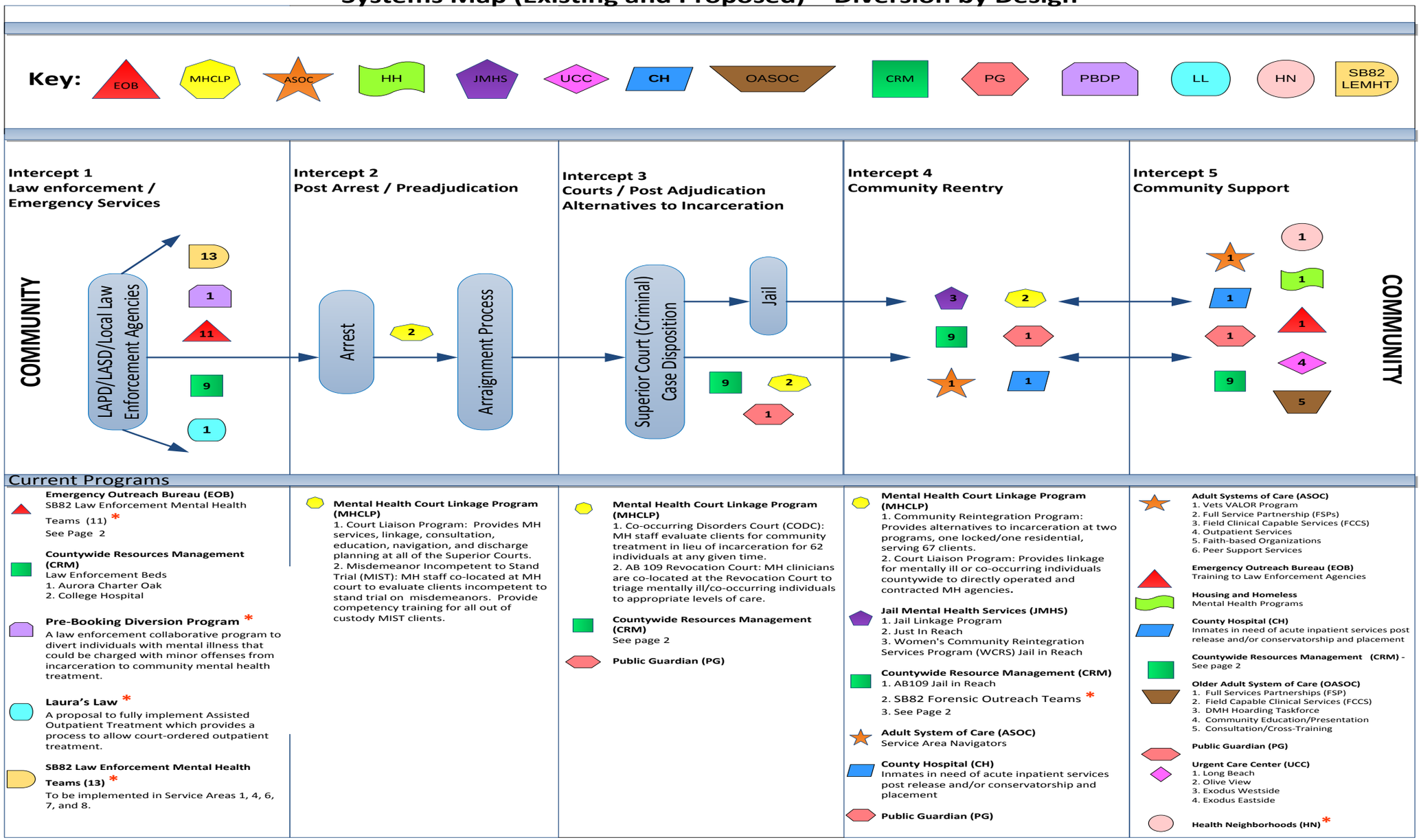
This recommendation is consistent with Recommendations 57, 60, 62, 63 and 64 (pp. 36-37) of the Task Force for Criminal Justice Collaboration on Mental Health Issues: Final Report.

Other than housing, which was a gap across all Intercepts, there were no specific gaps or priorities identified for this Intercept. There are many best practices and innovative programs operating at this Intercept, including specialized mental health Probation caseloads, co-location of Department of Mental Health staff in Probation Department offices and peer-run programs for Probation clients.

The Probation Department performs risk assessments to determine supervision and program needs utilizing the Risk, Need, Responsivity (RNR) principle. This principle targets specific criminogenic risk factors to reduce recidivism and guide the intensity of supervision required. https://cpoc.memberclicks.net/assets/Realignment/risk_need_2007-06_e.pdf. It is important for the Probation Department to uniformly share risk assessment information with behavioral health providers and to expand RNR training and Cognitive Behavioral Treatment interventions which insure that criminogenic needs are addressed in behavioral health settings.

Appendix 1:
LA DMH Systems Map

County of Los Angeles – Department of Mental Health
Systems Map (Existing and Proposed) – Diversion by Design



Current Programs

Emergency Outreach Bureau (EOB)
SB82 Law Enforcement Mental Health Teams (11) *
See Page 2

Countywide Resources Management (CRM)
Law Enforcement Beds
1. Aurora Charter Oak
2. College Hospital

Pre-Booking Diversion Program *
A law enforcement collaborative program to divert individuals with mental illness that could be charged with minor offenses from incarceration to community mental health treatment.

Laura's Law *
A proposal to fully implement Assisted Outpatient Treatment which provides a process to allow court-ordered outpatient treatment.

SB82 Law Enforcement Mental Health Teams (13) *
To be implemented in Service Areas 1, 4, 6, 7, and 8.

Mental Health Court Linkage Program (MHCLP)
1. Court Liaison Program: Provides MH services, linkage, consultation, education, navigation, and discharge planning at all of the Superior Courts.
2. Misdemeanor Incompetent to Stand Trial (MIST): MH staff co-located at MH court to evaluate clients incompetent to stand trial on misdemeanors. Provide competency training for all out of custody MIST clients.

Mental Health Court Linkage Program (MHCLP)
1. Co-occurring Disorders Court (CODC): MH staff evaluate clients for community treatment in lieu of incarceration for 62 individuals at any given time.
2. AB 109 Revocation Court: MH clinicians are co-located at the Revocation Court to triage mentally ill/co-occurring individuals to appropriate levels of care.

Countywide Resources Management (CRM)
See page 2

Public Guardian (PG)

Mental Health Court Linkage Program (MHCLP)
1. Community Reintegration Program: Provides alternatives to incarceration at two programs, one locked/one residential, serving 67 clients.
2. Court Liaison Program: Provides linkage for mentally ill or co-occurring individuals countywide to directly operated and contracted MH agencies.

Jail Mental Health Services (JMHS)
1. Jail Linkage Program
2. Just In Reach
3. Women's Community Reintegration Services Program (WCRS) Jail in Reach

Countywide Resource Management (CRM)
1. AB109 Jail in Reach
2. SB82 Forensic Outreach Teams *
3. See Page 2

Adult System of Care (ASOC)
Service Area Navigators

County Hospital (CH)
Inmates in need of acute inpatient services post release and/or conservatorship and placement

Public Guardian (PG)

Adult Systems of Care (ASOC)
1. Vets VALOR Program
2. Full Service Partnership (FSPs)
3. Field Clinical Capable Services (FCCS)
4. Outpatient Services
5. Faith-based Organizations
6. Peer Support Services

Emergency Outreach Bureau (EOB)
Training to Law Enforcement Agencies

Housing and Homeless
Mental Health Programs

County Hospital (CH)
Inmates in need of acute inpatient services post release and/or conservatorship and placement

Countywide Resources Management (CRM) -
See page 2

Older Adult System of Care (OASOC)
1. Full Services Partnerships (FSP)
2. Field Capable Clinical Services (FCCS)
3. DMH Hoarding Taskforce
4. Community Education/Presentation
5. Consultation/Cross-Training

Public Guardian (PG)

Urgent Care Center (UCC)
1. Long Beach
2. Olive View
3. Exodus Westside
4. Exodus Eastside

Health Neighborhoods (HN) *

* Proposed

County of Los Angeles – Department of Mental Health
Systems Map (Current)

Countywide Resource Management (CRM)

Assembly Bill 109

1. Countywide Resource Management – Community Reintegration (CRP)
    - Probation Pre-Release Screening Center Co-located DMH Staff
    - Probation HUBS
    - Daly Street Administration/Gatekeeping Unit
    - State Hospital (5 beds)
    - Sub Acute Forensic Programs (8 beds)
    - Institution for Mental Diseases (IMDs) + Special Treatment Program (STP) (7 beds)
        - IMD Step-down (85 beds)
        - Co-Occurring Integrated Network (COIN) (20 beds)
        - Permanent Supportive Housing Program (8 beds)
        - Outpatient Services:
            - Full Service Partnership-like
            - Field Clinical Capable Services-like
            - Wellness Services

Community Based Programs

2. IMD Administration /Long Term Care:
    - Sub-acute Facilities (563 beds)
    - IMD Programs (459 beds)
    - IMD Step-down (544 beds)
    - Crisis Residential Programs (37 beds)
    - Assisted Outpatient Treatment Program (voluntary only - 20 beds)
    - Recuperative Care Program (10 beds)
3. Continuing Care Unit:
    - Psychiatric Diversion Beds (6)
    - Law Enforcement Beds (12)
    - State Hospital (220 beds)
    - Psychiatric Health Facilities (36 beds)
    - Short/Doyle Inpatient Beds (77)
4. Residential and Bridging Services:
    - Gatekeeping Unit
    - County Hospital Linkage Program
    - Peer Bridging Program
    - Specialized Housing Program
    - Full Service Partnership (FSP) Interim Fund
5. Project 50 and Project 50 Homeless Replications (7)

SB82

6. Forensic Outreach Teams
7. Crisis Transition Specialists
8. Urgent Care Centers
9. Crisis Residential Treatment Programs

Emergency Outreach Bureau (EOB)

1. Alhambra Police Dept. Mental Evaluation Team
2. Santa Monica Police Dept. Homeless Liaison Program
3. Burbank Police Dept. Mental Health Evaluation Team
4. LA County Sheriff's Dept. Mental Evaluation Team
5. Long Beach Police Dept. Mental Evaluation Team
6. LA County Metropolitan Transit Authority Crisis Response Unit
7. Pasadena Police Department - HOPE
8. LA Police Dept. Case Assessment and Management Program (CAMP)
9. LA Police Dept. Systemwide Mental Assessment Response Team (SMART)
10. Psychiatric Mobile Response Teams
11. Mental Health Alert Team
12. ACCESS – 24/7 Call line that fields requests from DMH field response teams

Appendix 2:
IL Jail Data Link

Jail Data Link Frequent Users
A Data Matching Initiative in Illinois

Overview of the Initiative

The Corporation for Supportive Housing (CSH) has funded the expansion of a data matching initiative at Cook County Jail designed to identify users of both Cook County Jail and the State of Illinois Division of Mental Health (DMH).

This is a secure internet based database that assists communities in identifying frequent users of multiple systems to assist them in coordinating and leveraging scarce resources more effectively. Jail Data Link helps staff at a county jail to identify jail detainees who have had past contact with the state mental health system for purposes of discharge planning. This system allows both the jail staff and partnering case managers at community agencies to know when their current clients are in the jail. Jail Data Link, which began in Cook County in 1999, has expanded to four other counties as a result of funding provided by the Illinois Criminal Justice Information Authority and will expand to three additional counties in 2009. In 2008 the Proviso Mental Health Commission funded a dedicated case manager to work exclusively with the project and serve the residents of Proviso Township.

Target Population for Data Link Initiatives

This project targets people currently in a county jail who have had contact with the Illinois Division of Mental Heath.

- Jail Data Link – Cook County: Identifies on a daily basis detainees who have had documented inpatient/outpatient services with the Illinois Division of Mental Health. Participating agencies sign a data sharing agreement for this project.
- Jail Data Link – Cook County Frequent Users: Identifies those current detainees from the Cook County Jail census who have at least two previous State of Illinois psychiatric inpatient hospitalizations and at least two jail stays. This will assist the jail staff in targeting new housing resources as a part of a federally funded research project beginning in 2008.
- Jail Data Link – Expansion: The Illinois Criminal Justice Information Authority provided funding to expand the project to Will, Peoria, Jefferson and Marion Counties, and the Proviso Mental Health Commission for Proviso Township residents.

Legal Basis for the Data Matching Initiative

Effective January 1, 2000, the Illinois General Assembly adopted Public Act 91-0536 which modified the Mental Health and Developmental Disabilities Administrative Act. This act allows the Division of Mental Health, community agencies funded by DMH, and any Illinois county jail to disclose a recipient's record or communications, without consent, to each other, for the purpose of admission, treatment, planning, or discharge. No records may be disclosed to a county jail unless the Department has entered into a written agreement with the specific county jail. Effective July 12, 2005, the Illinois General Assembly also adopted Public Act 094-0182, which further modifies the Mental Health and Developmental Disabilities Administrative Act to allow sharing between the Illinois Department of Corrections and DMH.

Using this exception, individual prisons or jails are able to send their entire roster electronically to DMH. Prison and jail information is publically available. DMH matches this information against their own roster and notifies the Department of Corrections Discharge Planning Unit of matches between the two systems along with information about past history and/or involvement with community agencies for purposes of locating appropriate aftercare services.

Sample Data at a Demo Web Site

DMH has designed a password protected web site to post the results of the match and make those results accessible to the Illinois Department of Corrections facility. Community agencies are also able to view the names of their own clients if they have entered into a departmental agreement to use the site.

In addition, DMH set up a demo web site using encrypted data to show how the data match web site works. Use the web site link below and enter the User ID, Password, and PIN number to see sample data for the Returning Home Initiative.

- https://sisonline.dhs.state.il.us/JailLink/demo.html
  - UserID: cshdemo
  - Password: cshdemo
  - PIN: 1234

Program Partners and Funding Sources

- CSH's Returning Home Initiative: Utilizing funding from the Robert Wood Johnson Foundation, provided $25,000 towards programming and support for the creation of the Jail Data Link Frequent Users application.
- Illinois Department of Mental Health: Administering and financing on-going mental health services and providing secure internet database resource and maintenance.
- Cermak Health Services: Providing mental health services and supervision inside the jail facility.
- Cook County Sheriff's Office: Assisting with data integration and coordination.
- Community Mental Health Agencies: Fourteen (14) agencies statewide are entering and receiving data.
- Illinois Criminal Justice Authority: Provided funding for the Jail Data Link Expansion of data technology to three additional counties, as well as initial funding for three additional case managers and the project's evaluation and research through the University of Illinois.
- Proviso Township Mental Health Commission (708 Board): Supported Cook County Jail Data Link Expansion into Proviso Township by funding a full-time case manager.
- University of Illinois: Performing ongoing evaluation and research

Partnership Between Criminal Justice and Other Public Systems

Cook County Jail and Cermak Health Service have a long history of partnerships with the Illinois Department of Mental Health Services. Pilot projects, including the Thresholds Justice Project and the Felony Mental Health Court of Cook County, have received recognition for developing alternatives to the criminal justice system. Examining the systematic and targeted use of housing as an intervention is a logical extension of this previous work.

Managing the Partnership

CSH is the primary coordinator of a large federal research project studying the effects of permanent supportive housing on reducing recidivism and emergency costs of frequent users of Cook County Jail and the Illinois Department of Mental Health System. In order to facilitate this project, CSH funded the development of a new version of Jail Data Link to find the most frequent users of the jail and mental health inpatient system to augment an earlier version of Data Link in targeting subsidized housing and supportive mental health services.

About CSH and the Returning Home Initiative

The Corporation for Supportive Housing (CSH) is a national non-profit organization and Community Development Financial Institution that helps communities create permanent housing with services to prevent and end homelessness. Founded in 1991, CSH advances its mission by providing advocacy, expertise, leadership, and financial resources to make it easier to create and operate supportive housing. CSH seeks to help create an expanded supply of supportive housing for people, including single adults, families with children, and young adults, who have extremely low-incomes, who have disabling conditions, and/or face other significant challenges that place them at on-going risk of homelessness. For information regarding CSH's current office locations, please see www.csh.org/contactus.

CSH's national *Returning Home Initiative* aims to end the cycle of incarceration and homelessness that thousands of people face by engaging the criminal justice systems and integrating the efforts of housing, human service, corrections, and other agencies. *Returning Home* focuses on better serving people with histories of homelessness and incarceration by placing them to supportive housing.

Corporation for Supportive Housing
Illinois Program
205 W. Randolph, 23rd Fl
Chicago, IL 60606
T: 312.332.6690
F: 312.332.7040
E: il@csh.org
www.csh.org

Appendix 3:

Pre-Booking Diversion Proposal

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
PRE-BOOKING DIVERSION PROPOSAL
"AN OPEN DOOR TO RECOVERY"

September 2013

BACKGROUND

The Department of Mental Health (DMH) is a participant in a variety of collaborative criminal justice projects including law enforcement/mental health crisis intervention teams such as Mental Evaluation Teams (MET) and the Systemwide Mental Assessment Response Team (SMART), the Mental Health Court Linkage Program and most recently the Assembly Bill (AB) 109 Realignment Program. These interagency partnerships address the special needs of persons with mental illness who become involved with the criminal justice system. DMH is proposing to enhance its partnerships with law enforcement entities and the criminal justice system through the implementation of two pre-booking jail diversion programs, initially as pilot projects serving the Long Beach (LB) and Antelope Valley (AV) areas, and subsequently to be extended throughout Los Angeles County, utilizing the experience gained through the pilot projects.

The need for a pre-booking diversion program is significant. Police response to calls involving individuals with mental illness takes more time to complete than calls involving individuals who are not mentally ill. In the Los Angeles County jails, the cost to provide mental health treatment, as well as custodial care, to a daily census of over 2900 inmates with mental illness is substantial. Incarceration disrupts treatment in the community, impedes recovery, and may result in the exacerbation of symptoms. Defendants who are mentally ill and unable to afford bail have been found to spend longer times in custody than those that are not suffering from mental illness. Their court cases often take multiple court appearances to adjudicate, adding costs to the judicial system. A pre-booking interagency diversion program would provide a means of reducing the number of individuals entering the criminal justice system and a safety measure for individuals experiencing crisis.

Pre-booking diversion programs have been implemented in a number of jurisdictions throughout the country. Research indicates that these programs produce positive outcomes for persons with mental illness and for the community. The principal goal of the proposed project is to link individuals with mental illness to recovery services at the first point of contact with the criminal justice system as an alternative to repetitive incarcerations.

In August 2013 DMH Jail Mental Health Staff conducted a prevalence study to determine the number of potential mentally ill males incarcerated from the AV and LB areas that might benefit from a pre-booking diversion program. Findings indicate that 14% of those arrested for felonies and 33% of those arrested for misdemeanor charges may be more appropriately served by mental health treatment rather than incarceration (See Attachments 1 and 2).

PROJECT DESCRIPTION

The proposed LB and AV pilot projects would be housed in Urgent Care Centers (UCC) located in the AV and LB areas. The UCCs would serve as the entry point for the AV and LB Police Departments to link individuals to mental health services in lieu of their being charged with low level offenses. UCCs typically provide up to 24 hours of intensive crisis services and immediate care, including referrals to community based solutions, to individuals who otherwise would be brought to emergency rooms. The AV and LB UCCs would be expanded to allow specially trained law enforcement to divert individuals to mental health services whose low level offenses appear to be the result of or associated with their mental illness and who voluntarily agree to treatment. The diversion project would have the ability to link clients to needed services directly, including all levels of mental health care, health services, substance abuse treatment, housing, benefits (re)establishment, education and employment, and social services. The UCCs would be designated to receive or place individuals on 72-hour holds.

The goals of the Program are as follows:

- Enhanced coordination among law enforcement, mental health and other participating agencies
- Improved access to services for people with mental illness
- Diversion of people with mental illness from the criminal justice system
- Improved efficiency of police response to mental health related calls

DMH will use established partnerships to develop the proposed projects. As a first step, DMH plans to engage stakeholders such as the AV and LB Police Departments and law enforcement/mental health teams, the City Attorneys, the District Attorneys and Countywide Criminal Justice Coordination Committee to support the project. Once support is secured for the projects, a work group would be needed to coordinate tasks such as establishing agreements among participating agencies in each geographical area; identifying target populations and offenses; establishing program capacity and notification protocols when at capacity; developing training for police dispatchers and

specialized police officers; delineating the range of mental health and other services to which participants could be linked; establishing protocols, including information sharing; defining data tracking and outcome measures; and identifying funding sources.

This proposal would leverage existing County and local services - UCCs, other mental health providers and the mental health/law enforcement teams - to implement the programs. In addition to leveraging existing services, the projects will require additional funding including AB 109, Mental Health Services Act (MHSA) and Senate Bill (SB) 82. It is anticipated that both projects will require capital development and services funding including UCC staffing, recruitment, training, and development of enriched residential capacity to serve this population. Included in the UCC staffing will be a short-term case management team that can immediately house program participants if needed, provide treatment for mental health and co-occurring substance abuse disorders and follow participants for up to two months until connected to community services and supports. The timeline for the implementation of the AV pilot will be lengthier than LB pilot due to the need to develop a new UCC in the area.

Anticipated outcomes of the program include:

- Reduction in arrest for minor offenses of persons with mental illness
- Increased access to mental health services for individuals who come into contact with law enforcement
- Increased satisfaction of persons with mental illness with law enforcement services
- Increased training of police officers on recognizing mental health symptoms and resources.

Following successful implementation of these pilot projects, DMH envisions working with its partners to expand the programs in order to offer law enforcement personnel countywide a means to redirect people with mental illness away from the criminal justice system to recovery-based community treatment and services and to promote an end to the cycles of repeated incarcerations.

Pilot: Identification of Potential Correctional Mental Health Clients for Pre-Booking Diversion

Method: A prevalence study was conducted on August 5, 2013. All incarcerated inmates from Service Area 1 and 8 (Antelope Valley and Long Beach) were surveyed.

Total	N = 169	
Felony	N = 133	77%
Misdemeanor	N = 36	21%

Recommended Diversion Exclusions

Arrest Charge

1. Murder, Attempt Murder
2. ADW with use of firearm and/or GBI
3. Robbery 1st and 2nd degree
4. Manslaughter, 1st or 2nd degree
5. Any sexual offense
6. Any child offense
7. Domestic violence
8. Arson
9. Battery GBI
10. Kidnapping, False Imprisonment, Car jack
11. Co Ret. (State Hosp. Returnees)
12. All other offenses with 4 or more previous arrest as determined by CII (Criminal Information Index)

Felony Charge

Excluded by criteria	N = 48	36%
County Returnees	N = 11	8%
CII 4 or more (criminal charge)	N = 38	29%
CII 4 or more (drug charge)	N = 17	13%
Acceptable for Diversion	N = 18	14%

Misdemeanor Charge

Same exclusion criteria as for felonies, but previous arrests by CII increased to 10 with no previous arrest constituting any of above exclusions (item 1 – 11).

Misdemeanor Results
N = 36

Excluded by criteria	N = 19	53%
County Returnees	N = 5	14%
Acceptable for Diversion	N = 12	33%

Total (Felony and Misdemeanor) acceptable for Diversion = 30 18% of whole sample (e.g. based on 400 bookings in a day 72 would be diverted from jail)

These diversion criteria are considered to be based on conservative criteria.

Discussion

Pilot study results regarding the possible diversion of mental health arrestees from incarceration are very promising, but these data must be viewed in context. First, subjects were selected from 2 Los Angeles County Service Areas (Antelope Valley and Long Beach). Due to possible variances in personal and demographic differences, these results may not be readily generalizable to different County Service Areas, (e.g. Downtown). Additionally, these data were collected via a "spot prevalence" count of mental health men incarcerated on a single date. Length of jail stay was not determined. Positive diversion factors tend to correlate with short jail tenure and vice versa. This factor needs further exploration and may well result in an increase in the percentage of potential diversion candidates.

The concept of diversion of the mentally ill from incarceration is clearly supported by these preliminary data and has very broad and promising ramifications for appropriate community based treatment of the mentally ill.

Appendix 4:

CSH Mental Health, Jail Diversion and Supportive Housing Proposal

Mental Health, Jail Diversion, and Supportive Housing:

A Model for Community Integration and Stabilization

July 2014

Introduction

Men and women experiencing homelessness and suffering from mental illness are substantially more likely be involved with the criminal justice system than those individuals who live with mental illness, but are stably housed. For these men and women access to supportive housing (stable, safe, affordable housing combined with supportive services, mental health treatment and healthcare) has the single greatest impact on their likelihood of recidivating. A stable home in the community not only provides safety, security and shelter, but allows a level of stability, dignity and community integration that cannot be provided by any other intervention.

Supportive Housing

Supportive housing is an evidence-based practice that reduces homelessness and improves health outcomes for individuals experiencing long term homelessness and disabling conditions. By definition supportive housing is affordable housing combined with a wide array of supportive services. The housing is not time-limited. Tenants rent apartments and sign a lease that grants them full protection under state and local tenant landlord laws. Tenants can stay in their apartments as long as they choose granted that they do not violate the conditions of their lease. The housing affordability is generally provided through rental assistance in the form of the Housing Choice Voucher program or other federal and local rental assistance programs that allow tenants to pay rent based on 30% of their income regardless of how low their income may be or in some cases lack of any income at all.

Supportive housing is linked to comprehensive voluntary and flexible supportive services, behavioral healthcare and primary healthcare that is based on the tenants' needs and preferences. While the housing and services are linked, tenants are not required to participate in services. Services are completely voluntary and tenants cannot be asked to leave their housing because of their lack of participation in services or adherence to treatment plans. Services are provided using a proactive approach, where service providers actively engage tenants and develop treatment plans based on tenants' preferences.

To understand what supportive housing is, it is instructive to also understand what supportive housing is not. Supportive housing starkly differs from transitional housing, shelters, sober living programs, group homes or board and care facilities, including the following:

Supportive Housing Tenants	—versus—	Transitional Housing Residents
• Sign a lease (or sublease if master-leased) with landlord, have rights & responsibilities of tenancy under state & local law, are free to come & go or have guests		• Do not have leases, have no rights under landlord-tenant law, have restrictions on coming & going, as well as guests
• Have no restrictions on length of tenancy, can remain in apartment as long as complying with lease terms & desires to remain in apartment		• Do not determine their own length of stay (program decides length of stay)

Supportive Housing Tenants —versus—	Transitional Housing Residents
• May participate in accessible, usually comprehensive, flexible array of services tailored to needs of each tenant, with a case manager on call 24/7	• Service availability varies from program to program, without choice in services
• Are not required to participate in services as a condition of tenancy, of admission into housing, or of receipt of rental subsidies	• Are required to participate in services, or cannot remain in program or access subsidy
• Have rent based on income, in compliance with federal affordability guidelines (30-50% of income).	• May be asked to pay rent based on program's guidelines, not based on federal affordability guidelines
• Work closely with services staff who collaborate with (but are usually separate from) property management staff to resolve issues to prevent eviction	• Often have no advocate for resolving issues that may lead to eviction, as service providers usually the same as staff running home
• Live in housing that meets federal quality standards for safety & security	• May live in substandard conditions
• Usually occupy own bedroom, bathroom, and kitchen &, if sharing common areas, choose own roommates	• Have no choice over housemates, usually share bedroom with at least one (usually multiple) other tenants
• Are protected by Fair Housing law	• Are not protected by Fair Housing law

Supportive housing is community-based housing that can be provided in a single-site, or congregate, based model, mixed-population model, or a scattered-site model. Single-site supportive housing is a traditionally a single multi-family apartment building where all apartments are occupied by supportive housing residents. Single-site supportive housing is traditionally produced using community development or affordable housing financing and has the benefit of including on-site supportive services.

Mixed-population supportive housing is traditionally a single multi-family apartment building where a portion of the apartments are set-aside for supportive housing residents. Mixed-population models tend to combine traditional affordable housing dedicated to working families or individuals with a smaller or equal portion of apartments dedicated to supportive housing residents. Mixed-population developments are also traditionally produced using community development or affordable housing financing. Depending on the number of apartments dedicated to supportive housing residents these developments may or may not include on-site supportive services.

Scattered-site supportive housing is provided by dedicating tenant-based rental assistance to supportive housing residents who then secure rental housing from private landlords in the community. The most common program providing this form of supportive housing is the Housing Choice Voucher, or Section 8, program. In this model services are provided through mobile teams who provide services to tenants throughout the community.

Each of the models described above include unique opportunities and challenges. Some service providers prefer providing on-site services through a single-site model. While others prefer the community integration provided through scattered-site models. Similarly, some public agencies prefer the community development opportunities and increased housing supply produced by single-site models, while others prefer the speed of scattered-site approaches.

Across the country we have learned that communities need all models. Programs to expand supportive housing should include multiple approaches.

Los Angeles County currently has no supportive housing dedicated to justice-involved individuals. Today justice-involved individuals access supportive housing through the homeless service delivery system and by independently applying for housing. As a result, justice-involved individuals face long wait lists and may be denied housing as a result of their history of incarceration. Any strategy to divert individuals experiencing mental illness from entering or returning to jail must include the provision of new supportive housing.

Financial Modeling

CSH has prepared a financial model based on providing 1,000 new units of supportive housing for justice involved individuals. Each model includes housing, as well as supportive services and program administration. 400 of these supportive housing units would be provided through new construction or rehabilitation of single-site or mixed population developments. This model assumes leveraging community development and affordable housing financing including project based rental assistance provided by public housing authorities.

600 of these supportive housing units would be provided through a scattered-site model. CSH recommends investing in an existing Department of Health Services program, the Flexible Housing Subsidy Pool. The Flexible Housing Subsidy Pool has infrastructure in place today, which would allow virtual immediate access to housing. The Flexible Housing Subsidy Pool is also designed for a similar population, frequent users of LA County health services who, by in large, also suffer from mental illness, substance use disorders and histories of trauma.

Each model assumes a 5-year operating cycle. It should be noted that supportive housing is not time limited. These models would need a new investment at the end of the 5-year operating cycle to continue. For the new construction/rehabilitation model this would require an investment in social services only because the rental assistance is provided by the federal government. The Flexible Housing Subsidy Pool would require an additional investment in both rental assistance and social services.

Permanent Supportive Housing New Construction/ Rehabilitation	400 Units	5-Year Cost
Capital Subsidy	$75K/unit*400	$30,000,000
Integrated Case Management Services	$400/mon*60 mon*400 people	$9,600,000
Program Administration	1 FTE/5 years	$500,000
Total		**$40,100,000**

*Assumes leverage of Project Based Section 8 or Shelter Plus Care and traditional affordable housing capital financing including Low Income Housing Tax Credits

Flexible Housing Subsidy Pool	600 Units	5-Year Cost
Move-in Assistance	$2,000*600 people	$1,200,000
Rental Assistance	$800/mon*60 mon*600 people	$28,800,000
Program Coordination	$125/mon*60 mon*600 people	$4,500,000
Integrated Case Management Services	$400/mon*60 mon*600 people	$14,400,000
Program Administration	1 FTE/5 years	$500,000

Total		**$49,400,000**

Funding Sources

There is no magic bullet to fund supportive housing. That said, funding sources do exist that could offset a portion of the cost of this model.

County-Owned Land

The County owns large parcels of land, such as medical centers, that may include properties that are being under-utilized. This land could be made available to supportive housing developers to help offset the cost of development.

Medi-Cal

The majority of justice-involved individuals in the County became eligible for Medi-Cal under the Affordable Care Act beginning January 1, 2014. Medi-Cal can reimburse providers for a portion of case management, mental health treatment, primary healthcare and even substance abuse treatment. While Medi-Cal reimbursement is limited, there is a new option in the Affordable Care Act called Health Homes that could provide more comprehensive coverage for services. The state passed a bill, AB 361, in 2013 to implement this option of the Affordable Care Act and will soon begin a planning process for implementation.

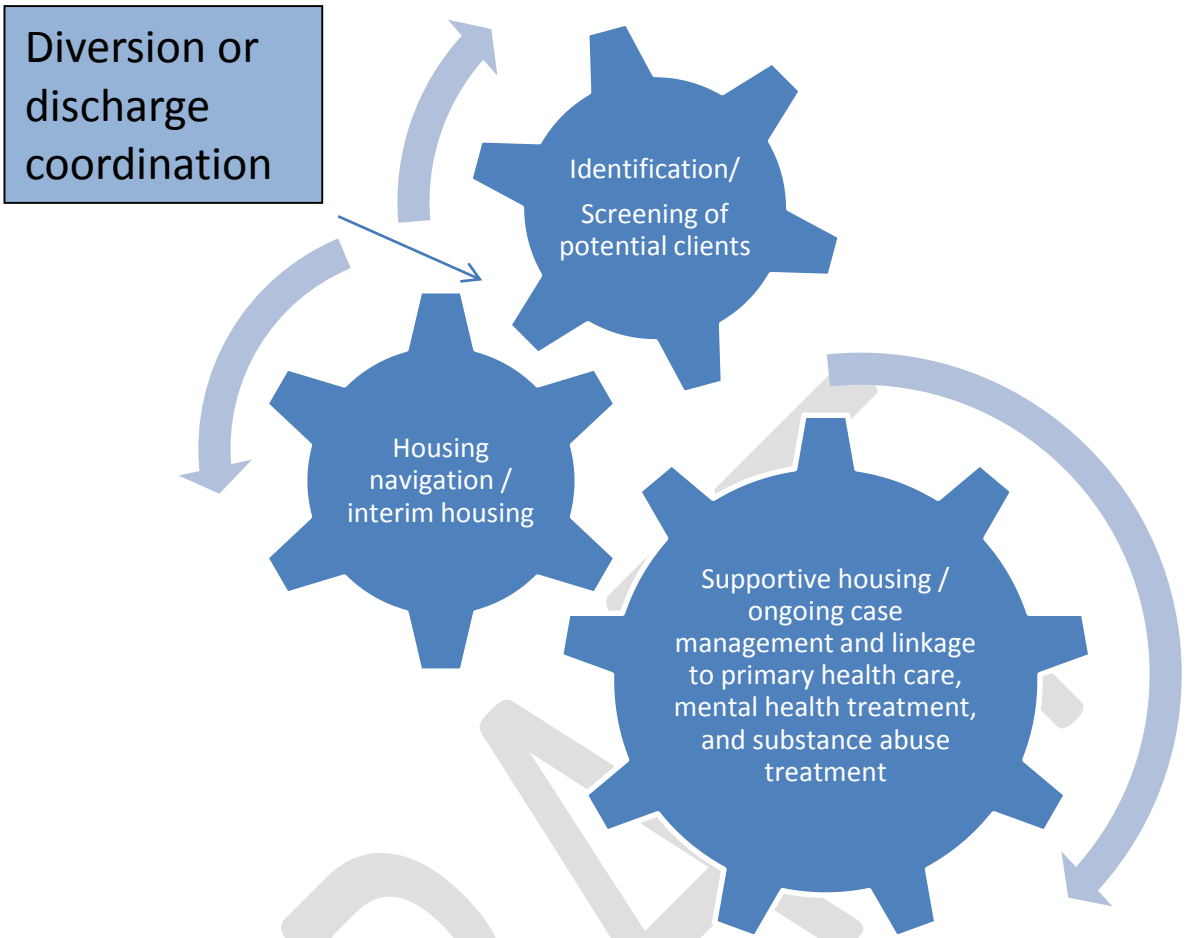
Mental Health Services Act

The Mental Health Services Act also includes funding that could be utilized to offset the cost of services. The Department of Mental Health currently has a program called Integrated Mobile Health Teams that combines Medi-Cal reimbursement with MHSA Innovations funding to fund a package of services that is similar to the integrated case management services included in the models above.

Linkages to Supportive Housing

Supportive housing works as diversion and discharge strategy when clients are effectively linked to supportive housing. Effective linkage is dependent on comprehensive programs that include the following components:

- Targeted and easily-implemented screening tools to identify clients
- Warm-hand off to Housing Navigators, who begin engagement in the court-room, jail, hospital or crisis stabilization unit
- Immediate access to low-barrier interim housing
- Immediate assistance with identification documents and housing application process
- Case management provided through a "whatever-it-takes" approach including transportation, food assistance, etc.
- Housing placement and ongoing intensive case management
- Linkage to primary healthcare, behavioral healthcare, and substance abuse treatment
- Connections to community, education, employment and family re-unification



CSH has implemented two programs that utilize this model to connect individuals in institutions to supportive housing in Los Angeles County. The **Just in Reach 2.0 project** connects individuals experiencing long-term homelessness in LA County jails to supportive housing through the provision of in-reach, discharge coordination, housing navigation, interim housing, supportive housing placement and on-going case management. The **10th Decile project** (including the Frequent Users System Engagement program and the Social Innovation Fund program) connects individuals experiencing long-term homelessness who are frequent users of the healthcare system to supportive housing through the provision of discharge coordination, housing navigation, interim housing, supportive housing placement and on-going case management. Both of these programs are ideal models for future diversion and re-entry programs.

Appendix 5:

LA Trauma TTT Participants

SAMHSA'S GAINS Center for Behavioral Health and Justice Transformation

SAMHSA
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road • Rockville, MD 20857
www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)

SAMHSA's GAINS Center
How Being Trauma-Informed Improves Criminal Justice System Responses
Train-the-Trainer Event

Los Angeles County, CA • July 15-16, 2014

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Appendix 6:
Peer Respites

Peer respites for mental health consumers prevent hospitalizations

August 12, 2014

By Lynn Graebner

As people with mental health crises overwhelm California's hospitals, jails and homeless shelters, counties across the state are gradually embracing residential respite houses located in neighborhoods and staffed by peers — people who have been consumers of the mental health system.

For people on the verge of a crisis, staying at a peer-run respite, typically for a couple of days or up to two weeks, can help them recover with support from people who have had similar experiences.

That can prevent incarceration or forced hospitalization, which often damages family relationships and can cause the loss of housing or jobs, said Yana Jacobs, chief of outpatient adult services for Mental Health and Substance Abuse Services at the Santa Cruz County Health Services Agency.

California has three peer-run respites, two in Los Angeles County and one in Santa Cruz. San Francisco and Santa Barbara Counties are in the process of opening respites and Alameda County is considering one.

The latter three would likely be largely staffed by peers but not considered peer-run as peers probably won't be in administrative positions. That distinction makes a big difference, say advocates.

"If respites are run by the traditional system, even peer workers can start behaving like clinicians," said Oryx Cohen, Director of the Technical Assistance Center at the National Empowerment Center, a Massachusetts-based nonprofit peer-run mental health organization.

Without peers at the helm, hierarchical administrations can undermine shared decision making; the sense of clients and support staff being equals, each having something to offer and the dropping of clinical labels.

The peer-run model is growing throughout the country with 12 peer-run respites and two hybrid programs in 11 states. Six more are planned and funded, said Laysha Ostrow, a postdoctoral fellow at Johns Hopkins Bloomberg School of Public Health.

Growth is slow but steady. One barrier is the stigma that mental health consumers can't handle crisis situations, Cohen said.

"Departments of mental health and behavioral health just need to be educated and need to see that this is a viable alternative," he said.

It has been for Asha Mc Laughlin, who knows well the trauma of being hospitalized. She suffers post-traumatic stress disorder, major depression and anxiety due to being abducted, raped and threatened with murder when she was 16. Chronic back pain also plagues her mental health.

She's spent a lot of time in psychiatric hospitals in the past, but rarely uses them now since finding the Second Story peer respite in Santa Cruz three years ago.

Peer counselors there are trained in the Intentional Peer Support method and, unlike psychiatrists, can share their own experiences, alleviating some of the isolation people feel, and creating relationships that are mutually supportive.
"It seems there's just automatic healing in that," Mc Laughlin said. "And when my understanding supports them, it means a lot to me."
At Second Story guests talk conversationally with peer counselors, handle their own meds, cook meals and can join or lead group sessions ranging from art and meditation to dealing with conflict and alternatives to suicide.

"We've found that when we treat people like responsible adults they behave like responsible adults," said Adrian Bernard, one of the administrators and a peer counselor.

"We have had a huge amount of success getting people out of the [mental health] system," he said.

San Francisco is one of the latest cities experimenting with peer respites. Its Department of Public Health plans to launch a psychiatric respite next to San Francisco General Hospital and Trauma Center this fall, said Kelly Hiramoto, acting director of Transitions at the San Francisco Department of Public Health.

San Francisco desperately needs these types of alternatives to hospitalization, incarceration and homelessness. Last year the city had almost 800 jail inmates diagnosed with a psychotic, bipolar or major depressive disorder, reported San Francisco Mayor Edwin M. Lee's office.

The San Francisco respite is one of several remedies the city is trying. It will start with four beds with room to grow to 12 or 14, and five peer counselors as well as six entry-level mental health rehabilitation workers, Hiramoto said.

The city didn't go as far as some local mental health advocates had hoped, but they say it's a start.

"We're very supportive of the psychiatric respite. We think that's a great thing that will fill a gap," said Michael Gause, Deputy Director, Mental Health Association of San Francisco, a nonprofit advocacy organization. But they would also like to see a pure peer-run respite, he said.

Several other counties are also getting their feet wet. In the last year two peer-run respites have opened in Los Angeles County, Hacienda of Hope in Long Beach and SHARE! Recovery Retreat in Monterey Park. They're both funded by the Los Angeles County Department of Mental Health Innovations Program as three-year pilots.

Santa Barbara County has approved a largely peer-staffed respite and is seeking a site, said Eric Baizer, with the Santa Barbara County Department of Alcohol, Drug and Mental Health Services.

And Manuel Jimenez, director of Alameda County Behavioral Health Care Services, said a stakeholder group has proposed a peer-staffed respite for his county and he's supportive.

Statewide, California had less than half the national average of psychiatric beds per capita as of 2007, according to a 2010 report by the California Mental Health Planning Council, an advisory body to state and local government.

Respites could help fill that gap. Crisis residential programs, including peer respites, cost roughly 25 percent of hospital inpatient care and are often more effective, the report states.

Jacobs said one of the reasons these respites are successful in reaching people is they don't focus on diagnosis. She believes only about 25 percent of people being diagnosed schizophrenic actually are.

"The rest have trauma and are being labeled," she said. "You don't want to tell someone they have a serious mental illness and will be disabled the rest of their lives."

Bernard, for example, hears voices but hasn't been hospitalized since 2003.

"Now I have a community around me and three or four times they've kept me from going to the brink," he said.

Jason Davis, who first came to Second Story as a guest and is now a peer counselor, agreed that the enormous camaraderie there is what helped him overcome his paranoia.

"I support the house and the house supports me," he said.

The nonprofit Human Services Research Institute is doing a five-year evaluation of Second Story, required by the grant it received from the federal Substance Abuse and Mental Health Services Administration. Early analysis suggests a reduction in use of high-cost hospitalizations and other emergency services by those who use the respite, said Bevin Croft, Policy Analyst for the organization.

That's certainly true for Bernard, Mc Laughlin and Davis since joining the Second Story community.

"For the first time in my life I feel like people understand me and can support my growth," Bernard said.

http://www.healthycal.org/archives/16402

Appendix 7:
DMH Fact Sheet

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
Investment in Mental Health Wellness Act of 2013 Fact Sheet
December 2013

OVERVIEW

In June of 2013, Governor Jerry Brown signed the Investment in Mental Health Wellness Act of 2013 (MHWA) into law. MHWA establishes new grant opportunities that funds California counties or their nonprofit/public agency designates to develop mental health crisis support programs. The MHWA provides $142.5 million in capital funding and $6.8 million for mobile crisis support teams to increase the capacity for client services, crisis intervention and stabilization, crisis residential treatment, rehabilitative mental health services, and mobile crisis support teams. The California Health Facilities Financing Authority (CHFFA) will support capital improvement, expansion and limited start-up costs. The County of Los Angeles (County), along with Tri-City Mental Health Authority is eligible for $40 million of these funds including an additional $1.9 million for mobile crisis support teams.

PROPOSED PROGRAMS

Utilizing the capital funding from the MHWA, the County of Los Angeles Department of Mental Health (DMH) intends to develop five new Psychiatric Urgent Care Centers and establish 10-15 Crisis Residential programs in each of the eight Service Areas (SA). Additionally, there will be an expansion of our current mobile crisis support teams throughout the county.

Urgent Care Centers—*Provide short-term (23 hour), crisis intervention services to individuals 13 years and older who would otherwise be taken to or access care in emergency rooms.*

DMH currently utilizes four adult urgent care centers:

- Olive View—SA2
- Eastside Exodus Urgent Care Center—SA 4
- Westside Exodus Urgent Care Center—SA5
- La Casa Mental Health Urgent Care Center—SA8

The MHWA would fund an additional five urgent cares to be located on the campus of Harbor UCLA Medical Center, SA 7, the Antelope Valley, the greater Hollywood area, and SA 3. A UCC at Martin Luther King, Jr. Medical Center is also scheduled to open early 2014.

Crisis Residential Programs—*Each program serves 10-12 persons for an average of 10-14 days. This program provides immediate, structured housing and supportive mental health services, most frequently as an alternative to extended acute psychiatric hospitalizations.*

DMH currently funds three crisis residential programs:

- Hillview Crisis Residential Program—SA 2
- Didi Hirsch Excelsior House—SA 8
- Didi Hirsch Jump Street—SA5

DMH proposes to increase crisis residential bed capacity by 160 beds countywide through the development of approximately 10-15 new crisis residential programs

Mobile Crisis Support—*DMH operates a psychiatric mobile emergency response system twenty-four hours per day, seven days per week. The Emergency Outreach Bureau has several programs that provide field response services including Psychiatric Mobile Response Teams (PMRT), Law Enforcement Teams (LET), School Threat Assessment and Response Team (START), and Homeless Outreach Mobile Engagement (HOME).*

The $1.9 million for mobile crisis support teams will expand the field response operations personnel. In addition, there is a total of $500,000 that can be used for the purchases of vehicles for these teams.

EVALUATION CRITERIA

CHFFA will evaluate an applicant's ability to meet the following criteria:

1. Project* expands access to and capacity for community based mental health crisis services that offer relevant alternatives to hospitalization and incarceration.
2. Application demonstrates a clear plan for a continuum of care before, during, and after crisis mental health intervention or treatment and for collaboration and integration with other health systems, social services, and law enforcement.
3. Identifies key outcomes and a plan for measuring them.
4. Project is feasible, sustainable and ready or will be feasible, sustainable and ready within six months of the Final Allocation.

* Project means startup or expansion of Program(s) and acquisition, construction, renovation or financing of capital assets; or equipping and staffing a Mobile Crisis Support Team.

Appendix 8:

CASES TCM Program Brief

POLICY RESEARCH ASSOCIATES

Successfully Engaging Misdemeanor Defendants with Mental Illness in Jail Diversion: The CASES Transitional Case Management Program

Jacob & Valeria Langeloth Foundation | CASES | Policy Research Associates August 2012

Goals of this document:

- Provide a description of the development and operation of an alternative-to-incarceration program for repetitive misdemeanants
- Outline the strategy used by the program to promote engagement with behavioral health services through case management
- Review the program's effectiveness in reducing arrests, compliance with the court mandate, and linking participants to long-term treatment services
- Explain the role of positive court relations, standardized court screening, same-day engagement, and flexibility of service provision in the program's success.

Individuals convicted of misdemeanor offenses receive relatively modest punishment within the criminal justice system. As a result, programs that divert misdemeanants with mental disorders into treatment services lack judicial leverage to counter noncompliance. Yet misdemeanor cases constitute a huge burden for criminal courts. For example, in 2007, misdemeanor cases accounted for three-quarters of all arraignments in the Manhattan Criminal Court. The behavioral, medical, and public safety implications of noncompliance present courts and service providers with a need for more effective engagement strategies.

The Center for Alternative Sentencing and Employment Services (CASES) launched the Transitional Case Management (TCM) alternative-to-incarceration program in 2007 for misdemeanor defendants in Manhattan Criminal Court. TCM has received funding from the New York City Department of Correction, New York Mayor's Office of the Criminal Justice Coordinator, Bureau of Justice Assistance Justice and Mental Health Collaboration Program, Jacob and Valeria Langeloth Foundation, van Ameringen Foundation, Schnurmacher Foundation, and the Manhattan Borough President's Office. TCM provides screening, community case management, and coordinated support for individuals with mental disorders or co-occurring mental and substance use disorders at risk of jail sentences.

Background

CASES clinical staff identify participants in arraignment, before sentencing, and also while completing a day custody program court mandate after sentencing. The participants are individuals with mental disorders or co-occurring mental and substance use disorders who have completed three days in the day

custody program or are mandated by the court to participate in three or five community case management sessions as an alternative to incarceration.

Participants recruited from the day custody program voluntarily enter TCM after completing the court mandate. Defendants mandated to TCM directly from court can voluntarily continue in the program for up to three months after satisfying the court mandate. TCM is staffed by a psychologist responsible for court-based screening and project coordination, a licensed social work supervisor, a bachelor-level substance abuse case manager, and a part-time forensic peer specialist.

Participants

TCM enrolled 178 individuals from July 2007 through November 2010. Approximately three-quarters (78%) of participants were male. The mean age of participants was 40. About half (56%) were Black, 25% were Hispanic or Latino, 12% were White, 2% were Asian, and 5% were multi-ethnic.

The majority of participants had a psychiatric diagnosis of bipolar disorder (38%), depressive disorder (20%), or schizophrenia (19%). Most participants (85%) had a co-occurring substance use disorder. Ninety-five participants (53%) were homeless upon entry into TCM.

TCM participants had an extensive criminal history, with a mean of 27 lifetime arrests and a mean of 3.6 arrests in the past year. Every participant had at least one prior misdemeanor conviction and 53% had one or more prior felony convictions.

The conviction that preceded enrollment in TCM was for a property crime in about half of the cases (51%). One-quarter (25%) were convicted of possession of a controlled substance. Seventeen percent (17%) were convicted of a crime against a person.

Outcomes

Rearrest

In the year after program entry, the participants experienced 2.5 mean arrests. This figure, compared with 3.6 mean arrests in the year prior to program entry, represents a 32% reduction between the two periods. This reduction is statistically significant at the $p<.001$ level. Seventy-two percent (72%) of participants were arrested at least once in the year after program entry.

Pre-Entry and Post-Entry Mean Arrests for TCM Participants, by Lifetime Arrests (n=178)

Lifetime Arrests	No.	%	1 Year Pre	1 Year Post
0-3	15	8.4	1.3	0.3
4-10	32	18.0	2.4	0.7
11-20	33	18.5	3.5	2.2
21-40	62	34.8	4.2	3.1
≥41	36	20.2	5.1	4.2
Total	178	100.0	3.6	2.5

Participants with more lifetime arrests experienced an attenuated reduction in arrests between the two periods. Participants with the most lifetime arrests (41 or more) experienced only an 18% reduction in mean arrests prior to and after program entry. Yet participants with three or fewer lifetime arrests experienced a 75% reduction in mean arrests. Mean arrests fell 70% for participants with 4 to 10 lifetime arrests, 37% for participants with 11 to 20

lifetime arrests, and 25% for participants with 21 to 40 lifetime arrests.

Compliance and Service Linkage

The majority (82%) of the mandated participants successfully completed the court mandate, and 85% of those participants chose to continue to receive case management services beyond the mandated period. On average, participants took part in 16 voluntary case management sessions over the course of 156 days. Thirty-nine percent (39%) of the TCM participants were linked to long-term services prior to TCM program enrollment, and the program linked and transferred 25% of participants to long-term treatment services.

Keys to Program Success

Positive Court Relations

The TCM program benefits from having a professional clinician maintain a daily presence in the arraignment parts. This criminal justice–savvy individual is readily available to administer the screening protocol, engage with defense counsel, and provide pertinent information to judges to advocate for defendants who are eligible for the program. The clinician fine-tunes the program's court operations in response to feedback from defense counsel and the judges.

Standardized Court Screening

The clinician administers the structured screening protocol in the courtroom interview pens to all referred defendants. The 75-minute protocol reviews mental health (Mental Health Screening Form III) and substance use (Texas Christian University Drug Screen II), psychosocial domains, risk factors, court mandate conditions, and program expectations and goals. As a result, the clinician is able to determine whether a defendant is eligible for TCM during the period before the individual appears before the judge. The majority of defendants referred by defense counsel and judges are eligible for TCM.

Same Day Engagement

The TCM case management protocol calls for immediate engagement of new participants in a standardized orientation protocol. The objective of the protocol is to increase the likelihood a new participant will engage in the case management services. Participant engagement begins with an orientation session that takes place immediately after release from court (participants referred from the day custody program are oriented on the day of admission). The project coordinator introduces the participant to project community staff. An evaluation of the participant is provided to staff, with a focus on immediate needs, risk factors, and details about the court mandate.

Flexibility in Service Provision

The high engagement in services is attributed to TCM's flexibility in delivering services to participants. TCM has the capacity to provide the frequency and duration of service contacts to participants based on their immediate and ongoing needs. Program participants are seen by program staff as often as needed in any community setting convenient for the participant. They are seen if they arrive late or miss an appointment. The participants are welcomed by the program whenever they arrive or make contact with the staff to obtain services.

Conclusion

The TCM program points to the value of case management services to support reductions in the criminal recidivism of people with mental disorders or co-occurring mental and substance use disorders arrested for misdemeanor crimes. The program is now working to enhance the nature of its case management services with the use of a validated risk and need instrument. This will provide the staff with specific information regarding the criminogenic needs of their clients that should be addressed with services to achieve greater reductions in recidivism.

For More Information...

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Reference

Criminal Court of the City of New York. (2008). *2007 annual report*. New York: Office of the Administrative Judge of New York City Criminal Court.