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*Building bridges between
criminal justice & behavioral health
to prevent incarceration*

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We would like to thank the many individuals who so graciously hosted COMIO members, stakeholders, or staff in order to gather information about programs, challenges, and opportunities to prevent the incarceration of individuals with mental illness. Fellow staff within various divisions of the California Department of Corrections and Rehabilitation including Juvenile Justice, Rehabilitative Programs, Adult Parole, the Office of Employee Wellness, the Office of Research, and Correctional Health Care Services, have been very helpful in sharing information about their work. Thank you to the National Institute of Corrections and the Mental Health Services Oversight and Accountability Commission for the opportunity to learn from staff and partners at The Center for Health Care Services in San Antonio and The Eleventh Judicial Criminal Mental Health Project in Miami-Dade County.

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Executive Summary

Since 2001 California, through the Council on Mentally Ill Offenders (COMIO), has recognized that individuals living with mental illness are at risk of becoming criminally involved without access to support and needed services. As a 12-member council chaired by the Secretary of the Department of Corrections and Rehabilitation (CDCR), COMIO is charged with investigating, identifying, and promoting cost-effective strategies that:

- Prevent adults and juveniles with mental health needs from becoming offenders,
- Improve services for adults and juveniles with mental health needs who have a history of offending, and
- Identify incentives to encourage state and local criminal justice, juvenile justice, and mental health programs to adopt such approaches.

Priorities for 2016

COMIO elected to continue to work on the three priority areas identified in 2015 with enhanced focus:

- ❖ Diversion – Overcoming Barriers to Build Capacity for Effective Interventions,
- ❖ Training – Supporting Skills and Competencies Beyond First Responders, and
- ❖ Juvenile Justice – Understanding and Addressing the Needs of a Changing Population.

Key Themes

Individuals with mental illness are a growing proportion of the jail and prison population putting at risk resources needed to support community alternatives. Waiting to address behavioral health needs due to incarceration will pull scarce resources towards the wrong end of the system. The time to invest in strategies that divert individuals from incarceration and enhance service and housing capacity for those with high needs and risks is now. Difficult decisions are ahead for local and state policymakers. This report provides guidance and encourages decision-making that supports the individual living with behavioral health needs, as well as, the various systems trying to serve that individual and fulfill their own obligations and duties.

Appendix A lists all key findings and recommendations from each of the three priority sections. Below is a summary of the most pertinent themes raised that influenced specific findings and recommendations:

- The stigma associated with mental illness, substance use disorder, and justice status must be recognized and not tolerated to ensure that policies and practices do not perpetuate inequities.
- Assumptions about what works and does not work must be challenged by insisting on measuring both reductions in recidivism and behavioral health symptoms.

- The majority of justice-involved individuals with mental illness have a co-occurring substance use disorder which complicates treatment and recovery. Access to adequate services for co-occurring disorders and medical conditions with qualified staff is necessary.
- Sharing sensitive information, both health and justice data, is essential to target efforts to prevent incarceration.
- Assessment tools must be utilized to identify the level of risk and need of each justice-involved individual with mental illness to assure that appropriate treatment and services are provided and directed towards reducing recidivism.
- Maximize the use of federally supported Medi-Cal funding in all diversion efforts.
- The housing crisis, high cost and accessibility of housing, and stigma towards justice-involved individuals with mental illness are real and present barriers to efforts to build and provide community alternatives to incarceration whether it be inpatient facilities, crisis residential, group homes, or independent living. Broad, comprehensive, and creative efforts beyond addressing the needs of the homeless or at-risk of homelessness are needed.
- Support expanded efforts to keep individuals with mental illness out of jails through examining bail and pre-trial detention policies that have a disproportional impact on individuals with mental illness.
- Consider how mental illness as a basis for diversion could be expanded. Review which offenses could be additionally considered for authorization of diversion.
- Crisis response is not just about trained first responders. What is needed is a planned response that goes beyond the initial contact and leads to ongoing treatment in the community. Without developing these capacities, no amount of training can resolve law enforcement's current burden.
- Law enforcement and community correctional officers are faced with an increasingly challenging mental health population. They need opportunities to build skills and support their own well-being so they can perform an increasingly demanding job.
- High-risk and high need justice-involved youth are congregating in detention facilities. Continued efforts to ensure the "difficult" to serve youth get the services they need, especially substance use treatment.

- At the state and local level prioritize support for data infrastructure, with the state only collecting data needed to monitor trends to inform policies and practices. Support local entities gain the capacity and access to further research and evaluation efforts on best practices.

Future Directions

2016 represented a year of change for COMIO with the addition of new leadership, members, and staff. COMIO embarked on efforts to strengthen our relationships with key partners across criminal justice and behavioral health systems. During this process we recognized a need to focus efforts on building bridges across systems to improve understanding of different perspectives and promote problem-solving to prevent incarceration.

Change has many positive outcomes, including an opportunity to look at COMIO's priorities and accomplishments and adjust to seize existing opportunities and tackle challenges. 2017 will be a year of further change by re-structuring committee and council meetings. This will allow for more intensive issue-specific work in fewer areas with more input from state and local experts and stakeholders.

To follow COMIO's work and to receive information about workshops and meetings, please visit our website at www.CDCR.ca.gov/COMIO/ and subscribe to our monthly newsletter by emailing comionews@gmail.com.

Introduction

Introduction:

The incarceration of individuals with behavioral health problems is a national, state, and local crisis. Incarceration due to untreated mental illness illustrates how systems and communities can fail those most in need. Prisons and jails have become de facto mental health treatment centers and police have become de facto mental health crisis first responders. While the deinstitutionalization of state hospitals in the 1970s and 1980s was the appropriate and humane approach to serving and supporting those suffering from mental illness, serious underfunding of the community-based system that was to replace it, has had substantial consequences. Today, law enforcement, the courts, hospitals, social welfare agencies, and community corrections professionals have been on the frontline experiencing how this growing social problem is changing the very nature of their work.

Two million admissions to U.S. jails annually are persons who are experiencing acute mental illness¹. Of that population, it is estimated that three-quarters have a co-occurring substance use disorder, which is a diagnosis of both a substance use disorder and a serious mental illness.² More than 50 percent of inmates in prisons in the year prior to their arrest met criteria for substance dependence or abuse, while that number is nearly 70 percent of those in jails³. While roughly 5 percent of the general population has a serious mental illness, and 16 percent have a substance use disorder, those numbers are 9 and 40 percent respectively for probationers and parolees.⁴ The National Alliance on Mental Illness (NAMI) estimates that between 25 and 40 percent of all Americans with mental illness will be jailed or incarcerated at some point in their lives.⁵

These numbers are consistent with local jails and prisons who are reporting that the number of incarcerated individuals with mental illness is growing. The California Department of Corrections and Rehabilitation (CDCR) has seen the population with mental health needs, particularly serious ones, grow significantly. In 2006 the mental health population as a percent of the total in custody population was just shy of 19 percent. As of July 2016 that number rose to almost 30 percent.⁶ The Public Policy Institute of California (PPIC) also concluded in a recent analysis of California's historic correction reforms that due to shifting the incarceration of most non-serious and non-violent offenders from state prison to county jails, there is now an urgent need for jails to become equipped with mental health beds, rehabilitation and reentry programming.⁷

History and Background:

Too often those with mental illness do not get treatment until they become justice-involved. Seeking to address this, the Council on Mentally Ill Offenders (COMIO) was created and codified in Penal Code Section 6044, which originally set forth a sunset date of December 31, 2006. In 2006 SB 1422 (Chapter 901, Statutes of 2006) eliminated the sunset date.

The Council's primary purpose is to "investigate and promote cost-effective approaches to meeting the long-term needs of adults and juveniles with mental disorders who are likely to become offenders or who have a history of offending." In pursuit of that goal, the Council is to:

- Identify strategies for preventing adults and juveniles with mental health needs from becoming offenders,

- Identify strategies for improving the cost-effectiveness of services for adults and juveniles with mental health needs who have a history of offending, and
- Identify incentives to encourage state and local criminal justice, juvenile justice, and mental health programs to adopt cost-effective approaches for serving adults and juveniles who are likely to offend or who have a history of offending.

The Council must consider strategies that improve service coordination among state and local mental health, criminal justice, and juvenile justice programs. As well as, strategies that improve the ability of adult and juvenile offenders with mental health needs to transition successfully between corrections-based, juvenile-based, and community-based treatment programs.

Penal Code Section 6044(h)(1) requires the Council to “file with the Legislature, not later than December 31 of each year, a report that shall provide details of the Council’s activities during the preceding year. The report shall include recommendations for improving the cost-effectiveness of mental health and criminal justice programs.”

The Council is comprised of twelve members. Existing law designates as permanent members: the Secretary of CDCR, the Director of the California Department of State Hospitals (DSH), and the Director of the California Department of Health Care Services (DHCS), with the CDCR Secretary serving as the chair. The vice chairperson is selected from the membership.

Other Council members are appointed as follows: three by the Governor, at least one representing mental health; two each by the Senate Rules Committee and the Speaker of the Assembly, each appointing a representative from law enforcement and a representative from mental health; one by the Attorney General; and one by the Chief Justice of the California Supreme Court. Six members of the Council constitute a quorum.

As of this writing, the Council is currently comprised of the following individuals:

- Chairperson: **Scott Kernan**, Secretary, CDCR. The Secretary of CDCR is a statutorily required member and chair of COMIO.
- Vice Chairperson: **Manuel J. Jimenez, Jr.**, MA, MFT, former Behavioral Health Director, Alameda County. Mr. Jimenez was appointed to COMIO by Governor Edmund G. Brown Jr. in 2012.
- **Pamela Ahlin**, Director, DSH. The Director of DSH is a statutorily required member of COMIO. Dr. Mark Grabau at times represented Ms. Ahlin on COMIO during 2016.
- **Jessica Cruz**, MPA, Executive Director, NAMI – California. Ms. Cruz was appointed to COMIO by Governor Edmund G. Brown Jr. in 2015.
- **Mack Jenkins**, Retired Chief Probation Officer, San Diego County Probation Department. Mr. Jenkins was appointed to COMIO by Governor Edmund G. Brown Jr. in 2015.
- **Alfred Joshua**, MD, MBA, FAAEM Chief Medical Officer, San Diego County Sheriff's Department. Dr. Joshua was appointed to COMIO by Assembly Speaker Toni G. Atkins in 2015.
- **Jennifer Kent**, Director, DHCS. The Director of DHCS is a statutorily required member of COMIO. Ms. Kent was represented on COMIO by Brenda Grealish.
- **Matthew D. Garcia**, Field Training Officer, Sacramento Police Department. Mr. Garcia was appointed to COMIO by the Senate Rules Committee (chaired by Senator Kevin de León) in 2016.

- **The Honorable Stephen V. Manley**, Santa Clara Superior Court Judge. Judge Manley was appointed to COMIO by Chief Justice Ronald M. George of the California Supreme Court in 2010.
- **David Meyer**, J.D., Clinical Professor/Research Scholar, USC Keck School of Medicine. Mr. Meyer was appointed to COMIO by Assembly Speaker Robert M. Hertzberg in 2002.
- **Lester P. Pincu**, D.CRIM. Dr. Pincu was appointed to COMIO by the Senate Rules Committee (chaired by Senator Kevin de León) in 2015.

Dave Lehman, Retired Probation Chief, Humboldt County and Charles Walters, Ph.D., Retired Assistant Sheriff, Orange County Sheriff-Coroner Department, both long-time COMIO members retired in 2016. COMIO is grateful for their service and dedication to COMIO's mission. Additionally, COMIO was supported by CDCR staff, including COMIO Executive Officer Stephanie Welch, COMIO Program Analyst Michelle Grant, and Norine Occhipinti and Renee Whitehead of the CDCR Office of the Secretary.

2016 Priority Work Areas:

In 2016 COMIO elected to continue the focus on three priority areas identified in 2015 with a few revisions, these include:

- ❖ Sharpening the focus on diversion to identify effective capacity building strategies and resources to support diversion,
- ❖ Broadening the training focus beyond first responders, and
- ❖ Expanding juvenile delinquency prevention to include strategies to support improved services for those who do come in contact with the juvenile justice system.

Obtaining information on each of these priorities took place during COMIO meetings, and Diversion, Training, and Juvenile Justice Committee meetings. COMIO also obtained information by conducting educational site visits, such as to Los Angeles County to talk to implementers and study programs associated with the Office of Diversion and Reentry (ODR) and the Los Angeles County Department of Mental Health (LACDMH). Additionally throughout the year, COMIO staff conducted informational interviews and program visits with criminal justice and behavioral health professionals and organizations across the state (see Appendix B). COMIO supports blending information from research and data with lessons learned from implementers and program participants. Together 15 committee and 6 full Council meetings were held with over 36 presentations from various experts and stakeholders. Materials and resources from all committee and full council meetings can be found on the COMIO website at <http://www.cdcr.ca.gov/COMIO/index.html>.

Recognizing that not all topics could be explored with the same rigor the annual legislative report for 2016 is organized into three reporting categories:

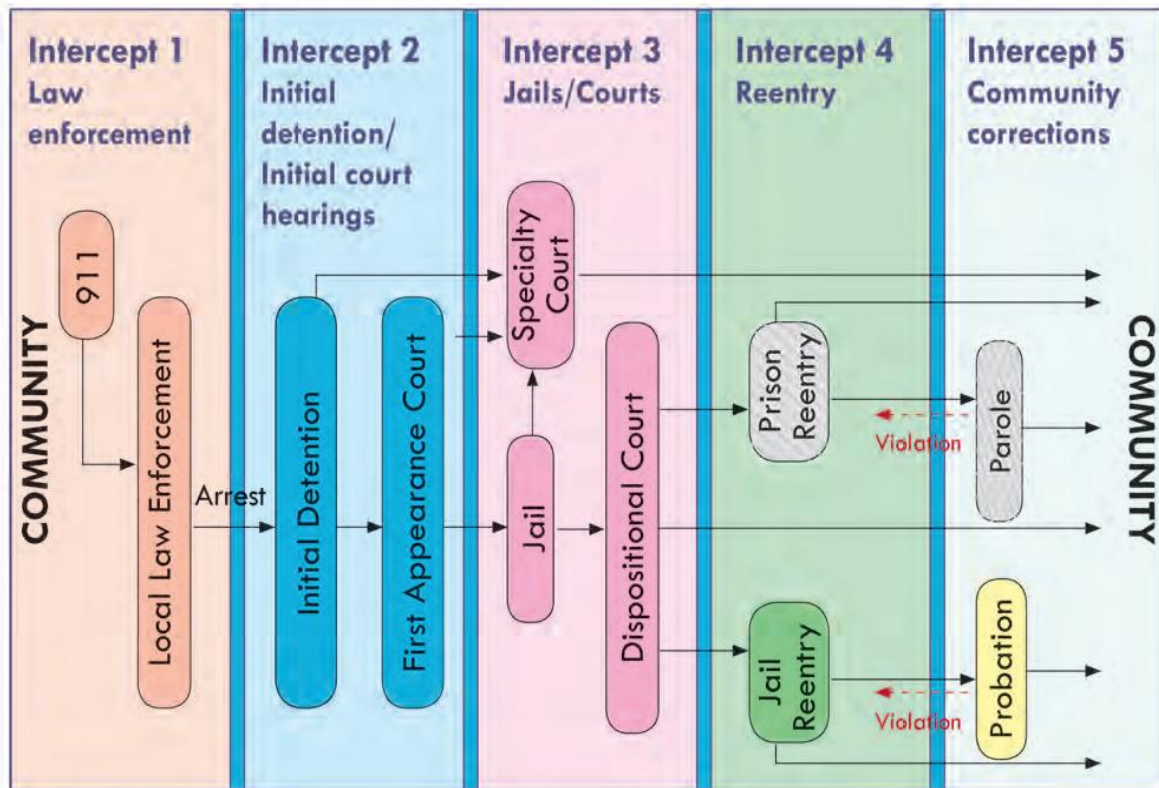
- Investigate – Study the problem and assess challenges,
- Identify – Examine the opportunities present and discover some examples of how, what, and where effective strategies are taking place, and
- Promote – Acknowledge effective strategies that have demonstrated impact.

Each priority area - Diversion, Training, and Juvenile Justice - reports in these three categories in sections two, three, and four of this report.

Foundation of COMIO’s Work:

COMIO’s work is grounded in support of the “Sequential Intercept Model” developed by Mark R. Munetz, MD and Patricia A. Griffin, PhD, which provides a framework for communities to use to design “points of interception” where an intervention can be made to divert individuals from falling deeper into the criminal justice system.⁸ The model assists in targeting strategies to the needs of distinct communities, identifying how to increase the diversion of people with mental illness from the criminal justice system to community treatment. The model includes law enforcement and crisis response services, post arrest and disposition options, jail services and alternatives provided through the courts, re-entry services, and community corrections and supports to prevent recidivism. In addition to the usefulness of this model, COMIO advocates that the most effective way to prevent the majority of incarceration among those with mental illness is to have an accessible and varied mental health and social service system that can address issues before individuals ever become justice-involved. For more information see Text Box A and Figure 1.

Figure 1: Sequential Intercept Model



Text Box A

The Five “Intercepts” in the Sequential Intercept Model

1. *Law enforcement and emergency services:*
 - a. *Police have become de facto mental health crisis responders, as they are frequently the first to be called to address a person with a mental health emergency. Law enforcement officers frequently report encountering someone having a mental health crisis;*
 - b. *Police and Sheriff Departments can work with mental health systems to create mobile crisis teams, staffed by the mental health system but employed by law enforcement, to address crisis in the field;*
 - c. *Another option is a team of mental health professionals that is reachable by phone that can assist officers in the field;*
 - d. *A third option is a team of police officers that receive additional specialized training to deal with crisis situations directly.*
2. *Post arrest, including initial detention and initial hearing:*
 - a. *The first appearance in court is a critical opportunity to divert low-level offenders;*
 - b. *Courts may hire mental health professionals to provide consultation, services, and linkage to the community or develop relationships with outside organizations (including county behavioral health) to assess offenders and advise judges about treatment alternatives;*
 - c. *Having accessible and appropriate services and housing options to divert individuals is critical, and often missing.*
3. *Post-initial hearings, including jail, courts, forensic evaluations and forensic commitments:*
 - a. *Since individuals with mental illness are more likely to stay in jail longer than their general population counterparts, it is essential that they receive proper treatment and services immediately;*
 - b. *Collaborative courts, for those selected to participate, have less of an emphasis on incarceration and more of an emphasis on rehabilitation and diversion. There are mental health courts comprised of a team from the district attorney’s office, a public defender, probation, and other groups that focus on problem-solving and linking the defendant to community resources and services in lieu of incarceration.*
4. *Reentry from jails, state prisons, and forensic hospitalization:*
 - a. *Reentry to the community represents significant opportunities to provide services to prevent recidivism;*
 - b. *Ensuring the continuum of care from jails, state prisons, and state hospitals back to the community is an issue that has been receiving increased attention and resources;*
 - c. *Preparing the necessary transfer of sensitive information about health and recidivism risks and needs is critical to support a smooth transition;*
 - d. *“In Reach” programs aim to engage individuals prior to release, building trusting relationships and conducting assessments to better inform treatment and service plans upon release.*
5. *Community corrections and community support:*
 - a. *Be mindful and seek to address the stigma associated with mental illness and justice-involvement that imposes additional barriers to community integration such as limited access to housing, employment, and various social welfare programs and supports;*
 - b. *Individuals with mental illness or other behavioral health issues also have recidivism risks that must be addressed along with treatment for psychiatric symptoms;*
 - c. *Failure to continue mental health treatment can be grounds for a parole or probation violation and possibly re-incarceration; and*
 - d. *Counties and the state could use probation and parole agents trained specifically to handle mental health caseloads.*

Opportunities and Challenges:

Today there is a political climate ready to implement strategies and solutions that can effectively address the swelling number of individuals with mental illness who are incarcerated. The National Association of Counties (NACo), with support from behavioral health and law enforcement organizations, is supporting the **Stepping Up Initiative**, which is aligning national, state, and local efforts to reduce the incarceration of people with mental illness.⁹ Twenty-one California counties are already participating in the initiative, supported by the Bureau of Justice Assistance (BJA), which also supplies technical assistance from the Council on State Governments Justice Center. For more information about the Stepping Up Initiative see Text Box B. Counties are actively assessing and mapping where they can focus and enhance interventions across the intercept model with blended resources, including funds from public safety realignment, the mental health services act, Medi-Cal, federal and state grants, and local county general funds. Even the state budget supplied considerable resources in fiscal year 2016-17 to efforts such as, strengthen rehabilitation and re-entry efforts, law enforcement training, supportive housing development and investments to address poverty such as raising the Supplemental Security Insurance (SSI) Cost-of-Living Adjustment (COLA) for the disabled.

As we seize this opportunity we must also address a critical barrier that COMIO encountered when examining effective strategies in Diversion, Training, and Juvenile Justice - Stigma. COMIO members asked an esteemed researcher studying effective strategies with offenders with mental illness, Dr. Jennifer Skeem of the University of California Berkeley, School of Social Welfare, what the Council should do to have the most meaningful impact, she replied without hesitation:

“One of the things that we have been recommending for a long time either at the officer or judicial level is having people ask themselves ‘would I be making this decision if not for the mental illness?’ If the answer to that question is ‘no,’ then that means it is time to start unpacking some alternative solutions to the problem. Anybody that is making critical decisions about those facing mental health and/or substance use challenges should be targeted.”

In other words the challenge during this time is to ensure that stigma does not influence the policies and practices that impact individuals with mental health challenges who are, or who are at risk of becoming justice-involved. Myths and misperceptions can reinforce the marginalized status of justice-involved individuals with mental illness, which are far-reaching and can be significantly debilitating. *“Norms and beliefs related to behavioral health, such as the stigma associated with mental illness and substance use disorders, are created and reinforced at multiple levels, including day to day contact with affected individuals, organizational policies and practices, community norms and beliefs, the media and governmental law and policy.”*¹⁰ COMIO is committed to challenging this cycle of unfair judgment and resulting behavior. By raising awareness and consciousness, we can work to reduce the stigmas inflicting this population and support recovery and reintegration.

Stigma based policies and practices consistently impede the adoption of effective practices to prevent incarceration and recidivism. How stigma imposes challenges and what can be done to address them is identified below, including recommendations for COMIO to take action in future work.

Text Box B

Stepping Up Initiative

Launched in May 2015, Stepping Up is a national initiative to reduce the number of people in jails with mental illness and co-occurring substance disorders. The initiative is collaboration between NACo, the Council of State Governments (CSG) Justice Center, and the American Psychiatric Foundation (APF), and is supported by the U.S. Justice Department's Bureau of Justice Assistance (BJA). COMIO has endorsed and promoted the initiative here in California.

The initiative encourages a Call to Action for county and state leadership to commit to the completion of the following six actions:

- 1. Convene a diverse team of leaders and decision makers from multiple agencies committed to safely reducing the number of people in jails with mental illnesses.*
- 2. Collect and review prevalence numbers and assess individuals' needs to better identify adults entering jails with mental illnesses and their recidivism risk.*
- 3. Examine treatment and service capacity to determine which programs and services are available in the county for people with mental illnesses and co-occurring substance use disorders.*
- 4. Develop a plan with measurable outcomes that draws on the jail assessment and prevalence data and the examination of available treatment and service capacity, while considering identified barriers.*
- 5. Implement research-based approaches that advance the plan.*
- 6. Create a process to track progress using data and information systems, and to report on successes.*

County leaders, national and state associations, criminal justice and behavioral health professionals, state and local policymakers, others with jail authority, and individuals are able to sign on to the Call to Action.

A national summit was held in April 2016 and it has aided in identifying what needs to be done to support counties to effectively implement diversion strategies. In California over twenty counties representing about 60% of the state's average daily jail population are currently participating. Support to stepping up counties includes technical assistance on issues such as data collection and measurement, peer to peer learning and policy analyses to identify places counties need support such as Medi-Cal expansion. A California-specific summit will be taking place in early 2017.

For more information about the Stepping Up Initiative, visit <https://stepuptogether.org/>.

Finding: Address the challenges stigma presents to building capacity and alternatives to incarceration

Addressing stigma associated with mental illness is essential to ensuring there are alternatives to incarceration in the community, and that those alternatives get appropriate resources and referrals. Most importantly, individuals using those alternatives should be provided equitable opportunities for recovery and community acceptance. Below are a few examples of how myths and misperceptions about mental illness and can influence policies and practices with a potential negative impact.¹¹

Ensure alternatives to incarceration

- Myth: Personality weakness or character flaws cause mental health problems. People with mental health problems can snap out of it if they try hard enough.
 - Fact: Mental health problems have nothing to do with being lazy or weak and many people need help to get better. Many factors contribute to mental health problems including: biological factors, such as genes, physical illness, injury, or brain chemistry; life experiences, such as trauma or a history of abuse; and family history of mental health problems.
 - Impact: Could lead to policies or reduced investments in mental health services and treatment as an alternative to incarceration because there is no belief that treatment will make any difference.

Support appropriate resources and referrals to alternatives

- Myth: People who have mental illness are more violent and dangerous.
 - Fact: Only 3-5 percent of violent acts can be attributed to people with a serious mental illness. However, according to the U.S. Department of Health and Human Services (HHS), people who have severe mental illness are 10 times more likely to be victims of violence.
 - Impact: A person with mental illness arrested on theft with no prior history of violence could have a higher bond than a person without mental illness who was arrested for the same crime, or not be considered for a service/treatment diversion program due to fears of violence.

Provide equitable opportunities for recovery and community acceptance

- Myth: People with mental health needs, even those who are managing their mental illness, cannot tolerate the stress of holding down a job.
 - Fact: People with mental health problems are just as productive as other employees. Employers who hire people with mental health problems report good attendance and punctuality as well as motivation, quality work, and job tenure that is on par with or greater than other employees. When employees with mental health problems receive effective treatment, it can result in: lower total medical costs, increased productivity, lower absenteeism, and decreased disability costs.
 - Impact: Justice-involved individuals with mental illness might not be considered for rehabilitation opportunities, including education and vocational trainings while in custody, upon re-entry, or even prior to incarceration.

The stigma of mental illness is certainly not the only hurdle to building capacity and creating alternatives. This year COMIO investigated the stigma of having a criminal background, which is challenging enough let alone in addition to a mental illness. For the justice-involved person with mental illness, reintegration and a reduction in recidivism seem only possible if there is a conscientious effort to remove the layers of stigma which can be collectively debilitating. While including race, ethnicity, and sexual orientation were not within this years' scope, such an analysis would document an exponential impact. We investigated barriers and solutions in important life domains such as education and training, employment, and social welfare. Below are a few examples. For a more complete analysis see the infographic in Appendix C.

- Education and Training:
 - Barrier: Since 1995 people that are currently in prison or jail have not been allowed to apply for Federal Pell Grants. These grants provide assistance for college that does not have to be repaid. In addition, the American Opportunity Tax Credit which is up to \$2,500 per year, comparable to Pell Grants, is denied to those with felony drug convictions.
 - Solution: The US Department of Education launched a Second Chance Pell Grant Pilot Program. Through this pilot program, incarcerated individuals who otherwise meet Title IV eligibility requirements and are eligible for release within the next 5 years could access Pell Grants to pursue postsecondary education and training. The goal is to increase access to high-quality educational opportunities and to help these individuals successfully transition out of prison and back into the classroom or the workforce.¹²
- Employment:
 - Barrier: Having any arrest during one's life decreases employment opportunities more than any other employment stigma, such as long-term unemployment, receipt of public assistance, or having a GED instead of a high school diploma. Beyond that, an estimated 87percent of employers conduct criminal background checks on their applicants.¹³
 - Solution: Assembly Bill (AB) 218 signed by Governor Brown in 2014 prohibits a state or local agency from asking an applicant to disclose information regarding a criminal conviction, except as specified, until the agency has determined the applicant meets the minimum employment qualifications for the position.
- Social Welfare:
 - Barrier: SSI is suspended while incarcerated and payments can be reinstated in the month of release. However, if your confinement lasts for 12 consecutive months or longer, your eligibility will be terminated. Former SSI recipients are not automatically deemed eligible once released, so one must reapply.¹⁴
 - Solution: SSI/SSDI Outreach, Access, and Recovery (SOAR) is a national program designed to increase access to the disability income benefit programs administered by the Social Security Administration (SSA) for eligible adults who are experiencing or at-risk of homelessness and have a mental illness, medical impairment, and/or co-occurring substance use disorder. Several counties in California have been trained in SOAR and find it very effective <http://soarworks.prainc.com/content/what-soar>.

Recommendation 1a. COMIO will continue to support and collaborate with stakeholders to dispel myths about mental illness, justice-involvement, and the prevalence of co-occurring substance use among two-thirds of this population. COMIO can provide information regarding best practices in diversion and be available to provide referrals to experts in the field. Communicate the message that both criminal justice and behavioral health systems have joint responsibilities with shared resources over this population and its diversion from incarceration.

Recommendation 2a. COMIO will use workshops, educational site visits, local outreach, the website and newsletter to further identify and disseminate effective strategies, and to raise awareness to combat stigma-based decision-making.

Recommendation 3a. COMIO will include the Board of Supervisors (BOS), Chief Administrative Officers (CAO), and other decision-makers in educational efforts about people with mental health

and substance use disorders who are justice-involved and the barriers they face due to their criminal background.

Recommendation 4a. COMIO will encourage diversion stakeholders to participate in the local MHSA planning process to encourage that MHSA resources support efforts to prevent and reduce the incarceration of people with mental illness. One of the primary goals of MHSA is to prevent incarceration. Counties already have several efforts underway with MHSA funds. Explore what else can be done, especially through leveraging other funding opportunities for diversion (e.g. Prop 47 and AB 109).

The challenge of developing capacity and providing community alternatives like housing and supportive services to the justice-involved with mental illness and substance use disorders is so immense that it must be called out above other challenges. “Not in My Backyard” or NIMBY can be defined as “objecting to the siting of something perceived as unpleasant or potentially dangerous in one’s neighborhood, such as a landfill or hazardous waste facility, especially while raising no such objections to similar developments elsewhere”.¹⁵ NIMBY would be a problem if the population to be housed or provided services was just for the justice-involved or individuals with behavioral health issues but both simultaneously poses tremendous difficulty. In addition, NIMBY also exists as opposition to affordable and supportive housing and according to Disability Rights California (DRC) “has deep roots in fear, racism, classism, ableism, and growing antidevelopment reactions ... it is a governance problem, economic problem, and civil rights problem.” For more information see Text Box C.

While efforts should be made to ensure that local laws are complying with land use, fair housing and anti-discrimination laws, careful attention should be paid to successfully managing public opposition. The Non-profit Housing Association of Northern California (NPH) has developed a useful guide called *Six Steps to Getting Local Governmental Approval* and these strategies closely mirror recommendations put forth by the National Institute of Corrections (NIC) regarding siting for correctional facilities.¹⁶

Text Box C

DRC produced policy recommendations for California to address NIMBY in 2014, they include:

- *State and local governments should continue to support efforts to reduce stigma against people with mental illness, such as cities and counties conducting community outreach and training to community development agencies, fair housing, land use and planning staff, section 504 coordinators and others about land use and fair housing rights.*
- *Local governments should facilitate or participate in community discussions regarding zoning approval and communicate that housing providers and perspective tenants have land use and fair housing rights that protect housing developments against NIMBY opposition.*
- *Local governments should ensure that their land use, planning, and zoning efforts, enable supportive housing and discourage NIMBYism, such as, ensuring that their housing elements and consolidated plans are current and approved, that the disability and fair housing assessment and program portions of these planning documents promote and encourage supportive housing, and that changes are made to zoning codes as needed to comply with current and approved housing elements and consolidated plans.*

Recommendation 5a. Promote the implementation of DRC’s NIMBY reduction policy recommendations, especially efforts to ensure that local governments are complying with land use/planning, fair housing and anti-discrimination laws. Ensure that people with disabilities are not discriminated against based on their criminal background, and that they receive reasonable accommodations from landlords and municipalities that make land-use decisions.

¹ Henry J. Steadman, Ph.D., et al. “Prevalence of Serious Mental Illness Among Jail Inmates,” (Jun. 2009) *PSYCHIATRIC SERVICES*, pp. 761–765 <<http://ps.psychiatryonline.org/doi/pdf/10.1176/ps.2009.60.6.761>> (accessed Nov. 28 2016); and Paula M. Ditton, *Mental Health and Treatment of Inmates and Probationers*, (July 1999), U.S. Department of Justice, Office of Justice Programs <<http://www.bjs.gov/content/pub/pdf/mhtip.pdf>.

² Fred Osher, M.D., et al., *A Best Practice Approach to Community Re-entry from Jails for Inmates with Co-occurring Disorders: The APIC Model* (Sep. 2002) <https://www.prainc.com/wp-content/uploads/2015/10/best-practice-approach-community-re-entry-inmates-co-occurring-disorders.pdf>.

³ Mumola, C.; and Karberg, J.C. *Drug Use and Dependence, State and Federal Prisoners, 2004*. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, 2007. Available at <http://www.bjs.gov/content/pub/pdf/dudsfp04.pdf>

⁴ Feucht, T.E., and Gfroerer, *Mental and Substance Use Disorders among Adult Men on Probation and Parole: Some Success against a Persistent Challenge (2011)*, Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. Available at: <https://www.ncjrs.gov/pdffiles1/nij/235637.pdf>

⁵ Ford, M. (2015). America’s Largest Mental Health Hospital is a Jail. *The Atlantic*. Available at: <http://www.theatlantic.com/politics/archive/2015/06/americas-largest-mental-hospital-is-a-jail/395012/>

⁶ California Department of Corrections and Rehabilitation, Office of Research (2016). 2015 Outcome Evaluation Report, An examination of Offenders Released in 2011-2012. Available at: http://www.cdcr.ca.gov/Adult_Research_Branch/Research_Documents/2015_Outcome_Evaluation_Report_8-25-2016.pdf

⁷ Lofstrom, M., Bird, M., and Martin, B. (2016). California’s Historic Corrections Reforms. Public Policy Institute of California. Available at: http://www.ppic.org/content/pubs/report/R_916MLR.pdf

⁸ Munetz, M.R., and Griffin, P.A. (2006). Use of the Sequential Intercept Model as an Approach to Decriminalization of People with Serious Mental Illness. *Psychiatric Services*, 57(4): 544-549.

⁹ More information on the Stepping Up Initiative is available at: <https://stepuptogether.org> The toolkit is available at: <https://stepuptogether.org/toolkit>

¹⁰ National Academy of Sciences (2016). Ending Discrimination Against People with Mental and Substance Use Disorders: The Evidence for Stigma Change. Available at: <https://www.nap.edu/catalog/23442/ending-discrimination-against-people-with-mental-and-substance-use-disorders>

¹¹ These myths and facts can be reviewed at: <https://www.mentalhealth.gov/basics/myths-facts>

¹² U.S. Department of Education Launches Second Chance Pell Grant Pilot Program <https://www.ed.gov/news/press-releases/us-department-education-launches-second-chance-pell-pilot-program-incarcerated-individuals>

¹³ Decker, S., Spohn, C., Oritz, N., & Hedberg, E. (2014). Criminal Stigma, Race, Gender, and Employment. National Institute of Justice available at: <https://www.ncjrs.gov/pdffiles1/nij/grants/244756.pdf>

¹⁴ Social Security Administration (2015). Social Security What Prisoners Need to Know available at: <https://www.ssa.gov/pubs/EN-05-10133.pdf>

¹⁵ Disability Rights California (2014). Everyone’s Neighborhood: Addressing “Not in My Backyard” Opposition to Supportive Housing for People with Disabilities available at: <http://www.disabilityrightsca.org/pubs/CM5301.pdf>

¹⁶ NPH, Six Steps to Getting Local Government Approvals available at: http://www.hcd.ca.gov/hpd/nimby/six_steps.pdf

Diversion

Diversion: Overcoming Barriers to Build Capacity for Effective Interventions

A critical ingredient in a successful system of diversion is the availability and accessibility of alternatives to incarceration. In 2015 COMIO pointed this out calling for more attention to be paid regarding the dilemma of “divert to what and divert to where.” For 2016 the Diversion committee wanted to improve their understanding of why there was or was not capacity to provide available and accessible alternatives to incarceration. Capacity-building is needed to produce alternatives along all five intercepts from initial interaction with law enforcement to reintegration and community support. In this section of the report the categories of *investigating, identifying, and promoting* are used to examine the challenges of what is known or not known, recognize existing opportunities, and encourage the future adoption of examples of creative capacity building for alternatives to incarceration that are taking place both in and beyond California.

Investigate: Study the Problem and Assess Challenges

Finding: Explore a new paradigm to support effective practices to reduce recidivism and prevent incarceration among individuals with mental illness

Several years ago emerging evidence started to challenge long held beliefs that mental illness directly caused criminal justice involvement. The “direct cause” model that calls for building more capacity for community mental health services to support reduced recidivism had little evidence as untreated mental illness is, at best, a weak predictor of recidivism among criminal offenders.¹⁷ Dr. Jennifer Skeem argues that the perceived root cause of the problem, untreated mental illness, was frankly too simple and the “implicit model” of what works should be questioned. One study documented that only 10 percent of the persons incarcerated with mental illness committed a crime that could be directly linked back to psychiatric symptoms.¹⁸ The “implicit model” dictates that the offender with mental illness should be sentenced to treatment or a special program, that the program will provide services to lessen or control symptoms, and recidivism will be reduced.¹⁹

Skeem argues for alternatives to consider because there is little evidence that providing psychiatric services alone can reduce crime.²⁰ First, take into account that the vast majority, roughly three-quarters, of individuals with mental illness who are incarcerated have a co-occurring substance use disorder and likely committing crimes to support their addiction.²¹ Second, another group of offenders have other forms of deviant behavior, but their poverty situates them socially and geographically, at risk of engaging in many of the same behaviors displayed by persons without mental illness who are similarly situated.²² Taking both into consideration, Skeem advocates for an alternative model where the relationship between mental illness and criminal behavior is largely indirect and it is the mental illness that is the foundation for more general risk factors.²³ The onset of mental illness disrupts prosocial relationships, educational goals and employment, and increases the risk of misuse of substances. These are some of the very same risk factors that lead to anti-social and criminal behavior. While the reason for the presence of risk factors may be different for offenders with mental illness compared to those without, both have the same risk factors for recidivism that need to be addressed. Refining an effective model to reduce incarceration among people with mental illness requires additionally targeting robust risk factors like anti-social

behavior. Therefore there is a need to use evidenced-based correctional practices and psychiatric services to prevent incarceration.²⁴ Now this does not mean that all individuals with mental illness who interact with the justice system have criminal thinking and behavior. But when managing limited resources it does demonstrate the importance of having tools to determine who has the highest risks and needs, what type of programs will be effective based on that information, and assessing whether the existing and available staff have the skills to provide those interventions.

Current research identifies the “Risk-Need-Responsivity” (RNR) model as a tool for correctional authorities in facilities and in the community to identify and prioritize individuals to receive appropriate interventions.²⁵ Taking into consideration the alternative model outlined above, individuals with mental illness, substance use disorder, and co-occurring diagnoses, can also be assessed with the RNR model. This is already happening here in California. Several standardized tools are in use such as the Correctional Offender Management Profiling for Alternative Sanctions (COMPAS), Level of Service Inventory-Revised (LSI-R) and the Level of Service – Case Management Inventory (LS-CMI).²⁶ Offenders with low risk scores do not need intensive supervision and services in the community and if placed with high risk offenders their level of risk for reoffending actually increases. The model contains the following underlying principles:²⁷

- Risk Principle: Match the intensity of individuals’ treatment to their level of risk for reoffending,
- Need Principle: Target criminogenic needs – the dynamic factors that contribute to the likelihood of reoffending (i.e. substance use),
- Responsivity Principle: Address individuals’ barriers to learning in the design of treatment intervention (i.e. address cognitive impairments due to mental illness), and
- Criminogenic risk factors are “static” or “dynamic”: Static risk factors cannot be changed like gender or ethnicity, but dynamic risk factors can be changed with interventions.

Skeem recently studied the use of RNR on individuals with mental illness and did note that, “although there is preliminary evidence that higher-risk persons with mental illness should receive intensive services, caution is warranted in directly generalizing the risk principle.”²⁸ Skeem warned that support for mental health treatment should not be re-directed to support correctional services, but rather that interventions should be flexible enough so that when clinical impairment increases, mental health services increase, and the same for making adjustments when recidivism risk increases and therefore correctional services increase. In addition, Skeem urges for more evidence that the RNR model is effective for individuals with mental illness, especially as it relates to understanding the responsivity principle (i.e. mental health services working synergistically with correctional services). In other words, while mental illness is not a central risk factor, functional impairments and symptoms must be addressed to support the individual maximizing the impact of the correctional intervention. Following this guidance can support policy decisions regarding where to invest resources, as well as improve the mental well-being of offenders.

One of the goals of realignment legislation was to promote the use of evidence-based reentry practices and the belief that local systems with available resources knew what would work best for their unique population.²⁹ Today there is an opportunity to examine the growing evidence regarding effective models that can be used to both reduce recidivism and improve mental health status and recovery. Building upon the alternative model and the RNR model discussed previously, effective interventions focus on meeting individual needs and addressing what are often high scores on measures of criminogenic thinking. Cognitive-Behavioral Therapy (CBT) has been a long accepted evidence-based intervention for addressing distressing feelings, disturbing behavior, and

targeting improvements in symptoms such as depression and anxiety. The Gains Center for Behavioral Health and Justice Transition identified the following as typical CBT interventions in correctional settings:³⁰

- Thinking for Change (T4C) (Golden, 2002),
- Moral Recognition Therapy (MRT) (Little, 1998),
- Interactive Journaling (Walters, 1999), and
- Reasoning and Rehabilitation (R & R) (Ross, 1988).

Many of these have been adapted for individuals with serious mental illness with success and focus on “clinical features associated with criminality such as frustration intolerance, social skills deficits, and misperceptions of the environment.”³¹ Dialectical Behavioral Therapy (DBT) and Motivational Interviewing (MI) have particularly been found to be effective in addressing the “responsivity” factor for offenders with mental illness by supporting the management of symptoms to maximize benefits from correctional interventions.³² Special attention must be paid to the high risk of recidivism for those with substance use disorders or co-occurring disorders. This high risk is both direct through crime and indirectly due to the negative impact addiction has on responsivity to interventions. Considering that nearly three-quarters of individuals in jails with mental illness have a co-occurring substance use disorder, developing capacity to provide these kinds of interventions is critical. The Council on State Governments Justice Center (CSG) in collaboration with the NIC and the BJA created, *Adults with Behavioral Health Needs under Correctional Supervision: A Shared Framework for Reducing Recidivism and Promoting Recovery*, which is an excellent resource for entities looking for strategies to integrate intervention planning between correctional services and behavioral health services.³³

Recommendation 1b. Core competencies to provide effective integrated correctional and behavioral health services to better promote recovery and recidivism are significantly needed – both in custody and in the community. For resources to support necessary training and technical assistance, counties can explore the flexibility of existing funding sources or use technical assistance resources available through MHSA state administration funds, which is appropriate because reducing incarceration (including recidivism) is one of the primary goals of MHSA.

The hallmark components of today’s community behavioral health system, like individualized treatment plans, recovery and wellness service orientation, and cultural responsiveness should also be a part of effective integrated correctional and behavioral health services. Individuals with mental illness and/or substance use disorder, which are either at risk of initial incarceration or recidivism, need significant social support services such as food assistance and transportation, stable and affordable housing, employment and educational opportunities, and stable nurturing relationships. The Vera Institute for Justice is calling for a shift in the paradigm of how to serve individuals with mental illness who are justice-involved to “recovery informed practice”.³⁴ In this model policy and practice are trauma-informed, mental health and criminal justice labels are secondary to client services, a wellness approach focuses on addressing social determinants and peers and families are integrated into services and supports.

Peer support, and the use of peers in a variety of ways, clearly stood out during the course of COMIO’s work in 2016 as one of the most impactful and desired resources to reduce incarceration among those with mental illness and substance use disorders. While there are a variety of different models of peer support, the Substance Abuse and Mental Health Services Administration (SAMHSA) identifies the following core competencies of a peer support specialist:

- **Recovery-oriented:** Peer workers hold out hope to those they serve, partnering with them to envision and achieve a meaningful and purposeful life. Peer workers help those they serve to identify and build on strengths, empower personal decision-making, and to recognize that there are multiple pathways to recovery.
- **Person-centered:** Peer recovery support services are always directed by the person participating in services. Peer recovery support is personalized to align with the specific hopes, goals, and preferences of the individual served, and to respond to specific needs the individuals has identified to the peer worker.
- **Voluntary:** Peer workers are partners or consultants to those they serve. They do not dictate the types of services provided or the elements of recovery plans that will guide their work with peers. Participation in peer recovery support services is always contingent on peer choice.
- **Relationship-focused:** The relationship between the peer worker and the peer is the foundation on which peer recovery services and support are provided. The relationship between the peer worker and peer is respectful, trusting, empathetic, collaborative, and mutual.
- **Trauma-informed:** Peer recovery support utilizes a strength-based framework that emphasizes physical, psychological, and emotional safety and creates opportunities for survivors to rebuild a sense of control and empowerment.

Peers were used for everything from health education and Wellness Recovery Action Plan (WRAP) facilitators while in custody, to court liaisons for felony diversion programs.³⁵ The Inmate Peer Health Education Program (IPHEP) uses peers to teach other peers about victim awareness and personal management skills. Most often peers were used as “system navigators” whether it was for inside prisons and jails or for those re-entering the community. Several were working in “in-reach” programs such as Project In-Reach which is operated by the Neighborhood House Association (NHA) in partnership with the San Diego County Sheriff’s Department. Individuals are referred to the program 60 to 180 days before their scheduled release for therapy, treatment, and care coordination with a focus on transition back to the community. The recidivism rate of program participants is significantly less than non-participants with a rate of only 26 percent.³⁶ Transitions Clinic Network (TNC) which began in San Francisco, refers to peers (many are individuals who are formerly incarcerated in recovery from a mental illness or substance use disorder), as community health workers and mentors who provide “key outreach and coordination services, meeting individuals at parole encounters and in their homes, identifying critical social needs (e.g. clothing, housing, government identification), and guiding them through the health care system while addressing their physical and behavioral health needs”. The American Journal of Public Health rated the emergency department utilization among TNC patients in San Francisco 35 percent lower than other similar providers.³⁷

Several counties, if not the majority, are looking for innovative ways to use peers who are formerly justice-involved. Additional models that do not necessarily represent paid staff positions but are grounded in the peer support model include the Veterans Treatment Court Peer Program (Justice for Vets) and the NAMI Peer to Peer Program. With Justice for Vets, veteran volunteers mentor other veterans to secure housing and employment, or job training and education. As system navigators they also aid in accessing disability compensation claims and identify linkages for support at the local, state and federal level.³⁸ The NAMI Peer to Peer Program is a free 10-session educational program for adults living with a mental illness to better understand their condition,

support recovery and gain empowerment.³⁹ COMIO support efforts to provide appropriate training and compensation for peers who provide vital services in our communities.

Recommendation 2b. Promote the use of peers who are formerly justice-involved as an essential element of the service team. Encourage counties to support the hiring and training of the formerly incarcerated. All efforts to expand the use of peers in the workforce, including strategies that support Medi-Cal reimbursable services, should include the formerly incarcerated.

Finding: More data and information is needed to support planning and effective practices

A recent PPIC report stated, “Although jails are an increasingly important part of California’s correctional system, our understanding of the basic characteristics of the state’s jail population – who is in jail, why they are being held, how long they stay, and how they are released – is limited by data.”⁴⁰ To help resolve this, 12 counties representing over 50 percent of California’s population are participating in the Multi-County Study, which is collaboration between PPIC and the Board of State and Community Corrections (BSCC) with support from CDCR. The purpose of the study is to collect and merge state and local criminal justice data to evaluate the effects of key reforms. More importantly to COMIO, the study can identify effective recidivism policies and practices and assist counties with improving their data collection and the use of data for continuous self-evaluation.

The study is in its second phase and preparing for stage 3 in 2017. Stage 3 transfers the developed jail population forecasting tools and jail policy tools to BSCC who will continue to support counties. In the fall of 2016 PPIC presented COMIO some emerging findings specifically related individuals with mental health needs interfacing with local jails:

- While counties are using assessments, it is not on the entire population. Assessments include the brief justice mental health screen (BJMHS), correctional mental health screen for men (CMHS-M), correctional mental health screen for women (CMHS-W), and the jail screening assessment tool (JSAT).
- There appears to be emerging evidence similar to previous studies that show that there are identifiable “high jail utilizers” who experience repeated bookings and longer jail stays. These individuals often have mental illness and/or substance use disorder.
- There is a significant need for clarification and support to share information between agencies.

Recommendation 3b. Researchers, including PPIC as part of the 12-county study, could include questions that are specific to behavioral health impact when investigating correctional reforms, particularly public safety realignment.

- Do counties conduct risk assessments to support diversion efforts? At what point are assessments done - booking, pretrial, upon release?
- Are we measuring the rate of individuals with mental illnesses or substance use disorders returning to jail?
- Conduct a cost benefit or cost avoidance analysis to document the value of services and treatment over incarceration.

Finding: Know the problem that needs fixing when building capacity

In a brief produced as part of the **Stepping Up Initiative** experts in the field of diversion call out that one of the primary reasons more progress in reducing the incarceration of individuals with mental illness has not been achieved despite significant investments is because, “there is insufficient data to identify the target population and to inform efforts to develop a system-wide response.”⁴¹ The authors continue noting that data is not available to establish a baseline and because counties struggle to systematically collect information about the mental health and substance use needs of each person booked into jail, this information cannot be analyzed to inform planning for local investments. A necessary step is to ensure that all offenders booked into jail receive a brief mental health screen, and when appropriate a further assessment and re-assessment to determine qualifications for post-booking diversion. COMIO strongly supports several recommendations in the brief, including:

Recommendation 4b. Counties can use a standard definition of mental illness, substance abuse, and recidivism across the state in community corrections so that comparisons and trends across counties and statewide can be drawn. COMIO recommends the use of BSCC’s definition of recidivism and the statutory definition of mental illness (MI) and substance use disorder (SUD) as guidance for inclusion in Medi-Cal programs.

Recommendation 5b. Counties can better understand the prevalence of mental illness in the jail population by using validated screening and assessment tools at booking, including a brief screen for MI and SUD to determine treatment needs. Tools should be gender specific but simple enough anyone can administer them.

Recommendation 6b. Counties can then also screen for recidivism risk pre-trial to determine eligibility for diversion or alternative community supervision. The use of validated assessment tools can prioritize high risk, high need, and difficult to serve populations. The court can then consider when alternative treatment and services are appropriate.

Many counties recognize these challenges, are learning about these strategies, and are beginning to take the steps necessary to make data available to inform decision-making. California Forward (CA FWD), through the Justice System Change Initiative (J-SCI),⁴² has been working with counties to assess challenges and build needed infrastructure for data-informed decisions regarding justice-involved populations. CA FWD’s mission is to promote good governance through system change, so it is not surprising that they have aided counties to think creatively about the collision of two of the most significant policy reforms in recent decades, the expansion of health care and public safety realignment. Together these reforms offer tremendous opportunity to keep individuals with mental illness and substance use disorders from incarceration. J-SCI aims to build county capacity for data informed decision-making, reducing jail reliance by increasing success of alternatives, and decreasing overall costs through increased efficiency and effectiveness while ensuring public safety.

COMIO had the opportunity to learn specifically how J-SCI assisted Riverside County through an executive leadership committee that ensured data would be collected and shared to inform a Jail Utilization Report. Through J-SCI, Riverside County learned specifically who was in their jail and why to inform decision-making. They learned, similar to other counties, that individuals with serious mental illness were booked more frequently, stayed significantly longer, and did so for less serious crimes. In addition, the study identified that nearly half of the daily population were from people

breaking the rules (e.g. probation, parole) not committing new crimes, and that nearly two-thirds of jail bed days were pre-trial. Riverside is learning how to do the future data collection and analysis on their own and is focusing their change efforts on what they have learned, including:

- Examining Probation’s use of technical violations and other “side door” entries like warrants and holds,
- Supporting courts to be more efficient and maximize appropriate pre-trial releases;
- Develop interventions to improve mental health outcomes and reduce jail time, and
- Work collaboratively to build capacity to address substance use.

Recommendation 7b. Support the counties to know their populations. Through projects like CA FWD’s J-SCI counties can learn how to use data to make informed decisions about services and funding. Counties need baseline data to know who is in their jails and why. They also need support to develop projections as to what kinds of service alternatives they need and where to develop a system wide approach to diversion. Measuring the problem is essential in making arguments for behavioral health resources to BOS, Community Correctional Partnerships (CCP), and/or MHSA stakeholder bodies.

Finding: Provide guidance and confidence to support data-sharing

Implementers spoke about the challenge of data-sharing between behavioral health and criminal justice partners. They expressed concerns about what is allowable when exchanging sensitive health data, especially considering the increasing numbers of individuals with significantly complex physical health, mental health, and substance use disorders, were paramount. Some of the reasons for barriers include:

- Not knowing when patient consent is needed to exchange mental health information;
- Lack of data systems that have interoperability,
- Not having approved policies or agreements in place to share and exchange data, and
- Not having the training or staff capacity needed to collect, analyze or share data.

This year COMIO was not able to investigate this challenge thoroughly, but doing so should be continued in future work.

Recommendation 8b. The California Office of Health Information Integrity (CalOHII) based in the Health and Human Services Agency is working with stakeholders to produce a non-mandatory guidance document about the use, disclosure, and protection of sensitive health data. Guidance for when and how data can be exchanged with criminal justice partners, including law enforcement, corrections and the courts should be included in the effort.

Recommendation 9b. Further investigate what counties have uniquely done to overcome barriers both in building relationships and data systems such as the innovative ways LA County Department of Mental Health shares information with the Los Angeles Police Department (LAPD) and Los Angeles County Sheriff’s Department (LASD). Promote the exchange between counties of tools like sample interagency agreements and other local protocols. Help disseminate the results from the White House’s Data-Driven Justice Initiative of which Los Angeles, Oakland, San Diego, San Francisco, and Santa Clara are participating in currently.⁴³

There were also two areas in the investigative section where we were not able to complete our research, but are interested in continuing work in this area in the future.

Finding: Support counties to address the growth in the number and percentage of offenders booked into and held in jails with mental illness and substance use disorders

Recommendation 10b. Mental illness as a basis for diversion could be expanded. A review of which offenses could be additionally considered for authorization of diversion should be undertaken and recommendations made. As precedent, in 2015 Military Diversion was created as an option to support former military experiencing mental illness, substance use, traumatic brain injury (TBI) or sexual trauma to elect treatment over other action by the court.

Recommendation 11b. The state and relevant stakeholders, including the counties and DSH, are examining the reasons behind the growing numbers of Incompetent to Stand Trial (IST) cases. A thorough review is of critical importance, including an assessment of why more community treatment alternatives are not being utilized in the face of this growing and persistent dilemma. COMIO requests to participate in such examinations at the state level and to offer assistance in generating a list of solutions.

Identify: Recognize and Examine Existing Opportunities

Finding: Build capacity for community alternatives with effective and integrated behavioral health and correctional services

California has been diligent about maximizing opportunities under the Affordable Care Act (ACA), in particular opportunities to expand community-based care for special needs populations. With the ACA, 100 percent of the services provided to individuals enrolled in 2014 through the end of 2016 is covered by the federal government, with states picking up 5 percent in 2017 and gradually increasing to 10 percent by 2020. Due to the ACA many of the formerly incarcerated or at-risk of incarceration became eligible for affordable health care services or Medi-Cal services, especially males on probation and parole status. That “justice” status should not be a barrier to accessing needed health care services. Medi-Cal 2020 is the five-year renewal of the Section 1115 Waiver, which could bring upwards of \$7 billion in additional federal funds.⁴⁴ Medi-Cal services provide one of the viable sources of funding to support diversion efforts, from alternatives to booking into jail to community reentry and on-going supportive case management. One of the components of the waiver is the Whole Person Care (WPC) Pilot Program.

“California will create a Whole Person Care (WPC) pilot program in order to give counties new options to provide coordinated care for vulnerable, high utilizing Medicaid recipients. The overarching goal of the WPC pilots is to better coordinate health, behavioral health and social services, as applicable, in a patient-centered manner with the goals of improved beneficiary health and wellbeing through more efficient and effective use of resources. This program will help communities address social determinants of health, and offer vulnerable beneficiaries, innovative and potentially highly effective services on a pilot basis.” (CMH 12-30-16 Approval Letter to DHCS)


Up to \$1.5 billion in federal funds will be available to match local public funds over 5 years for the 18 counties that applied for the pilot, awardees were announced in November 2016. DHCS also recently announced that they will be conducting a second round of WPC pilot applications from

counties in March 2017. The WPC pilots are to identify high-risk, high-utilizing Medi-Cal beneficiaries, such as individuals with complex needs like mental illness and substance use disorder who are also at risk of experiencing homelessness due to release from institutions, like jails and prisons. The pilots will test how comprehensive, coordinated, and integrated services can lead to reduced spending with better health outcomes. One the most unique benefits of the WPC pilots is the ability to pay for housing support and other community support services. 7 pilots are targeting individuals existing institutional settings, including those incarcerated, and 4 pilots are specifically supporting post-incarceration services. For a list of the 18 counties participating in the WPC pilots and the amount of resources awarded over the next 5-year period see Figure 2. Potential services for those enrolled include:

- Health services – physical, mental health, and substance use disorder,
- Care coordination –system navigators, medication management support, transition from jail to home,
- Stabilization services – support homeless or at risk of homelessness populations to obtain housing and provide tenancy supports and an established flexible housing pool can take saving and use them for non-Federal Financial Participation (FFP) reimbursable needs like rental subsidies, and
- Other – transportation, benefit establishment, SSI advocacy, educational and vocational training.

California Whole Person Care Pilot Applications

Figure 2

 Whole Person Care Pilot			
	Lead Entity	Estimated 5 year Beneficiary	Total 5 Year Budget
	Alameda County Health Care Services Agency	20,000	\$283,453,400
	Contra Costa Health Services	52,500	\$203,958,160
	Kern Medical Center	2,000	\$157,346,500
	Los Angeles County Department of Health Services	137,700	\$900,000,000
	Monterey County Health Department	500	\$26,834,630
	Napa County	800	\$22,686,030
	County of Orange Health Care Agency	8,098	\$23,500,000
	Placer County Health and Human Services Department	450	\$20,126,290
	Riverside University Health System - Behavioral Health	38,000	\$35,386,995
	San Bernardino County - Arrowhead Regional Medical Center	2,000	\$24,537,000
	County of San Diego, Health and Human Services Agency	1,049	\$43,619,950
	San Francisco Department of Public Health	10,720	\$118,000,000
	San Joaquin County Health Care Services Agency	2,130	\$17,500,000
	San Mateo County Health System	5,000	\$165,367,710
	Santa Clara Valley Health and Hospital System	10,000	\$225,715,295
	Shasta County Health and Human Services Agency	600	\$19,403,550
	Solano County Health & Social Services	250	\$4,667,010
	Ventura County Health Care Agency	2,000	\$97,837,690

Source: Department of Health Care Services, November 2016

Recommendation 12b. COMO to monitor the progress of the WPC pilots, reaching out to county implementers, when appropriate, to hear about challenges that need to be addressed to support targeting the justice-involved with mental illness, particularly those with co-occurring disorders. Encourage more counties to apply and take advantage of the second round of WPC pilots.

Another critical opportunity to expand services to the justice-involved or at-risk population is through the Drug Medi-Cal Organized Delivery System (DMC-ODS) which is a pilot program intended to improve the quality and availability of SUD services giving state and county systems more authority to select quality providers. Similar to the WPC pilots DMC-ODS aims to reduce costs by preventing emergency room and hospital inpatient visits. DHCS estimates that 13.6 percent of the newly eligible Medi-Cal beneficiaries have a SUD treatment need.⁴⁵ The waiver is intended to fill gaps and make improvements to the existing Drug Medi-Cal service delivery system by developing a continuum of services modelled after the American Society of Addiction Medicine (ASAM) criteria for SUD treatment services, such as:

- Early Intervention (overseen through the managed care system),
- Outpatient Services,
- Intensive Outpatient Services,
- Short-Term Residential Services (up to 90 days with no facility bed limit),
- Withdrawal management,
- Opioid/Narcotic Treatment Program Services,
- Recovery Services,
- Case Management, and
- Physician Consultation.

The implementation is taking place in 5 phases with phase 4 starting in November 2016. Fourteen counties representing about 50 percent of California's population are now in review at DHCS with services starting soon. One of the critical elements of the waiver is to provide more intensive services to justice-involved populations who have multiple treatment needs. There are several examples in county implementation plans that demonstrate partnerships with criminal justice system partners. See Table 1 which summarizes currently available county plans.

A few suggestions have come from stakeholders to COMIO regarding improvements in the implementation of DMC-ODS and issues that need exploration for possible resolution in the future:

- Lessen or lift some of the barriers to licensing drug providers,
- Support same day billing for Mental Health and SUD services, and
- Support counties and providers who will need to site facilities (e.g. sober living) and obtain community housing alternatives.

COMIO can work with the County Behavioral Health Directors Association (CBHDA), Chief Probation Officers of California (CPOC), and CDCR to gather information regarding the challenges with using the DMC-ODS to serve the justice-involved population so that improvements can be made to maximize this opportunity. For example, there are gaps and challenges when implementing services under the current waiver, such as the twice per calendar year limit on utilizing residential substance use treatment. Yet, even if capacity was developed to offer such services, the lack of providers is nearly at a crisis point. Unless there are significant investments to address workforce shortages, new and effective interventions will not be able to reach but a fraction of the need.

Table 1: County Drug Medi-Cal Organized Delivery System Implementation Plans

Services Available to Justice-Involved Individuals										
County	Withdrawal Management	Residential Services	Outpatient	Opioid Treatment Programs	Recovery Support Services	Case Management	Additional Medication Assisted Treatment	Assessments/ Referrals	Drug Court	Drug Diversion and Intervention
Alameda*		X				X		X	X	
Contra Costa									X	X
Los Angeles		X			X					
Marin					X	X				
Monterey								X	X	X
Napa*	X					X		X		
Orange*		X	X			X	X	X		
Riverside	X	X	X	X			X		X	
San Francisco	X	X	X	X			X		X	
San Luis Obispo*		X	X					X		
San Mateo		X	X				X			
Santa Clara	X			X		X	X	X	X	X
Santa Cruz						X	X	X		
Sonoma*				X		X		X	X	X
Ventura								X		X

Source: Department of Health Care Services, November 2016

*indicates that Implementation Plan is only available in draft form

Note: Marin, San Luis Obispo, and Santa Clara counties stated in their plans that reduced recidivism is an outcome measure for the success of their programs. To view full Implementation Plans, visit <http://www.dhcs.ca.gov/provgovpart/Pages/County-Implementation-Plans-.aspx>

Recommendation 13b. Work with CBHDA and DHCS to identify strategies to increase the number of Drug Medi-Cal certified providers who serve the reentry population, what barriers exist to licensing drug providers, identifying actionable steps to take forward to increase numbers.

Recommendation 14b. Work with partners to better understand resources at the federal, state, and local levels for workforce development. Explore whether the California Office of Statewide Health Care Planning (OSHP) has any recommendations for strategies we could be pursuing.

Finding: Maximize every opportunity to use Medi-Cal to cover the needs of the justice-involved

While these pilots are excellent opportunities to develop capacity for interventions designed for individuals with mental illness who are justice-involved, every opportunity to use federally reimbursed services under Medi-Cal to cover the needs of the justice-involved (incarcerated or on community supervision) is critical to creating capacity for alternatives to incarceration. According to the Centers of Medicare and Medicaid Services (CMS) in State Health Official Letter 16-007 Medicaid connects individuals to the care they need once they are in the community and can help lower health care costs, hospitalizations and emergency department visits, as well as decrease mortality and recidivism for justice-involved individuals.⁴⁶ Some noteworthy clarifications include:

- State Medicaid agencies must accept applications from inmates during their incarceration and if eligibility is met, must enroll or renew the enrollment effective before, during or after the period of time spent incarcerated.
- States may provide Medicaid coverage for health care services delivered outside the correctional institution, such as a hospital or nursing home when the person has been admitted for 24 hours or more. Federal reimbursement is up to 100 percent for the newly enrolled. If the inmate/person is eligible but not enrolled at the time, states may secure retroactive Medicaid coverage so long as the inmate/person applies within three months of receiving treatment.
- CMS encourages the completion of the full application, by paper or electronically, and not presumptive eligibility, at the outset to ensure a more streamlined connection to services as one transitions through the justice system.
- CMS has long encouraged the use of suspension policies and for suspension to be lifted promptly. CMS reaffirms this noting that the state may either suspend the person's eligibility or leave enrollment unaltered or ensure that claims are not approved for excluded services. One way this can be done systematically is by establishing "edits" in the state Medicaid claims processing systems. Edits are automated safeguards that states use through their Medicaid program to prevent improper payments.⁴⁷ This is a strategy that California could explore as an alternative to 1-year suspension policies. Whatever policy is the most effective in maximizing the drawdown of federal Medicaid reimbursement should be used.
- CMS explained how payments to contractors for Medicaid-eligible inmates are handled appropriately to support continuity of care when managed care organizations are being used, especially to support reimbursement for pre-release discharge planning.
- For persons not defined as inmates (incarcerated) but on community supervision (which is 69 percent of the justice-involved), the guidance from CMS reversed previous policy regarding coverage when residing in state or local community residential facilities under correctional supervision. Benefits are now allowed as long as the facility affords freedom of

movement but can be closed or locked during certain hours, require reporting to staff, and place other restrictions like no traveling to high crime neighborhoods.

California should examine this direction carefully and consider the benefits of community supervision versus incarceration for individuals with mental illness and substance use, whether it be an alternative to jail or prison. While these individuals may have committed crimes, the faster they can get into treatment and services to support recovery and stabilization the better. Not only will they be in an environment where they are far more likely to get well, but federal reimbursement will cover the costs.

Recommendation 15b. California can examine this direction provided in CMS Letter 16-007 to consider the benefits of community supervision versus incarceration for individuals with mental illness and substance use. The faster individuals with these needs can move to the community to access treatment for recovery and stabilization the better. Not only will they be in an environment where they are far more likely to get well but federal reimbursement, in most cases, will cover the majority of the costs.

Recommendation 16b. Work with partners providing community-based services for the justice-involved, including CBHDA, to identify some of the major gaps or challenges with maximizing Medi-Cal funds. Are there alternatives to residential treatment that begin with harm reduction and engagement?

Above all, aggressive enrollment strategies for inmates prior to release, whether it is prison or jail, should be a top priority. CDCR has made substantial progress in this area, according to a recent report from the California Rehabilitation Oversight Board (C-ROB) noting a 70 percent approval rate for Medi-Cal applications.⁴⁸ Considering the significant number of uninsured persons in jails, PPIC concluded, “enrollment assistance efforts offer the potential to leverage federal and state Medi-Cal resources to improve access to needed physical and behavioral health resources for the re-entry population ... reducing recidivism and the associated cost savings have the potential both to reduce correctional cost burden on counties and to free up resources for additional reentry programming.”⁴⁹ The analysis further states that most counties provide some kind of health insurance enrollment assistance covering the cost of these efforts in various ways including public safety realignment funds, county general funds, and state and federal Medi-Cal administrative funds.

CCP’s established under public safety realignment, could be an effective place to coordinate aggressive enrollment strategies between correctional and court systems and social services and health systems and setting priorities for enrollment. Pre-trial diversion, probation and parole are all points in which Medi-Cal enrollment could be addressed. PPIC also uncovered that the short stays in jails pose a significant challenge to effective enrollment.⁵⁰ Counties have to make difficult choices with limited resources regarding where to target efforts. Considering the high rates of recidivism and high costs associated with the justice-involved with mental illness and substance use disorders, it would likely be more cost-effective to target limited capacity towards this target population. Further analysis from PPIC to assist in identifying best practices in enrollment is needed.

Recommendation 17b. Support aggressive Medi-Cal enrollment strategies in jails, using assessment and screening tool to identify high need/high risk populations like those with co-occurring behavioral health issues. Support further analysis and identification of best practices in enrollment.

Recommendation 18b. Eliminate the practice of Medi-Cal terminations for individuals who are incarcerated for more than a year and replace the practice with suspension during incarceration (regardless of length) and exiting incarceration with benefits intact.

Recommendation 19b. Explore the usefulness of a waiver currently requested by New York State that would allow federal Medicaid matching funding to provide care management and other supportive services to incarcerated individuals in the 30 days prior to their release. In California this would aid in supporting the continuity of care transfer from jails and prisons to community-based providers.

Finding: Address building capacity challenges for housing and facilities beyond NIMBY

A decade ago the discussion regarding the lack of housing and facilities for individuals with behavioral health challenges who were justice-involved would have primarily focused on using strategies to reduce the impact of NIMBYism. Certainly that remains a significant challenge, but today there is a compounding challenge due to the lack of affordable land or space for treatment facilities, such as crisis residential and urgent care centers, and the lack of affordable housing options. For the purposes of this report we are focusing on the challenges associated with housing because stable and affordable housing is essential to diversion programs and re-entry and if solutions are to be explored COMIO wants the needs of the justice-involved with behavioral health issues to be understood and addressed.

The first challenge is how to support the expansion of housing options. The Legislative Analyst's Office (LAO) recently stated that "California's housing crisis is one of the most difficult challenges facing the state's policymakers" and noted that there is an urgent need to look beyond just improving affordable housing programs.⁵¹ Rather, they recommended that the state find ways to encourage more private housing development to relieve low-income households, so that the affordable housing programs can help the most disadvantaged residents in California, who are often disabled, elderly or suffer from chronic illness like mental illness. While governments have used tools like increasing the supply of affordable housing (subsidies for units), paying for a portion of rent (vouchers), and placing limits on rent increases to help low income households, these strategies are not doing enough for California's significant unmet need. Several counties have nearly exhausted these strategies for high need populations with mental illness who may also be justice-involved. LAO concluded that while there are significant policies to review, such as environmental protections and local planning and land use, doing so will be an important investment for future solutions.

In the interim to address the affordable housing crisis and to ensure that housing options are available to the most vulnerable, counties and cities are taking to the voters for more resources and voters have demonstrated support. Last year the City of San Francisco passed a \$310 million bond proposal for construction of affordable housing. This year several others followed this example, including:

- Alameda County passed a \$580 million bond that will dedicate the majority of funds to rental housing programs with the remainder for homeowner programs such as down payment assistance.
- The City of Los Angeles passed a \$1.2 billion bond that will dedicate 80 percent of funds to support building permanent supportive housing for the homeless and 20 percent to fund affordable housing for very low income persons and persons at risk of homelessness.

- San Mateo County extended a ½ cent sales tax increase from 10 to 20 years with revenues for supporting affordable housing and public services as well as the BOS establishing a fund with a current budget of \$10 million to provide loans to those willing to purchase existing affordable multi-family rental housing with the promise to keep existing tenants and retain affordable rents for at least 30 years.
- Santa Clara County passed a \$980 million affordable housing bond that will roll out in three phases each providing over \$300 million for housing projects targeting vulnerable populations including those with mental illness and substance use disorders.⁵²

Considering the scarcity of existing housing, another challenge to overcome is to use available housing as wisely as possible. The first step would be to use the most effective method, and *Housing First* models are increasingly promoted as a best practice including individuals with behavioral health challenges who have been justice-involved. According to the U.S. Department of Housing and Urban Development (HUD):

“Housing first is an approach to quickly and successfully connect individuals and families experiencing homelessness to permanent housing without barriers to entry such as sobriety, treatment or service participation requirements. Supportive services are offered to maximize housing stability and prevent returns to homelessness as opposed to addressing predetermined treatment goals prior to permanent housing entry.”⁵³

While models of *Housing First* consisting of permanent supportive housing and rapid re-housing are demonstrating effectiveness,⁵⁴ they could pose some challenges for individuals trying to meet conditions of probation or parole. These models do not mandate participation in services for behavioral health problems either before obtaining housing or to retain housing which can be in conflict with conditions of community supervision requiring compliance with a treatment plan. An opportunity to explore best practices on how to ensure that individuals on community supervision can still participate in *Housing First* initiatives could be explored by the new Homeless Coordinating and Financing Council which will oversee the implementation of *Housing First* initiatives in California. In addition, the No Place Like Home Initiative (NPLH) provides future opportunities for housing that linked to services, can effectively support recovery for individuals with mental illness and substance use disorders. See Text Box D for more details.

The second step to wisely using available housing is to prioritize housing for the most vulnerable and in need. While the housing crisis is not specific to individuals with mental health needs, considering the impact of stigma-based policies, it is fair to assume that individuals with these challenges are not first on a landlord’s list of desirable tenants even if housing is identified and affordable. According to the CSH:

- California has the highest rate of chronic homelessness in the country at 36 percent, with 21 percent of the national homeless population of which a fifth are individuals with mental illness.
- The impact of homeless on Californians with behavioral health challenges and/or justice-involvement is significant with an estimated one-third of California.
- One-third of children in foster care cannot be reunified with their birth parents because the parents lack a home.
- Each homeless person costs Medi-Cal over \$21,500 per year and those with substance use disorders average \$60,000.
- Homeless parolees and probationers are seven times more likely to recidivate.⁵⁵

Text Box D

No Place Like Home

No Place Like Home is a program signed into law on July 1, 2016 and invests \$2 billion in bond proceeds to development permanent supportive housing for persons who are in need of mental health services and are experiencing homelessness, chronic homelessness, or are at risk of chronic homelessness. The bonds are to be repaid with funds from the Mental Health Service Act (MHSA).

The program is designed to serve adults with serious mental illness, or children with severe emotional disorders and their families, and persons who require or at risk of requiring acute psychiatric inpatient care, residential treatment, or outpatient crisis intervention because of a mental disorder with symptoms of psychosis, suicidality or violence and who are homeless, chronically homeless, or at risk of chronic homelessness.

Key features of the program:

- *Counties will be eligible applicants (either solely or with a housing development sponsor);*
- *Funding for permanent supportive housing must utilize low barrier tenant selection practices that prioritize vulnerable populations and offer flexible, voluntary, and individualized supportive services; and*
- *Counties must commit to provide mental health services and help coordinate access to other community based supportive services.*

According to the preliminary timeframe for the program, the framework paper outlining implementation is to be released for public comment in winter 2016, and guideline development should begin during spring 2017.

*For more information on the No Place Like Home Initiative, visit the following links:
<http://www.hcd.ca.gov/financial-assistance/no-place-like-home/index.html>*

The U.S. Interagency Council on Homelessness assessed that nearly 50,000 people per year enter shelters directly after release from correctional facilities.⁵⁶ Prioritizing housing for individuals just released from incarceration is critical due to the risk of death. One study conducted by the Washington State Department of Corrections found the risk of death due to overdose was ten times greater than the expected rate of the general population, with the highest risk within the first week of release.⁵⁷ Experts in the field, including Council members, often argue that unless housing is available, providing services to address criminogenic and/or behavioral health needs will not be successful.

A method being used to support prioritizing housing for the most vulnerable is broadly referred to as *coordinated entry*. HUD's policy is that people experiencing chronic homelessness should be prioritized for permanent supportive housing and outlines their prioritization process in Notice CPD-014-12. HUD contends that the *coordinated entry* process can also prioritize people who are more vulnerable to the effects of homelessness and that will need specific assistance to end their homelessness. Individual communities can use available data and research to decide which factors are most important to determine priority such as significant health or behavioral health challenges and functional impairments or the high utilization of crisis services including emergency rooms, psychiatric facilities, and jails.⁵⁸ Use of *coordinated entry* includes an assessment process which can improve accuracy, speed, and consistency to target scarce resources.⁵⁹ Many counties use the Vulnerability Index Service Prioritization Decision Assistance Tool (VI-SPDAT) and have included justice status as an important factor in assessment. Efforts like this that target formerly

incarcerated individuals with high health and behavioral health needs who are at risk of homelessness are demonstrating improved housing outcomes, reduced incarceration, and saving money. A study of the Frequent Service Enhancement (FUSE) program in New York City found that after 12 months 91 percent of FUSE participants remained housed and experienced a 40 percent reduction in days incarcerated and over a 24-month period the total per person cost saving was 76 percent.⁶⁰

Recommendation 20b. Opportunities for *Housing First* initiatives must not exclude people based on justice status, explicitly or implicitly. COMIO will monitor and participate in the to be established Homeless Coordinating and Financing Council that will oversee the implementation of *Housing First* Initiatives. COMIO can help explore how conditions of probation and parole and *Housing First* initiatives may be able to work together to provide more housing opportunities for the justice-involved.

Recommendation 21b. COMIO supports the California Department of Housing and Community Development (HCD) inclusion of criteria for those who are “at risk” of chronic homelessness in the administration of the NPLH Initiative. The sole use of the definition “chronic homelessness” could exclude those exiting incarceration. This is because it requires having to meet the criteria of homelessness prior to incarceration and for many of the justice-involved with mental illness it is incarceration that causes the loss of independent housing. The inclusion of “at risk” of chronic homelessness should be included in other or future HCD programs and initiatives.

Recommendation 22b. Housing and service providers could further explore opportunities to expand group housing options as an alternative to single family units. Group housing not only could be more accessible and affordable but might be a better fit for individuals with behavioral health challenges.

Recommendation 23b. Prioritize housing for the most vulnerable – high risk and high need individuals with mental illness, substance use, and justice involvement. The Los Angeles County uses a *coordinated entry* system which is now available throughout the County.
<http://ceslosangeles.weebly.com/about-ces.html>.

Finally, the third step to using available housing wisely is to create equitable housing assistance opportunities and to enforce existing housing laws to protect from discrimination. A Federal Interagency Reentry Council was established in 2011 to bring together over 20 federal agencies to investigate issues that affect the lives of those released from incarceration and the “collateral consequences” individuals and families face due to involvement with the criminal justice system.⁶¹ As a participant in this council, HUD has provided significant guidance regarding criminal backgrounds and how they related to housing decisions. First, HUD issued Notice PIH 2015-19/H 2015-10 to inform Public Housing Authorities (PHA) and owners of other federally assisted housing that arrest records may not be the basis for denying admission, terminating assistance or evicting tenants.⁶² The notice clarified that an arrest is not evidence of criminal activity that can support a rejection of admission, termination, or eviction and requires that termination of assistance (e.g. section 8 voucher) or eviction due to criminal activity must be based on a “preponderance of evidence” and that the PHA must be prepared to persuade the court that there is evidence of criminal activity which is in violation of the lease.⁶³

HUD also issued guidance on the application of Fair Housing Standards to the use of criminal records by all public and private providers of housing recognizing that “many formerly incarcerated

individuals, as well as individuals who were convicted but not incarcerated, encounter significant barriers to securing housing, including public and other federally subsidized housing, because of their criminal history.”⁶⁴ The guidance outlines steps that should be taken to analyze claims that a housing providers’ use of criminal history to deny housing opportunities results in discrimination including whether the provider can prove that the challenged policy is justified by supplying reliable evidence that a housing decision based on criminal history assisted in protecting resident safety or property. The guidance concludes that due to the disproportionate over-representation of racial and ethnic groups in the criminal justice system, policies and practices that deny anyone housing with a prior arrest or criminal conviction that cannot be justified would violate the Fair Housing Act.

Local communities are using this guidance and their local flexibility to improve opportunities for individuals with criminal backgrounds. Some examples include:

- Modifying standards of admission and screening – e.g. shorten the length of time in which a review of a conviction or public safety concern can be considered, using individualized assessments and allowing for explanations for special circumstances,
- Eliminating all provision screening applicants out of the Housing Choice Voucher (Section 8) and Public Housing programs due to probation or parole status like Los Angeles County did in 2015, and
- Directing PHA to prioritize people who are justice-involved and have a behavioral health or serious health need for Section 8 or other public housing admissions like several counties have recently done.

Recommendation 24b. Educate local PHA, providers, and advocates about the recent clarifications of the application of fair housing act standards to the use of criminal records. Arrest records cannot be the basis for denying admission, terminating assistance, or evicting tenants. Review local policies and ensure they are consistent with the law. Support Californians to know their housing rights and file grievances when they are denied.

Finding: Maximizing existing initiatives by leveraging resources, disseminating lessons learned, and facilitating exchange of practices

There are several existing initiatives under way that provide opportunities to expand community alternatives that support diversion, but these opportunities should be approached with a focus on using effective practices. Below is a list of such initiatives and further information may be provided in text boxes throughout the report:

- Seize opportunities now available under the 21st Century Cures Act signed by President Obama in early December 2016. This act signifies bipartisan support for efforts to prevent the incarceration of individuals with behavioral health challenges and to support expanded services to treat mental illness and substance use disorders. The comprehensive bill supports a range of initiatives including several criminal justice reform measures related to mental health, such as the enactment of the Comprehensive Justice and Mental Health Act (CJMHA) and the reauthorization of the Mentally Ill Offender Treatment and Crime Reduction Act (MIOTCRA). For more information see Text Box E.

- Encourage counties to take advantage of the ***Stepping Up Initiative*** and the technical assistance that is currently available through the Council on State Governments Justice Center. This opportunity to have experts support strategic planning processes to aid counties in addressing barriers and challenges to developing a comprehensive system of diversion across all five intercepts in the Sequential Intercept Model is unprecedented and has exponential value. As more counties participate and work together, more lessons learned can be exchanged, tools can be shared, and barriers tackled.
- Capitalize the impact of \$67.5 million in state general funds to California Health Facilities Financing Authority (CHFFA) to administer a Community Services Infrastructure (CSI) competitive grant program that expands community alternatives to jails and prisons. The program seeks to expand access to diversion programs and services for those with mental health illness, substance use disorders, or who have suffered from trauma. Working with cities and counties, the grant program will fund facility acquisition, construction/renovation, equipment acquisition, and applicable startup or expansion costs for facilities that provide mental health services, substance use treatment, or trauma recovery services.
- Support the Investment in Mental Wellness Grants of 2013 to develop a range of mental health crisis programs. Funds aim to “increase capacity for client assistance and services in crisis intervention, crisis stabilization, crisis residential treatment, rehabilitative mental health services, and mobile crisis support teams.” Encourage the Mental Health Service Oversight and Accountability Commission (MHSOAC) to review county reports to identify patterns, trends, and emerging models of the crisis continuum of services. Support counties to have the capacity to exchange lessons learned and strategies developed throughout this process so that promising and effective practices are widely shared and adopted.⁶⁵ For more information see Text Box F.
- Support the BSCC to have the capacity to expose all interested counties to the lessons learned from Mentally Ill Offender Crime Reduction (MIOCR) grantees. While COMIO strongly supports MIOCR grants, we also believe counties can use other funding sources to support similar programs. Sharing tools and resources across participating and non-participating counties can facilitate adoption of best practices. For more information see Text Box G.
- Address existing gaps in diversion programs for individuals with mental illness which could support the addition of evidence-based strategies to address recidivism risk and not just psychiatric needs. Legislative clarification regarding the criteria for use of Proposition 47 funds identified that funds could be used to permit proposals to expand the capacity of an existing program and prohibit proposals from using the fund to supplant funding for an existing program SB 1056 (Chapter 438, Status of 2015). For more information see Text Box H.
- Maximize equitable opportunities for access to supportive housing through the NPLH, as well as using this initiative to explore policy changes that can reduce zoning and procedural requirements. For more information see Text Box D.

- Monitor the Law Enforcement Assisted Diversion (LEAD) program that provides \$15 million for up to three jurisdictions to make treatment, counseling, housing and other services available to willing individuals instead of prosecution. The dual goals of the program are to reduce costs associated with incarceration and prosecution by diverting low-level offenders to social service programs. For more information see Text Box I.

Text Box E

Investment in Mental Wellness (IMHW) Act of 2013

The Investment in Mental Health Wellness Act of 2013 established a competitive grant program to support new or expanded mental health crisis residential treatment, crisis stabilization, and mobile crisis support team programs. The statute charged the California Health Facilities Financing Authority (CHFFA) and the Mental Health Services Oversight and Accountability Commission (MHSOAC) with implementing the grant and requires the addition of a minimum of 25 mobile crisis support teams and 2,000 crisis stabilization and crisis residential treatment beds. These grant funds are meant to “provide counties with funding to increase their capacity and access to community based mental health crisis services that are wellness, resiliency, and recovery oriented in the least restrictive manner possible”. Funds have been used both to hire crisis personnel and for brick-and-mortar facilities. CHFFA was given a three-year appropriation authority for the one-time general fund allocation of \$142 million. For more information regarding IMHW, visit <http://www.treasurer.ca.gov/chffa/imhwa/>.

The triage services funded by IMHW grant funds are administered by MHSOAC and aim to link people to appropriate services while they are in crisis to divert them from incarceration or hospital emergency rooms. For more information on triage projects monitored by MHSOAC, visit <http://mhsaac.ca.gov/triage-homepage>.

According to CHFFA’s 2016 report to the legislature, projects have made the following progress as of September 2016:

- *Counties hired over 55 individuals for mobile crisis support teams (“MCST”).*
- *A total of 119 Crisis Stabilization Unit (“CSU”) and Crisis Residential Treatment (“CRT”) beds have been added.*

It is expected that by December 31, 2016, an additional 14 beds and information technology (“IT”) for an equivalent of 26 MCST teams will be added.

Text Box F

21st Century Cures Act

In December of 2016 Congress passed and President Obama signed a \$6 billion public health and medical research bill, called the 21st Century Cures Act. The act includes a variety of health initiatives, from authorizing money to fight the nation's opioid crisis, to support for expanded mental health services, and efforts to decrease the incarceration of individuals with behavioral health issues. The Act with strong bipartisan support represents solid progressive policy regarding the need to address co-occurring substance use and mental health disorders, particularly to prevent incarceration. Some of the major elements of the act pertaining to the intersection of criminal justice and behavioral health systems are outlined below.

Medicaid Coverage, Delivery and Administrative Changes:

- *The Department of Health and Human Services (HHS) must provide states with an opportunity to design innovative delivery systems for adults and children with mental illness.*
- *HHS will establish an assistant secretary position for mental health and substance abuse, evaluating these issues within the agency through a strategic plan and other actions to identify and disseminate best practices.*
- *HHS will establish a telephone hotline and website to help families find mental health and substance use services.*

Mental Health Parity and Protected Health Information (PHI):

- *HHS inspector general will issue guidance to improve compliance with mental health and substance abuse treatment parity requirements.*
- *HHS will create an action plan for enforcement of parity with stakeholder input.*
- *HHS to issue guidance clarifying when a healthcare provider or other entity can share PHI to caregivers and family members under the Health Insurance Portability and Accountability Act (HIPAA) and create a training program to support practice adoption.*

Mental Health Authorizations:

- *Reauthorize SAMHSA's Substance Abuse Prevention and Treatment Block Grant and the Community Mental Health Services Block Grant Program through 2022.*
- *Funding would address a variety of regional and local need including the following of interest to COMIO:*
 - *\$64.6 million for homeless transition assistance grants and \$41.3 million for grants to provide treatment and recovery services for the homeless,*
 - *\$14.7 million for mental health awareness grants for training for law enforcement,*
 - *\$12.7 million to increase knowledge of mental health and substance use disorders and treatment for diverse racial and ethnic communities,*
 - *\$12.5 million to establish a database providing real-time information regarding available hospital beds, and*
 - *\$4.3 million for jail diversion program grants.*

Text Box F (cont.)

Criminal Justice and Mental Health – Enacts the Comprehensive Justice and Mental Health Act (CJMHA) and Reauthorizes the Mentally Ill Offender Treatment and Crime Reduction Act (MIOTCRA):

- *Reauthorizes MIOTCRA for 4 years at \$50 million per year, updating the legislation to provide new commitments to training first responders and gives additional resources for veterans' courts to help those with behavioral or post-traumatic stress disorders.*
- *Amends MIOTCRA, the federal Drug Court Grant Program, the Residential Substance Abuse Treatment Grant Program, and the Prosecution Drug Treatment Alternatives to Incarceration Program to allow and expand treatment and court diversion for people who have co-occurring mental health and substance use disorders.*
- *Requires the attorney general to create a Drug and Mental Health Court pilot program in at least one federal judicial district, following the model used in many state and local jurisdictions, including California.*
- *Authorizes funding for prison and jail-based programs, including reentry programs that aim to reduce the likelihood of recidivism when a person with a mental illness is released.*
- *Allows Second Chance Act funds to be used for mental health treatment and transitional services, such as housing assistance, for people returning home after prison or jail.*
- *Supports expanded training efforts through the Byrne Justice Assistance Grants and Community Oriented Policing Services Grant Program (COPS). New provisions allow specialized training for first responders and paramedics responding to mental health emergencies, including crisis de-escalation training and other training requirements for federal agencies.*
- *Creates the National Criminal Justice and Mental Health Training Center under the attorney general to identify best practices and provide technical assistance to government agencies implementing these practices.*
- *Targets people with mental illnesses who are high utilizers of crisis response services, ensuring that all grant resources are spent on policies and programs that are proven effective, requiring the U.S. Department of Justice (DOJ) to prioritize grant awards to applicants who use evidence-based interventions and risk assessment tools to help reduce recidivism*
- *Requires a new report by the U.S. Government Accountability Office on what practices federal first responders, tactical units, and corrections officers are trained to use, what procedures are used to appropriately respond to interactions with people with mental illnesses, the application of evidence-based practices in criminal justice settings, and recommendations on how DOJ can improve information-sharing and dissemination of best practices.*

For more information and analysis visit:

The Council on State Government - Justice Center at <https://csjusticecenter.org/jc/five-things-to-know-about-the-21st-century-cures-act/>

The National Association of County Behavioral Health and Developmental Disability Directors: <http://www.nacbhd.org/Home.aspx>

We appreciate all of the work both organizations do to keep COMIO informed on federal policy

Text Box G

Mentally Ill Offender Crime Reduction (MIOCR) Grant Program—California

The Mentally Ill Offender Crime Reduction (MIOCR) Grant Program is administered by the Board of State and Community Corrections (BSCC) and supports prevention, intervention, diversion, supervision, services, and strategies aimed at reducing recidivism in California’s mentally ill offender population and to improve outcomes for these offenders while continuing to protect public safety. Penal Code Section 6045 requires that “grant funds be awarded to implement locally developed, collaborative and multidisciplinary projects that provide a cost-effective continuum of responses designed to reduce jail crowding, provide youthful offenders with alternatives to detention, reduce crime and criminal justice costs as they relate to the mentally ill, and maximize available and/or new local resources for prevention, intervention, detention and aftercare services for adult and juvenile mentally ill offenders.”

\$18.8 million in Recidivism Reduction Funds was appropriated for the MIOCR grant, half of which is to fund projects for mentally ill adult offenders and half to fund those for mentally ill juvenile offenders. Applicants were required to create a four-year local plan for their projects and will be funded for 3 years; a minimum of 25 percent match is required.

The current cohort of MIOCR grantees includes 10 adult projects, one of which is partially funded, and 11 juvenile projects. The grant cycle began July 1, 2015 and will end June 30, 2018. All grantees will submit a local evaluation report at the end of the grant cycle. Plans are required to include mental health treatment programs, practices, and strategies that have a demonstrated evidence foundation, and are appropriate and effective correctional interventions for the identified target population.

For more information on the MIOCR Grant Program visit

http://www.bscc.ca.gov/s_cppmiocrgrant.php.

Text Box H

Proposition 47: Safe Neighborhoods and Schools Act

Proposition 47 was approved by voters in 2014 and enacted the Safe Neighborhoods and Schools Act. The Act focuses prison spending on violent and serious offenses, supporting investments from the generated savings from this policy shift into prevention and support programs. It stipulates that the Board of State and Community Corrections (BSCC) will implement a grant program to support mental health treatment, substance abuse treatment, and diversion programs for people in the criminal justice system. The program funds public agencies and aims to reduce recidivism of people convicted of less serious crimes and those who have mental health and/or substance abuse issues. AB 1056 (Chapter 438, Statutes of 2015), specified that funds will support housing-related assistance and community-based supportive services. The RFP for Prop 47 was released to the public on November 18, 2016 with proposals due February 21, 2017. Eligible applicants include public agencies and community-based organizations.

The law stipulates the following should be provided by selected grantees:

- *Mental health services, substance use disorder treatment services, misdemeanor diversion programs, or combination of one or more of these.*
- *Housing-related assistance that utilizes evidence-based models. Housing-related assistance may include, but is not limited to, the following:*
 - *Financial assistance, including security deposits, utility payments, moving-cost assistance, and up to 24 months of rental assistance;*
 - *Housing stabilization assistance, including case management, relocation assistance, outreach and engagement, landlord recruitment, housing navigation and placement, and credit repair.*
- *Other community-based supportive services, such as job skills training, case management, and civil legal services.*

The law also requires that when selecting grantees the following should be prioritized:

- *leveraging existing contracts, partnerships, memoranda of understanding, or other formal relationships to provide one or more of the services;*
- *public agency partnerships with philanthropic or nonprofit organizations; and*
- *inter-agency and regional collaborations.*

Applicants must also “have a proven track record working with the target population and the capacity to support data collection and evaluation efforts.”

Awards will be funded with the first three years of Prop 47 savings totaling an estimated \$103,651,000 through FY 2018-19. There are two different categories in which public agencies will compete for funds – smaller scope and larger scope projects. The maximum funding threshold for smaller scope projects is \$1 million, for larger scope projects it is \$6 million, the exception being Los Angeles County – which may apply for up to \$20 million.

For more information on the Safe Neighborhoods and Schools Act visit:

http://bscc.ca.gov/s_bscprop47.php.

For the full text of AB 1056, visit:

http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520160AB1056.

Text Box I

Law Enforcement Assisted Diversion (LEAD) Grant Program

Established by SB 843 (Chapter 33, Statutes of 2016), the Law Enforcement Assisted Diversion (LEAD) Pilot Program was modeled after the LEAD project in Seattle, Washington. The grant aims to “improve public safety and reduce recidivism by increasing the availability and use of social service resources while reducing costs to law enforcement agencies and courts stemming from repeated incarceration”. SB 843 appropriated \$15 million from the General Fund for the LEAD project. The bill authorizes the BSCC to contract with an outside evaluator to determine the program’s effectiveness and to provide technical assistance to grantees.

LEAD is designed to divert low-level drug offenders and those arrested for prostitution to social services including, but not limited to, case management, housing, medical care, mental health care, treatment for alcohol or substance use disorders, nutritional counseling and treatment, psychological counseling, employment, employment training and education, civil legal services, and system navigation. The pilot will be a two-year program, funding up to three jurisdictions, beginning April 27, 2017 and ending June 30, 2019 and requires a report of the evaluation findings to be submitted to the Governor and the Legislature by January 1, 2020.

The Request for Proposals for the LEAD program was released in November 2016 and the deadline to submit proposals is February 1, 2017. For more information about the LEAD program, visit <http://bscc.ca.gov/scppleadgrant.php>.

Recommendation 25b. The state and/or state-level partners (e.g. associations, foundations, and universities) should support counties with resources to take advantage of the **Stepping Up Initiative** and its technical assistance. Resources could bring counties together and facilitate the exchange of knowledge, tools and resources. The state can listen and help address barriers to aid county level strategies and interventions. COMIO is eager to support such activities in the future.

Recommendation 26b. Applicants for the CSI program could be required to leverage with existing efforts or enhance by additional sustainable funding for diversion services within a capitol project. Provide needed tailored assistance to smaller counties with unique challenges. Support efforts that use cost effective or evidence-based practices.

Recommendation 27b. HCD could ensure that parolees are eligible for NPLH placements by supporting screening for fitness for supportive housing due to mental illness to determine eligibility rather than justice-status.

Recommendation 28b. HCD could consider streamlining zoning procedural requirements as part of the implementation of NPLH in part to help ease the burden on interested providers who already will be operating in an extremely expensive market and burdensome regulatory environment.

Promote: Comprehensive Systems of Diversion and Exemplary Programs Working Along the Sequential Intercept Model

Throughout the year COMIO was honored to hear testimony and to directly visit dozens of innovative programs working in all five intercepts across the sequential intercept model. This section of the report provides brief highlights from several of the programs reviewed.

Santa Clara County and the Jail Diversion and Behavioral Health Subcommittee

The swift and creative work of this committee exemplifies what can be accomplished when various constituencies come together under a clear goal with a willingness to share and repurpose available resources across departments and agencies. The subcommittee underwent several meetings to develop a set of recommendations, 35 in total, which they then prioritized in order of importance, and finally reduced to 10 recommendations for action based on a strategic analysis that considered target population needs, current system gaps, costs and flexibility of various funding sources, and estimated timeframes for implementation and results.⁶⁶ One area of particular creativity is how barriers to developing needed housing and land for facilities are addressed, which include the following:

- Adding flex funds to fill gaps in housing subsidies for criminal justice populations in full service partnerships with public safety realignment funds,
- Establishing the permanent supportive housing (PSH) program that will aggressively leverage Medi-Cal funds while working to address land use and neighborhood or NIMBY issues,
- Putting a multi-million dollar bond measure on the November ballot (that passed) to build and subsidize housing for the homeless and at-risk of homelessness, and
- Exploring various ways to use county land because the cost of land for new projects is not affordable.

Several counties are also engaged in similar efforts, including many of the ***Stepping Up Initiative*** participants.

Los Angeles County's District Attorney's Office and the Office of Diversion and Re-Entry

In July 2016, COMIO recognized the leadership of the Los Angeles County District Attorney Jackie Lacey's Office and the Los Angeles County Mental Health Advisory Board with a Best Practices Award for the ***Blueprint for Change***,⁶⁷ an implementation plan for a comprehensive system of diversion from incarceration for youth and adults with mental illness. To address the needs identified and implement the problem-solving programs outlined in the ***Blueprint for Change***, the Office of Diversion and Reentry was created by the Los Angeles County Board of Supervisors to provide long-term oversight and coordination support for diversion efforts. In addition to the county's initial investment of \$120 million, at least \$10 million in annual funding will be provided to the office, and the office is aggressively seeking additional funding opportunities. It is estimated that at least 40 percent of the funds will be allocated towards housing and 50 percent for the cost of expanding existing successful or promising diversion and anti-recidivism programs, especially those that are community based.⁶⁸ The plan outlined in the ***Blueprint for Change*** also builds upon existing programming administered by various county agencies and departments, particularly the Department of Mental Health who have also been leaders investing in crisis response and behavioral health programs to support diversion for decades. Collectively these resources will

divert low-risk offenders with serious mental illness and substance abuse disorders from incarceration through providing housing and services such as health, mental health, alcohol and drug prevention, employment, and legal assistance. Without District Attorney Lacey’s leadership such significant shifts in policy and practice would not have materialized so swiftly.

Urgent Care Centers (UCCs)

While the model of UCCs is growing across the state, the LACDMH has championed this model for a decade. UCCs provide crisis stabilization services and linkage to community-based services for individuals aged 13 and older who otherwise would be taken to the emergency room or incarcerated. Services are available 24/7 and law enforcement expressed to COMIO that the UCCs have been the most effective service in reducing their “wall” or wait-time because they can drop off appropriate individuals and get back to work. There are currently five UCCs with four more under-development and LACDMH estimates that between 15 to 20 percent of individuals diverted to UCCs would have been incarcerated.⁶⁹

The Center for Health Care Services Restoration Center and Haven for Hope (Bexar County, TX)

The Restoration Center consists of a variety of services including residential detoxification, sobering, outpatient substance abuse treatment and in-housing recovery treatment programming. The service centers on a strong partnership with law enforcement that are trained in crisis intervention skills and conduct outreach as well as respond to crisis calls. Law enforcement and the public can drop-off appropriate individual’s 24-hours a day. This partnership, as reported by the provider, has saved \$10 million annually in reduced jail days, emergency room visits, and officers getting back on the streets.⁷⁰

Additional services on the campus are expansive including:

- Intensive treatment programs for mental illnesses and substance use disorders,
- Jail Outreach Programs with Peer Specialists and Navigators,
- Integrated HealthCare Clinic (Medical, Dental, Vision),
- Education and employment programs, legal services, and ID recovery, and
- Safe sleeping area, crisis residential housing, and links to permanent housing.

The programs are collectively resourced by private, local (city/county), state, and federal funds. Since the program began in 2010 they estimate the following outcomes:

- Jail recidivism for program participants is down to 32 percent for those in sheltered housing and 24 percent for those in programs (county average is 80 percent) and jail population is down by 1000 beds,
- Downtown homeless count has decreased by 80 percent,
- Nearly 3,000 participants have exited to permanent housing, and
- Nearly 2000 participants have attained employment that has been retained for 6 months or longer.⁷¹

San Diego County's Project One for All

Early this year San Diego announced they were launching an effort to provide long-term housing and care to as many as 1,250 homeless with mental illness over the next two years. Through participating in the White House Data-Driven Justice Initiative,⁷² San Diego County identified that nearly two-thirds of the chronically homeless population had some sort of criminal justice background. As a result this initiative will target several of the justice-involved who are high cost service utilizers. The county is investing \$16 million in year one and \$19 million the following year. Funding comes from a mix of sources, including MHPA, state and federal funds and resources from the county and city public housing authorities. Recognizing the link between health and housing, the county has also integrated the local HCD into the Health and Human Services Agency in support of the project.⁷³

Los Angeles County's Flexible Housing Pool

The Flexible Housing Subsidy Pool (FHSP) is a supportive housing rental subsidy program of the Los Angeles County Department of Health Services (DHS), along with other governmental partners and the Conrad N. Hilton Foundation. The goal of the FHSP is to secure quality affordable housing for DHS patients who are homeless. Launched in 2014 with \$18 million in funds the program has a goal of increasing funds and providing up to 2400 rental subsidies by 2017. A non-profit community agency (Brilliant Corners) operates the FHSP and acquires a range of housing options from single family homes to apartment units to entire buildings ensuring safe and affordable housing options across the county. They provide move-in assistance, monthly rental subsidies, and support landlords and case managers. All tenants housed through the FHSP are linked to intensive case management and wraparound services to support their transition to permanent housing and promote housing stability. Case managers are available to respond when issues arise and support the long-term success of the tenant.⁷⁴

Miami-Dade County Pre and Post Booking Diversion

The 11th Judicial Circuit Mental Health Project (CMPH) was established in 2000 to divert nonviolent misdemeanor defendants with serious mental illness and later expanded to include less serious felonies when appropriate. The programs consist of two components a) pre-booking diversion through Crisis Intervention Training with law enforcement and b) post-booking which serves individuals awaiting adjudication. All CMPH participants are screened for mental health, substance use, and criminogenic risks and needs to determine the appropriate level of treatment, support services, and community supervision. The evidence-based screening tools used include the Mental Health Screen form III (MHSF-III), the Texas Christian University Drug Screen V (TCUDS V), and the Ohio Risk Assessment Community Supervision Tool (ORAS-CST). Entitlement benefits are sought and peer specialists are used by the court to support engagement and community reentry. The program is currently expanding and building a Mental Health Diversion Facility that will provide a full continuum of care including a crisis stabilization unit, short-term residential services, transitional housing, intensive case management and specialized services for the unique needs of the individuals with mental illness and recidivism risk.

From 2011 to 2014, CMHP has provided CIT training to an estimated 4,600 law enforcement officers from 36 local municipalities, including public schools and CDCR. The average daily census in the jail has dropped nearly 40 percent and the county has closed one entire jail facility at a cost-saving to taxpayers of \$12 million per year. The misdemeanor jail diversion program receives

approximately 300 referrals annually and the recidivism rate among program participants has decreased roughly from 75 percent to 20 percent annually. Individuals participating in the felony diversion program demonstrate reductions in jail days of more than 75 percent.⁷⁵

Misdemeanor Incompetent to Stand Trial Community-Based Restoration Program (MIST CBR)

Like many other counties, Los Angeles County has experienced a sharp increase in IST referrals to their Mental Health Court, an estimated increase of 350 percent over the last five years.⁷⁶ While there is a lot of investigation underway to better understand the cause of this increase, county officials are now working with the Mental Health Court, Law Enforcement, the District Attorney and the Office of the Public Defender through MIST CBR, which is a program that moves inmates into community care settings rather than jail, to swiftly restore competency and avoid costly and inappropriate placements in jail. The program required several county agencies to create policies and relationships that did not exist before. After only 6 months of operation the program showed promise with over 90 individuals enrolled into MIST CBR with 70 conditionally released into the community.⁷⁷

Peer Navigator and Support Programs

There were dozens of examples of how peers can be powerful and effective partners in diversion programming reviewed this year. The San Bernardino County Department of Public Health created the “bridges pilot program” which uses peer providers who were formerly incarcerated and living in recovery from mental illness or substance use disorder to act as a “bridge” from jail to the community. They did in-reach into the jails to support discharge planning and then followed individuals into the community to help navigate both the probation and behavioral health systems. The program achieved a nearly 12 percent recidivism rate for program participants, which is 45 percent less than the county average.⁷⁸ Alameda County created a reentry workforce development program by blending AB 109 funds and MHSA Innovation funds. The program aims to support the peers be successful in their careers, achieve intended outcomes for their clients, and to create pathways for sustained county employment as providers of Medi-Cal billable services.

Re-entry Pre and Post Release Programs

- Alameda County has a Youth and Family Services Bureau which is a behavioral health unit within the Alameda County Sheriff’s Office (ACSO). The unit administers Operation My Home Town (OMHT) a re-entry pre and post release clinical case management model for clients re-entering the community from jail. The program uses the LS-CMI to create an individualized plan and provides correctional evidence-based practice services like cognitive behavioral therapy to reduce recidivism and increase self-sufficiency. Linkages beyond behavioral health services include housing, employment, legal advocacy, family supports, educational resources, and social services.⁷⁹
- Santa Cruz County has developed an entire forensic continuum of care to provide specialized services for individuals with behavioral health needs who are justice-involved from prevention and early intervention to intensive services. The Mentally Ill Offenders Crime Reduction Grant allowed the county to strengthen the Maintain Ongoing Stability through Treatment (MOST) Team which brings together behavioral health and probation to provide alternatives to incarceration and wrap around services, support achievement of community supervision terms, and to develop employment skills through community service.⁸⁰

- Sutter and Yuba counties are taking advantage of having two systems to compare the efficacy of pre-release programs and post-release programs to determine if beginning services prior to release from custody, most often into probation, improves outcomes of recovery. Preliminary findings shared at a COMIO meeting demonstrate that while both programs show a decrease in the service intensive need after release, those who began service prior to release have higher measures of recovery.⁸¹

¹⁷ Skeem, J.L., Kennealy, P.J., Winter, E., & Loudon, J.E. (2014). Offenders with mental illness have criminogenic needs too, towards recidivism reduction. *Law and Human Behavior, Vol 38 (3), 212-224.*

¹⁸ Peterson, J.K., Kennealy, P.J., & Skeem, J.L. (2014). How often and how consistently do symptoms directly precede criminal behavior among offenders with mental illness. *Law and Human Behavior, Vol 38,439-449.*

¹⁹ Dr. Skeem's presentation to COMIO *What works for justice-involved people with mental illness* has been turned into training video accompanied by an FAQ, both are available at: <http://www.cdcr.ca.gov/COMIO/>

²⁰ Cuddleback, G.S., Morrissey, J.P. (2011) Program planning and staff competencies for forensic assertive community treatment: ACT eligible versus FACT eligible. *Journal of the American Psychiatric Nurses Association 17(1), 90-97.*

²¹ James, D. J., and Karberg, J. C. (2005). *Substance Dependence, Abuse, and Treatment of Jail Inmates, 2002.* Washington, DC: U.S. Department of Justice, Office of Justice Programs. Available at: <http://www.csdp.org/research/sdatji02.pdf>.

²² Presented as part of the following presentation to COMIO, http://www.cdcr.ca.gov/COMIO/Uploadfile/pdfs/2016/May19/COMIO_2016_skeem.pdf

²³ Skeem, J.L., Steadman, H.J., & Manchak, S.M. (2015). Applicability of the risk-need-responsivity model to persons with mental illness involved in the criminal justice system. *Psychiatric Services, Vol 66(9), 916-922.*

²⁴ Pope, L., Hopper, K., Davis, C., & Cloud, D. (2016) First-episode incarceration, creating a recovery-informed framework for integrated mental health and criminal justice responses. Vera Institute of Justice available at: <https://www.vera.org/publications/first-episode-incarceration-creating-a-recovery-informed-framework-for-integrated-mental-health-and-criminal-justice-responses>

²⁵ D.A., Andrews, Bonta, J., & Hoge, R.D. (1990). Classification for effective rehabilitation: rediscovering psychology. *Criminal Justice and Behavior 17(1), 19-52.*

²⁶ For more information about COMPAS visit http://www.cdcr.ca.gov/rehabilitation/docs/FS_COMPAS_Final_4-15-09.pdf

²⁷ Osher, F., D'Amora, D., Poltkin, M., Jarrett, N., Eggleston, A. (2012). Adults with behavioral health needs under correctional supervision: A shared framework for reducing recidivism and promoting recovery. Council of State Governments Justice Center, Criminal Justice/Mental Health Consensus project. Available at: https://www.bja.gov/Publications/CSG_Behavioral_Framework.pdf

²⁸ Skeem, J.L., Steadman, H.J., & Manchak, S.M. Applicability of the risk-need-responsivity model to persons with mental illness involved in the criminal justice system.

²⁹ Bird, M., Grattet, R. (2014). Do local realignment policies affect recidivism in California? Public Policy Institute of California, available at: <http://www.ppic.org/main/publication.asp?i=1111>

³⁰ Rotter, M., & Carr, A. (2013). Reducing criminal recidivism for justice-involved persons with mental illness: risk/needs/responsivity/ and cognitive behavioral interventions. SAMHSA GAINS center for Behavioral Health and Justice Transformation, available at: <https://www.prainc.com/wp-content/uploads/2016/02/ReduceCrimRecidRNR.pdf>

³¹ *Ibid.*

³² *Ibid.*

³³ To access the report visit: https://www.bja.gov/Publications/CSG_Behavioral_Framework.pdf

³⁴ Pope, L., Hopper, K., Davis, C., & Cloud, D. (2016) First-episode incarceration, creating a recovery-informed framework for integrated mental health and criminal justice responses.

³⁵ For more information visit: <http://mentalhealthrecovery.com/info-center/wrap-in-the-criminal-justice-system/>

³⁶ For more information visit: <http://www.neighborhoodhouse.org/project-in-reach/#sthash.BTiBxrHy.dpbs>

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- ³⁷ Heiss, C., Somers, S., & Larson, M. (2016). Coordinating access to services for justice-involved populations. Milbank Memorial Fund available at www.milbank.org
- ³⁸ For more see: <http://justiceforvets.org/veteran-mentors>
- ³⁹ For more information see: <https://www.nami.org/Find-Support/NAMI-Programs/NAMI-Peer-to-Peer>
- ⁴⁰ Grattet, R., Tafoya, S., Bird, M., & Nguyen, V. (2016). California's county jails in the era of reform. Public Policy Institute of California available at: http://www.ppic.org/main/publication_quick.asp?i=1210
- ⁴¹ Haneberg, R., Fabelo, T., Osher, F., & and Thompson, M. *Reducing the Number of People with Mental Illnesses in Jail: Six Questions County Leaders Need to Ask* (New York: The Council of State Governments Justice Center, forthcoming).
- ⁴² For more information visit: <http://www.cdcr.ca.gov/COMIO/Uploadfile/pdfs/2016/Sept14/JusticeSystemChangeInitiativeReport.pdf> and <http://www.cdcr.ca.gov/COMIO/Uploadfile/pdfs/2016/Sept14/JusticeSystemChangeInitiativePresentation.pdf>
- ⁴³ For more information about this initiative visit: <https://www.whitehouse.gov/the-press-office/2016/06/30/fact-sheet-launching-data-driven-justice-initiative-disrupting-cycle>
- ⁴⁴ For more information about California Medi-Cal 2020 review: http://www.dhcs.ca.gov/provgovpart/Documents/Letter_to_State-CA_Redacted.pdf
- ⁴⁵ For more information see: http://www.dhcs.ca.gov/provgovpart/Documents/11.10.15_Revised_DMC_ODS_FACT_SHEET.pdf
- ⁴⁶ To review the full contents of the letter visit: <https://www.medicaid.gov/federal-policy-guidance/downloads/sho16007.pdf>
- ⁴⁷ How and when Medicaid covers people under correctional supervision: New federal guidelines clarify and revise long-standing policies. PEW Charitable Trusts available at: <http://www.pewtrusts.org/en/research-and-analysis/issue-briefs/2016/08/how-and-when-medicaid-covers-people-under-correctional-supervision>
- ⁴⁸ California Rehabilitation Oversight Board September 2016 report available at: <http://www.oig.ca.gov/pages/c-rob.php#>
- ⁴⁹ McConville, S., Bird, M., & Nguyen, V. (2016). Expanding health coverage in California: County jails as enrollment sites available at: http://www.ppic.org/main/publication_quick.asp?i=1196
- ⁵⁰ *Ibid.*
- ⁵¹ Perspectives on Helping Low Income Californians Afford Housing. Legislative Analyst's Office available at: <http://www.lao.ca.gov/Publications/Report/3345>
- ⁵² Full content of ballot measures and the percent of votes received were reviewed at <https://ballotpedia.org>
- ⁵³ <https://www.hudexchange.info/resources/documents/Housing-First-Permanent-Supportive-Housing-Brief.pdf>
- ⁵⁴ For more information view fact sheets at <https://www.huduser.gov/portal/publications/hsgfirst.pdf> and <http://www.endhomelessness.org/page/-/files/2016-04-26%20Housing%20First%20Fact%20Sheet.pdf>
- ⁵⁵ Statistics retrieved from CSH <http://www.csh.org/> and from http://www.endhomelessness.org/page/-/files/State_of_Homelessness_2015_FINAL_online.pdf
- ⁵⁶ U.S. Interagency Council on Homelessness (2016). Connecting People Returning from Incarceration with Housing and Homelessness Assistance available at: <https://www.usich.gov/tools-for-action/reentry-housing-resource-tip-sheet>
- ⁵⁷ Binswanger, I.A., Blatchford, P.J., Mueller, S.R. and Stern, M.F., (2013). Mortality after prison release: Opioid overdose and other causes of death, risk factors, and time trends from 1999 to 2009. *Annals of Internal Medicine*, 159 (9): 592-600.
- ⁵⁸ HUD <https://www.hudexchange.info/resources/documents/Coordinated-Entry-Policy-Brief.pdf>
- ⁵⁹ Improving Communitywide Targeting of Supportive Housing to End Homelessness: The Promise of Coordinated Assessment January 2015 CSH http://www.csh.org/wp-content/uploads/2015/01/TargetingSHthoroughCA_Jan15.pdf
- ⁶⁰ U.S. Interagency Council on Homelessness (2016). Connecting People Returning from Incarceration with Housing and Homelessness Assistance. : <https://www.usich.gov/tools-for-action/reentry-housing-resource-tip-sheet>
- ⁶¹ For more information on the initiatives of the Council members, see <https://csgjusticecenter.org/nrrc/projects/firc/snapshots/>

⁶² U.S. Department of Housing and Urban Development Office of Public and Indian Housing (2015). Notice PHI 2015-19 available at: <https://portal.hud.gov/hudportal/documents/huddoc?id=PIH2015-19.pdf>

⁶³ Ibid.

⁶⁴ HUD (2016). Office of the General Counsel Guidance on Application of Fair Housing Act Standards to the Use of Criminal Records by Providers of Housing and Real Estate-Related Transactions. Available at: https://portal.hud.gov/hudportal/documents/huddoc?id=HUD_OGCGuidAppFHStandCR.pdf

⁶⁵ For more information about the 21st Century Cures Act and to review the signed legislation visit: <https://www.congress.gov/bill/114th-congress/house-bill/34/text?q=%7B%22search%22%3A%5B%22Cures%22%5D%7D&r=1>

⁶⁶ For more information to review work of the committee and recommendations and action taken by the Board of Supervisors visit: <http://www.fmhac.net/trainingw2d.html> and download items posted as part of the Words to Deeds conference or <http://sccgov.iqm2.com/Citizens/calendar.aspx>

⁶⁷ To review the full report, The Blueprint for Change, produced by the Los Angeles District Attorney's Office in 2015 visit: <http://da.lacounty.gov/sites/default/files/policies/Mental-Health-Report-072915.pdf>

⁶⁸ For more information about the actions of the Los Angeles Board of Supervisors and the Office of Diversion and Re-entry visit: <http://ridley-thomas.lacounty.gov/index.php/board-approves-the-creation-of-an-office-of-diversion-and-re-entry/>

⁶⁹ See: http://www.mhsoac.ca.gov/sites/default/files/documents/2016-09/OAC_092216_RobinKayResponse.pdf

⁷⁰ For more information visit: <http://chcsbc.org/get-help/transformational-services-homelessness/>

⁷¹ For more information and to request slides regarding outcomes visit: <http://www.havenforhope.org/new/>

⁷² For more information visit: <https://www.whitehouse.gov/the-press-office/2016/06/30/fact-sheet-launching-data-driven-justice-initiative-disrupting-cycle>

⁷³ For more information visit: <http://www.countynewscenter.com/new-program-to-help-people-off-streets/>

⁷⁴ For more information visit: [http://file.lacounty.gov/SDSInter/dhs/218377_FHSP082614\(bleed--screenview\).pdf](http://file.lacounty.gov/SDSInter/dhs/218377_FHSP082614(bleed--screenview).pdf)

⁷⁵ For more information and to request copies of outcome materials visit:

<http://www.jud11.flcourts.org/Criminal-Mental-Health-Project>

⁷⁶ Information was gathered from a May 23 2016 Memo to the LA Board of Supervisors from the Health Care Services Agencies. Board agendas can be downloaded at: <http://bos.lacounty.gov/Board-Meeting/Board-Agendas>

⁷⁷ For more information visit: http://file.lacounty.gov/SDSInter/dhs/240469_fast_facts_02_29_16.pdf

⁷⁸ Findings were presented at: <http://www.frbsf.org/community-development/events/2016/october/2016-reentry-solutions-for-success/>

⁷⁹ For more information visit: <http://www.acsoyfsb.org/reentry.php>

⁸⁰: For more information visit:

<http://www.santacruzhealth.org/HSAHome/HSADivisions/BehavioralHealth/AdultMentalHealthServices/CoordinatedCareTeamsandSpecializedServices.aspx>

⁸¹ For more information visit:

<http://www.cdcr.ca.gov/COMIO/Uploadfile/pdfs/2016/Sept14/AB109InnovationsProjectPresentation.pdf>

Training

Training: Supporting Skills and Competencies Beyond First Responders

2016 marked a year of increased dialogue around law enforcement, first responders and their interaction with people in mental health crisis. High profile incidents that resulted in the shooting deaths of individuals in mental health crisis took place in California and called attention to the complex challenge of identifying what could have been done better in our perspective roles (criminal justice and behavioral health) to prevent such tragedies. Questions regarding whether there is adequate support of community correctional officers to provide effective response and supervision for the justice-involved with mental illness repeatedly surfaced with constituencies and stakeholders. Considering the growing interactions taking place with individuals with mental illness, are we aiding officers to get the support and care they need to manage their own stress and the potential impact of trauma experienced on the job? COMIO explored these questions this year, some with more capacity than others. In this section of the report the categories of *investigate, identify, and promote* are used to examine these challenges, recognize existing opportunities, and encourage future adoption or exploration of promising strategies. Above all COMIO found that investments in training are only as effective as the commitment to culture change – one where stigma has no place in determining action rather, action is guided by skills and reasonable empathy.

In California there is an existing commitment to improving law enforcement’s interactions with individuals, and often their families and loved ones, who are experiencing a mental health crisis. In 2015 legislation was signed by Governor Brown requiring the following:

- Field Training Officers (FTO) must have 8 hours of behavioral health crisis intervention training,
- FTO must have 4 hours of crisis intervention behavioral health training as part of the Field Training Officer Course,
- The Commission on Peace Officer Standards and Training (POST) must conduct an evaluation of the required competencies of the FTO program and Police Training Program,
- The Regular Basic Course taught in the academy - Learning Domain 37 Mental Health - must be at least 15 hours, and
- POST must develop and make available three hours of training to law enforcement personnel as it relates to behavioral health.⁸⁰

COMIO was pleased to participate in the process of implementing these new requirements and contributed to updates and new learning objectives that will meet these new requirements. Despite this, COMIO maintains that these additions are only minimum requirements and that more can be done to support law enforcement with having multiple opportunities for enhanced training and skill building. In addition to support for enhanced crisis intervention training, the Investment in Mental Health Wellness (IMHW) Act of 2013 has provided significant opportunities to improve crisis response infrastructure in California. As reported in Text Box E the act supports counties to develop or enhance crisis response strategies. The following section investigates how to best maximize these opportunities.

Investigate: Study the Problem and Assess Challenges

Finding: Seize opportunities to expand crisis intervention training and models, learn more about what works and does not work

Intercept one, crisis response strategies, are essential to effectively preventing incarceration. Law enforcement and mental health encounters are numerous (roughly 1 in 10 calls) and among the most complex and time-consuming calls for law enforcement to respond to. In the last decade, especially in California with the addition of resources from MHSA, several different models of police-mental health collaborations have emerged to provide crisis response skills and services for pre-booking diversion strategies. In October the BJA launched a toolkit to support law enforcement entities around the country to plan and implement public safety responses to people who have mental illness. As part of this project Los Angeles and Pasadena serve as “learning sites” that host site visits for officers from other departments nationwide. According to the toolkit, there are five general models of crisis response as described below.⁸¹

- Crisis Intervention Team (CIT) – According to CIT International, CIT is a community partnership of law enforcement, mental health and addiction professionals, individuals who live with mental illness and/or addiction disorders, their families and other advocates. It is a first-responder model of police-based crisis intervention training to help persons with mental disorders and/or addictions, access medical treatment rather than place them in the criminal justice system due to illness related behaviors. It also promotes officer safety and the safety of the individual in crisis. The CIT Model was first developed in Memphis and has spread throughout the country. It is known as the “Memphis Model.” The model reduces both stigma and the need for further involvement with the criminal justice system. CIT provides a forum for effective problem solving regarding the interaction between the criminal justice and mental health care system, and creates the context for sustainable change.⁸² (e.g. San Mateo)
- Co-Responder Team – A team where a specially trained officer and a mental health crisis worker respond together to mental health calls for service. The expertise of the officer and the mental health professional combine to effectively link people with mental illness to services or provide other efficient responses as appropriate. (e.g. Sacramento)
- Mobile Crisis Team – A team of mental health professionals respond to calls at the request of officers, family members or the general public. These teams work to help stabilize encounters and assume responsibility for securing mental health services. (e.g. San Diego)
- Case Management – Officers work in collaboration with mental health professionals to carry a caseload of consumers who engage in frequent interactions with law enforcement. Case managers work to develop solutions that are specific to individual needs to reduce repeat interactions. This approach aims to encourage individuals to stay connected to mental health services, adhere to a treatment plan, and to fulfil other responsibilities such as work, school or training. (e.g. LAPD)
- Hybrid Approach – A law enforcement agency intentionally selects various response options to build a comprehensive and robust program. The agency begins with the expectation that every patrol officer must be able to respond effectively to mental health calls and enhances their patrol force with officers or detectives whose primary responsibilities are to liaise with stakeholders and to coordinate criminal justice and mental health resources.⁸³ (e.g. LAPD)

With such a variety, what does the evidence say is the most effective and why? This is a critical assessment which COMIO did not have the capacity to conduct this year but strongly argues that it needs to be done in the near future. For the purposes of this report, COMIO was able to begin this assessment. According to an analysis presented to COMIO from the University of California (UC) Davis which is currently *in press*, the evidence for the effectiveness of police-based pre-booking diversion programs in reducing arrests of people with mental illness is limited.⁸⁴ The analysis conducts a systematic literature review to examine the state of knowledge regarding the effectiveness of police-based pre-booking diversion programs in addressing the criminalization of mental illness. Two of the above types of interventions were examined, CIT and mobile crisis units. While there are limitations to the study, the authors concluded that while CIT and mobile crisis units did significantly increase the probability of people accessing mental health services, it was not associated with reduced arrests.⁸⁵ The authors believe one of the reasons why is due to the nature of the reason for police contact, which is law enforcement fulfilling their role to arrest in hopes of accessing treatment.

An alternative that may have impacts on arrests noted in the study is a program called Neighborhood Outreach Scheme (NOS), a model consistent with the case management and hybrid models discussed above. The program is designed to preempt crisis and police contact by using a community psychiatric nurse who accepts referrals from police and mental health specialists to follow-up on vulnerable people from the neighborhood. These are individuals who do not meet the criteria for crisis response but could be a risk of future police contact.⁸⁶ In other words, while training police and having crisis response models is important to accessing mental health services, if the goal is to reduce arrests then mechanisms that build capacity for non-police response to mental health crisis need to be considered.

Recommendation 1c. Encourage the Center for Behavioral Health Excellence at UC Davis who has already begun to assess the effectiveness of police-mental health collaborations, to identify the critical ingredients for the most measurable impacts among various crisis response programs. Such an analysis could be helpful to direct investments in training and programs statewide and locally.

These findings also raise the issue of what else might be out there, and who else should be trained to be as effective as possible in reducing outcomes. Are outcomes being achieved such as reduced use of force and unnecessary arrests, or improving referrals to services and rates of successful crisis resolution? There are dozens of entities, particularly those that represent the viewpoints of consumers of services and their family members, which provide additional training ranging from recovery and wellness to suicide prevention and crisis management. What if a full 40 hours of CIT is not plausible or as relevant as other skill building opportunities, do we know what should absolutely be available beyond crisis management and de-escalation techniques? Could additional critical elements to training include addressing stigma and bias and teaching empathy and respect? How can such opportunities for additional training be made available to other key first responders including fire, emergency medical services, emergency psychiatric services, and beyond?

Recommendation 2c. COMIO can work with partners in the field and researchers to develop recommendations regarding what competencies are critically needed for which populations (i.e. dispatcher vs emergency room technician) and help identify how training and skill-building can be resourced.

Finding: More could be done to understand the challenges law enforcement and community corrections professionals face in the field

Today there is general acknowledgment that law enforcement and correctional officers experience a significant amount of stress and trauma in the workplace. COMIO's intent is not to investigate research on this subject in detail, but to address an observation. COMIO observed that the impact of stress and trauma does not appear to be well-known or understood among stakeholders in diversion practices. To support the well-being of individuals with mental illness, we cannot ignore the well-being of those they interact with in the criminal justice system. Furthermore, an improved understanding of what officers' experience can support the kind of empathy needed to facilitate common ground and collaborative criminal justice-behavioral health partnerships.

Police and corrections work is challenging and "officers often experience potentially traumatic incidents that may jeopardize their own lives or the lives of their fellow officers."⁸⁷ Similar to other professions there are operational and organizational stressors, but the level of traumatic stressors exceeds the average job. Traumatic stress differs in a number of ways, including the event being unexpected, causing distress, possibly overwhelming coping capacity, and having the potential to alter the way one views the world.⁸⁸ Examples of primary traumatic stress range from witnessing violent incidents like motor vehicle fatalities, child abuse, and suicide to being assaulted or threatened repeatedly. Symptoms from traumatic stress are physical (muscle tension), cognitive (numbness, rumination), emotional (irritability, depression), and behavioral (alcohol/ drug use, sleep disturbance). In addition, secondary traumatic stress is experienced and often referred to as "compassion or corrections fatigue." On a daily basis, these professionals are exposed to interacting with victims, conducting pre-sentencing investigations, or having to observe violence or witness co-workers harmed in the line of duty. Vicarious trauma, which is exposure to someone else's trauma, can cause a change in how one views the world, most often increasing suspicion, cynicism and intrapersonal relationship problems while reducing empathy.⁸⁹ In the most extreme cases, repeat and prolonged exposure to trauma can result in post-traumatic stress disorder. In short, police and corrections work can result in psychological distress, burnout, and maladaptive coping mechanisms, all of which have a personal and professional toll.

Recommendation 3c. COMIO will seek opportunities to raise awareness about the impact of trauma and stress on law enforcement and correctional professionals to increase understanding and support collaborative criminal justice-behavioral health partnerships.

Finding: More resources are needed for law enforcement and community corrections professionals to support their wellness and improve outcomes for those they interact with who have mental illness

A recent survey of the membership of the American Probation and Parole Association (APPA) found that nearly a third of respondents reported four or more primary traumatic events in their career, but only a third felt "somewhat" supported by their agency after the primary traumatic event.⁹⁰ There are several things that can be done to support law enforcement and community corrections professionals from the impact of trauma and any potential unintended impact on those they interact with. Education and training can be provided, even at the cadet and academy training level, so that officers are aware of the possible impact of trauma and how to identify signs and changes in behavior that may signify a potential problem. It is also critical to have a work culture that promotes healthy coping and self-care practices.⁹¹ Peer support programs have been growing in

popularity and have several benefits such as providing help to those who might be reluctant to access external resources. Peer support programs can focus on meeting the needs of employees experiencing secondary and vicarious trauma and the offer of peer support services should be procedural following incidents associated with high stress.

But others argue that while peer support officers are dedicated, caring and giving people, “many programs are voluntary and lack support in areas such as budget, training, and compensatory time or detail.”⁹² Many departments have dedicated police psychologists and Employee Assistance Programs (EAP), although these typically focus on resolving issues once they develop, not on preventing them.⁹³ EAP programs receive mixed reviews from officers for reasons that range from distrust of the licensed therapist due to being an outsider, to challenges finding and maintaining a consistent therapist. Officers often experience unique and complex issues, and even the most skilled counselors determine they need to develop a basic understanding of law enforcement culture.⁹⁴

Some advocate that it is time to move beyond peer support and EAPs and move towards proactive efforts, like the Indianapolis Metro Police Department (IMPD) who support officer wellness by:

- Improving the screening and application process,
- Recruiting for physical, behavioral and mental health,
- Providing formal mentoring from day one on the job,
- Providing spouse and family education and support programs,
- Providing career development support, and
- Providing financial and retirement planning.

With support from the union and police leadership, IMPD created a full-time confidential officer advocacy program that encourages officer development through formal mentoring, education on stress management, and identification of available resources.⁹⁵ The IMPD wellness and development program oversees physical and mental health referrals through a network of prescreened resources—medical, professional, clinical, and educational. The program is credited with helping officers strengthen family relationships and careers. The National Law Enforcement Officers Memorial Foundation and U.S. Attorney General Loretta Lynch have honored the program, which in a 4-year period reduced disciplinary referrals by 40 percent.⁹⁶

Recommendation 4c. Invest in a comprehensive review of best practices in Officer Wellness and Peer Support Programs, including models from other states and countries. Investigate whether there is evidence to suggest that officer wellness is linked to improved outcomes for the justice-involved, like reduced critical incidents, use of force, and improved behavior.

Identify: Recognize and Examine Existing Opportunities

Finding: By building relationships and providing resources, current opportunities to strengthen skills for law enforcement and community corrections can achieve outcomes

This year COMIO became aware of a significant number of enhanced training activities across the state, but for these opportunities to be capitalized on, strong relationships and resources are needed. Law enforcement and community corrections expressed support and eagerness for more skills to effectively communicate, de-escalate, supervise and support individuals with mental illness

who are justice-involved. In addition to the implementation of new mental health training requirements under POST, BSCC has begun a comprehensive process to review and propose updates to core training requirements for Adult Corrections Officers (ACO), Juvenile Corrections Officers (JCO), and Probation Officers.⁹⁷ The training requirements are specific to each classification and are based on a job analysis that identifies what skills and abilities are needed to perform job duties. Currently there are specific courses and hours dedicated to mental health training issues, as well as, mental health training woven into related classes like interpersonal communication. A group of subject matter experts from both behavioral health and criminal justice has been convening to advise such revisions and COMIO has been pleased to participate. Some of the key issues experts noted:

- Start by making it clear that it is an expectation of the job to work appropriately and support the well-being of people with mental illness,
- Consider including mechanisms during screening to support selecting individuals that will work appropriately with individuals with mental illness,
- Move beyond teaching people about the myths and misperceptions of what mental illness is and instead work with peers of the trainees to disclose personal experiences with mental illness. Hearing from individuals about their experiences is the most effective way to erode stigma, and
- Use scenario-based and role-play learning so there are multiple opportunities to practice skill sets.

In addition to the dozens of counties with CIT programs for law enforcement, several counties also are providing or developing additional mental health training specifically for custody staff such as Santa Clara who is offering an additional 16-hours and the LA Sheriff's Department that is providing an additional 32-hours.

Recommendation 5c. Request that CDCR share lessons learned from the Commission on Correctional Peace Officer Standards and Training (C-POST) revision of curriculum to include 24 hours of crisis de-escalation into existing training with the BSCC or other community correctional systems that are in the process of strengthening this type of training.

Recommendation 6c. Encourage POST and/or BSCC to explore the use of an application process for cost reimbursement to law enforcement and community correctional entities for enhanced crisis intervention and mental health training that can document a need and commitment to maximize training opportunities.

By building relationships between mental health (consumers, family members, providers and administrators) and criminal justice (law enforcement, community corrections professionals, courts) constituencies a better understanding of community resources and perspectives can be gained and exchanged. Many law enforcement entities participate in community service planning meetings, such as MHSA stakeholder meetings or host their own community forums to receive feedback regarding community needs. Organizations like the NAMI (<http://namica.org>), Mental Health America of California (MHAC), (www.mhac.org), and the California Association of Mental Health and Peer run Organizations (CAMHPRO) (<https://camhpro.org>) offer their own trainings and may be available to support skill building on understanding cultural and generational differences, working with families effectively, and strategies to foster recovery and wellness for individuals with mental illness.

Recommendation 7c. COMIO will encourage criminal justice constituencies to visit mental health programs and vice versa for mental health constituencies to better understand each other's perspectives and leverage resources. COMIO can use workshops and educational site visits to support such cross-system collaboration.

Finding: Invest in the criminal justice and behavioral health workforce, especially the nexus between the two

While more work is needed to understand and implement effective integrated correctional and behavioral health programs as discussed previously in this report, in the interim supporting the use of evidenced-based practices and building a workforce that can implement them, can be a priority. Below are a few examples of effective programs that COMIO identified in 2016:

- Specialty Mental Health Probation – Justice-involved individuals with mental illness are assigned to be supervised by a specialty trained probation officer with a relatively small caseload. Practices include establishing a fair, firm, and caring relationship with probationers and avoiding heavy reliance on negative compliance strategies. Researchers report that this form of supervision results in better officer's practices (e.g. problem solving and boundary spanning), greater rates of treatment involvement, and lower rates of violations.⁹⁸
- Cognitive Behavioral Interventions Comprehensive Curriculum (CBI-CC) – This curriculum has been developed to include justice-involved individuals with mental illness to participate in structured interventions that target all criminogenic needs and is designed to manage risky, difficult, or challenging situations by developing more prosocial thoughts, attitudes, and behaviors. The model was piloted both in custody and in community-based mental health programs for men and women.⁹⁹
- Cognitive Behavioral Interventions for Offenders Seeking Employment (CBI-EMP) – This curriculum addresses thought patterns and behaviors that would be barriers to sustain employment for those with significant employment needs. Through the five modules, individuals learn how to manage challenging situations in the workplace. Reentry, custody and community corrections staff can all be trained to provide these interventions.¹⁰⁰
- Correctional Program Checklist (CPC) – Is a set of tools that evaluate the extent to which correctional programs adhere to the principles of effective interventions. The CPC assists agencies (e.g. Probation Departments) to develop and improve the services provided to justice-involved populations, monitor contracts for performance and fidelity, and support research on the effectiveness of correctional treatment programs. San Diego County has implemented the CPC and identified six common issues that lead to success: never mix high and low risk, target criminogenic needs 4:1, consistently practice and rehearse prosocial responses, use validated assessment tools for measuring RNR, don't mix genders, and formal training and protocols and necessary.¹⁰¹

A common concern expressed was that the existing behavioral health workforce had not been exposed to evidence-based correctional interventions and might not be familiar with and even harbor their own biases towards individuals who have been justice-involved. Curriculum for skill building in the area of servicing the justice-involved could be made more available through entities that provide continuing education credits for licensed professionals. Considering the extensive need for such skills, educational institutions that are training and producing future behavioral

health professionals should consider the addition of learning modules into core curriculum about working with the justice-involved into core curriculum or as an area of elective study.

Recommendation 8c. COMIO will share the findings from the 2016 report with key professional guilds and educational institutions, and request further dialogue about strategies that can support the need for skill building for core correctional services among behavioral health providers.

Promote: Training and Officer Wellness

Throughout the year COMIO was honored to hear testimony, visit, or research efforts to support skill-building and officer wellness. This section of the report provides brief highlights from several of the programs reviewed.

California Highway Patrol (CHP) Mental Illness Response Program (MIRP)

In response to a growing emphasis on law enforcement interactions with mental health consumers and to ensure the appropriate competencies were provided to officers, CHP established the MIRP unit in early 2014. The unit has strong support from CHP leadership, and is a piece of a much larger commitment to a cultural shift supported by policy change that measures improvements in CHP officer interactions with individuals in mental health crisis. The MIRP unit coordinates and is responsible for the Crisis Intervention Behavioral Health training for both uniformed and non-uniformed CHP employees. The MIRP unit created its curriculum by drawing on expertise from other law enforcement officers as well as mental health advocates and consumers. To meet departmental training needs, the MIRP unit has developed a 4-phase approach to training:

- Eight-hour training for all CHP employees,
- Additional four-hour training for all uniformed managers,
- Additional 12-hour training at local level for Sergeants and Officers, and
Additional 20-hour advanced skill training for Sergeants and Officers.

Additional training includes:

- Academy Basic Course for Cadets - 15 hours
- Field Training and Evaluation Program – 4 hours
- Middle Management Training Course – 2 hours
- First-Line Supervisors – 2 hours
- Drug Evaluation and Classification Program – 2 hours
- CIT for Public Safety Dispatcher – In development
- Non-uniformed “Professional Staff” – In development
- 32-hour allied agency CIT Instructor course, this will allow CHP to instruct the CIT curriculum to allied agencies throughout California. This allows for standardized statewide training curriculum as well as provides assistance to agencies which may not possess the resources necessary to develop and implement CIT training.

COMIO honored CHP Commissioner Farrow and the MIRP with a Best Practices Award in November for efforts to implement best practices and supportive partnerships with critical constituencies such as NAMI, CBHDA, DHCS, and POST.¹⁰²

Los Angeles County Police Department Mental Evaluation Unit (MEU)

COMIO was graciously hosted twice by various staff from this unit, as well as, partnering staff from LADMH. The collective goals of the program include:

- Preventing the unnecessary incarceration and/or hospitalization of individuals with mental illness,
- Providing alternative care in the least restrictive environment through a coordinated and comprehensive system-wide approach,
- Preventing the duplication of mental health services, and
- Facilitating the speedy return of police patrol units to patrol activities.

There are several elements of the overall program which include:

- Multi-layered approach that includes co-response teams, follow-up case managers, and triage/dispatch operators,
- Embedded mental health professionals,
- Comprehensive data collection and information sharing procedures,
- Robust training strategy that includes 40-hour mental health intervention training, and
- Mental Health Crisis Response Program Advisory Board to support community outreach and engagement.

Some of the lessons learned, shared by staff of the various programs within the MEU, including the System-wide Mental Assessment Response Team (SMART), the Case Assessment Management Program (CAMP), Triage and Training are:

- Cultural change begins with leadership establishing goals rather than minimum standards. Policies and procedures shift behavior towards goal attainment. Training can sustain and reinforce change but never propel it,
- Outreach, education, and partnership with the community is essential to making crisis response programs work,
- Skills are important but attitude is essential. Focus on the attitude of the officer and support him or her to see people with disabilities as deserving respect and empathy,
- Use data at every opportunity as it can tell a story about where efforts are needed to reach leadership's goals,
- Use technology to identify people and support partnerships with other first responders like fire and emergency medical services,
- Operate within a much larger system recognizing that effective crisis response can only work if other elements are in place, such as triage services and drop-off locations, and adequate housing and service alternatives to incarceration, and
- Consider alternatives to police for crisis response, such as using nurse practitioner response units that can provide medical clearance for diversion to a mental health alternative.

The BJA has acknowledged LAPD MEU as a distinguished training site and with such a resource COMIO strongly supports agencies in need of training or technical assistance to reach out to LAPD MEU.¹⁰³

CDCR 28-Hour Communication and De-Escalation Techniques Curriculum

In 2015 CDCR adopted a revised 28 hours of curriculum for all basic correctional officer academy cadets to support skill sets to resolve conflict at the lowest and least invasive level as possible. Some sample learning objectives include:

- Use of active listening skills,
- Strategies to prevent the escalation of conflict,
- Understanding techniques that assist in communicating with inmates who have a mental illness,
- Identification of adaptive support services,
- Understanding of conflict resolution,
- Use of the 4 stages of de-escalation,
- Understanding of common mental health disorders, and
- Understanding of when to make mental health referrals.

These skills are in addition to skill building, specific to inmates with mental illness while at the academy, such as use of force training, understanding services provided by the correctional mental health, the role of rehabilitation and rehabilitative services, services prevention, etc. CDCR's intensive experience with inmates who have serious mental illness could be helpful to community corrections professionals providing custody services who may not have had the same exposure to such inmates for a significant duration of time. COMIO encourages an exchange of lessons learned.¹⁰⁴

CDCR Peer Support Program (PSP)

This program ensures that staff involved in work related critical incidents are provided with intervention and available resources to cope with the immediate effects of a traumatic incident. Local PSP teams are available at each CDCR location and consist of volunteer trained custody and non-custody staff who will listen, answer questions, and offer resources to help the employee deal with his/her situation in a confidential environment. The PSP also has a Suicide Prevention/Intervention Program and a Military Peer Support Program for military service employees. There are over 1,200 CDCR trained peer supporters.

The program is located within the Office of Employee Wellness that produces a monthly series of educational events to support the health of employees, including emotional well-being. The office hosts events in support of Mental Health Awareness Month and Suicide Prevention week and provides weekly tips and resources to achieve and maintain positive health.¹⁰⁵

Los Angeles Sheriff's Bureau of Psychological Services

The bureau provides accessible and confidential psychological services to staff of the Sheriff's department and is one of the largest law enforcement psychology services in the country. The bureau uses psychology and the behavioral sciences to enhance the welfare of its employees, its organizational efficiency, and its law enforcement mission. It provides therapy and support services but also training and evaluation services. Most of the bureau staff participate in the 24/7 on-call emergency response service. The Department has started making a number of these services available, through a Memorandum of Understanding (MOU), to the Los Angeles County Department of Probation.

COMIO felt the work of the bureau was unique in that it offered support above and beyond what can be provided through PSP and EAP. The bureau also maintains a commitment to addressing stigma by deploying staff to institutions to provide lunch-time seminars and conduct other forms of outreach and engagement.¹⁰⁶

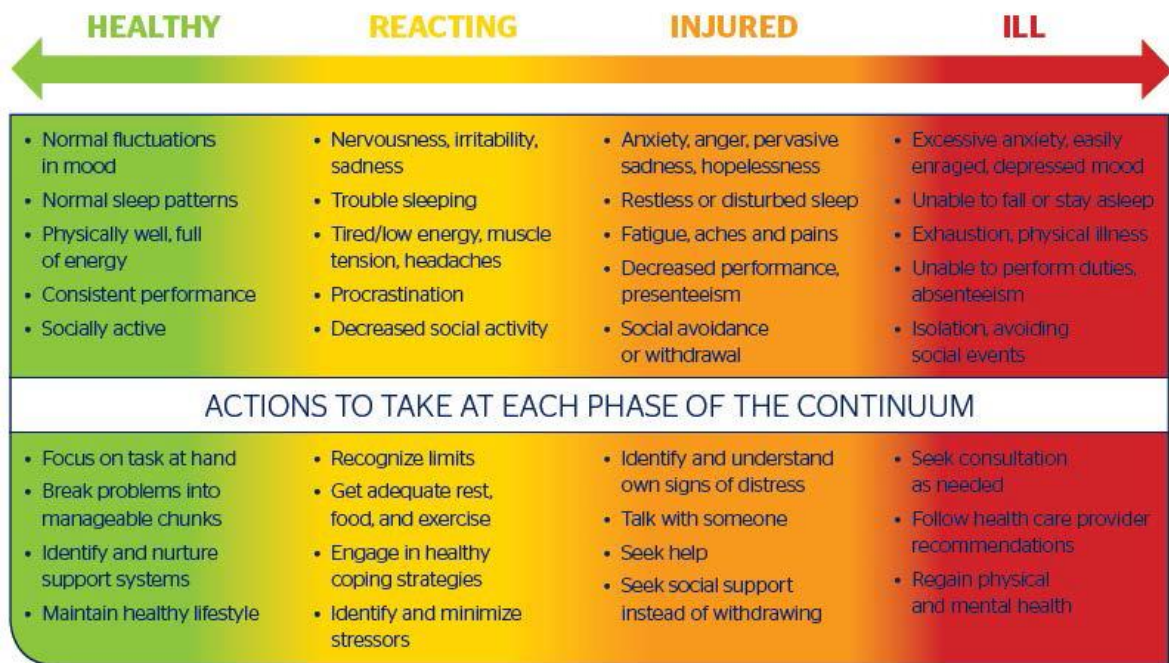
Road to Mental Readiness (R2MR) for law enforcement, first responders, and correctional staff – The Mental Health Commission of Canada

The R2MR is a unique program designed to both reduce the stigma associated with mental illness and to address and promote the mental health and resiliency in the law enforcement/first responder/and correctional workplace setting. The program began as an initiative of the Canadian Department of National Defense and has been adapted for several additional workplaces. Training modules are centered on the mental health continuum model see Figure 3 which is a self-assessment tool to teach participants indicators of positive, declining, or poor mental health. The program aims to create health workplaces and workers where staff and supervisors are trained not only to monitor their own wellness, but identify behaviors in others who might be in need of further support. Cognitive behavioral techniques are taught to help manage stress and resiliency with the goal of creating a healthy worker and therefore a healthy approach to conducting work in crisis response.

The program has demonstrated success with returning military with pre-post tests showing medium to large positive effects on attitudes towards mental health and help-seeking and feeling of self-efficacy.¹⁰⁷ R2MR is currently being evaluated by health economists to measure cost effectiveness over a three-year implementation period. If the program demonstrates reduced days of lost work and productivity, in addition to, improved health and well-being measures, examining applicability to California would certainly be warranted.¹⁰⁸

Figure 3

MENTAL HEALTH CONTINUUM MODEL



Source: Mental Health Commission of Canada, November 2016

⁸⁰ For more information visit POST at: <https://www.post.ca.gov/crisis-intervention-behavioral-health-training.aspx>

⁸¹ Council of State Governments Justice Center (2016). *Police-Mental Health Collaboration Programs – A Different Way of Policing* available at: <https://csgjusticecenter.org/law-enforcement/webinars/police-mental-health-collaboration-programs-a-different-way-of-policing/>

⁸² For more information please see <http://citinternational.org/>

⁸³ Council of State Governments Justice Center (2016). *Police-Mental Health Collaboration Programs – A Different Way of Policing* available at: <https://csgjusticecenter.org/law-enforcement/webinars/police-mental-health-collaboration-programs-a-different-way-of-policing/>

⁸⁴ Dewa, C. (2016). Evidence for the Effectiveness of Police-Based Pre-Booking Programs in Decriminalizing Mental Illness: A Systematic Literature Review. IN PRESS

⁸⁵ For more information see:

http://www.cdcr.ca.gov/COMIO/Uploadfile/pdfs/2016/Sept14/PrebookingDiv_091316FIN.pdf *Ibid*, UC Davis Study

⁸⁶ Earl et al 2015

⁸⁷ Anderson, J.P., and Papzoglou, K. (2015). Compassion Fatigue and Compassion Satisfaction among Police Officers: An Understudied Topic. *International Journal of Emergency Mental Health and Human Resilience*, Vol. 17, (3), pp.661-663.

⁸⁸ *Surviving the Trenches: The Impact of Trauma Exposure on Corrections Professionals* (2015) Council of State Governments, available at: https://csgjusticecenter.org/nrrc/webinars/surviving-the-trenches-the-impact-of-trauma-exposure-on-corrections-professionals/?utm_source=CSG%20Justice%20Center%20Primary%20List

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- ⁸⁹ Steed, L. G. & Downing, R. (1998). A phenomenological study of vicarious traumatization amongst psychologists and professional counselors working in the field of sexual abuse/assault. *The Australasian Journal of Disaster and Trauma Studies*, 1998-2.
- ⁹⁰ Lewis, K. (2016). *Surviving the trenches: The impact of trauma exposure on correctional professionals*. A webinar hosted by the National Reentry Resource Center and the American Probation and Parole Association February 17, 2016.
- ⁹¹ *Police-Mental Health Collaboration Programs – A Different Way of Policing* available at: [https://csgjusticecenter.org/law-enforcement/webinars/police-mental-health-collaboration-programs-a-different-way-of-policing/...](https://csgjusticecenter.org/law-enforcement/webinars/police-mental-health-collaboration-programs-a-different-way-of-policing/)
- ⁹² Nanavaty, B.R. (2015). Addressing Officer Crisis and Suicide: Improving Officer Wellness. Federal Bureau of Investigation Law Enforcement Bulletin. Available at: <https://leb.fbi.gov/2015/september/addressing-officer-crisis-and-suicide-improving-officer-wellness>
- ⁹³ U.S. Department of Health and Human Services, Federal Occupational Health, “Employee Assistance Programs,” available at: <http://www.foh.dhhs.gov/services/EAP/EAP.asp>.
- ⁹⁴ Nanavaty, Addressing Officer Crisis and Suicide: Improving Officer Wellness
- ⁹⁵ Police One, “Police Wellness Program,” BLUtube website <http://blutube.policeone.com/health-physical-and-mental-fitness-videos/2805777683001-police-wellness-program/>.
- ⁹⁶ <http://www.wfyi.org/news/articles/nations-top-cop-lauds-impd-for-officer-wellness-program>; Bureau of Justice Assistance and the National Law Enforcement Officers Memorial Foundation awarded IMPD the 2015 Destination Zero award for law enforcement safety and wellness programs.
- ⁹⁷ For more information see materials shared with the COMIO training committee on August 17, 2016 at <http://www.cdcr.ca.gov/COMIO/Uploadfile/pdfs/2016/Aug17/BSSC%20Training%20and%20Mental%20Health%20.pdf>
- ⁹⁸ Manchak, S.M., Skeem, J.L., Kennealy, P.J., & Eno Loudon, J. (2014). High-Fidelity Specialty Mental Health Probation Improves Officer Practices, Treatment Access, and Rule Compliance. *Law and Human Behavior*. <http://dx.doi.org/10.1037/lhb0000076>
- ⁹⁹ For more information: https://www.uc.edu/corrections/services/trainings/changing_offender_behavior/cbi-cc-training-overview.html
- ¹⁰⁰ For more information: https://www.uc.edu/corrections/services/trainings/changing_offender_behavior/cbi-emptrainingoverview.html
- ¹⁰¹ Information about the CPC was presented to COMIO on August 17 2016 and is available at: http://www.cdcr.ca.gov/COMIO/Uploadfile/pdfs/2016/Aug17/The_CPC_and_Promoting_Effective_Practices_for_JI_Youth_and_Adults.pdf
- ¹⁰² MIRP presentation to COMIO is available at: http://www.cdcr.ca.gov/COMIO/Uploadfile/pdfs/2016/CHP_MIRP_Training_Speaking_Points_for_COMIO.pdf
- ¹⁰³ Please see materials from the April 13th COMIO meeting at: <http://www.cdcr.ca.gov/COMIO/Uploadfile/pdfs/2016/April20/MEU%20Program%20Outline%20updated%20OUPDATED%204-13--2016.pdf> and <https://csgjusticecenter.org/wp-content/uploads/2015/05/LAPDOverview.pdf>
- ¹⁰⁴ For more information about CPOST visit: <http://www.cpost.ca.gov/>
- ¹⁰⁵ For more information visit: <http://www.cdcr.ca.gov/Wellness/psp.html>
- ¹⁰⁶ Please see materials from the April 13th COMIO meeting at: <http://www.cdcr.ca.gov/COMIO/meetings-2016.html>
- ¹⁰⁷ Zamorski, M.A., Guest, K., Bailey, S., & Garber, B.G. (2012). Beyond battlemind: evaluation of a news mental health training program for Canadian forces personnel participating in third-location decompression. *Military Medicine*, 177(11), 1245-1253.
- ¹⁰⁸ For more information visit: <http://www.forces.gc.ca/en/caf-community-health-services-r2mr/index.page> and http://www.mentalhealthcommission.ca/sites/default/files/1%252520PG%252520R2MR%252520Police%252520Backgrounder%252520ENG_0_0.PDF

Juvenile Justice

Juvenile Justice: A Changing Population

In 2015 COMIO focused on promoting effective ways to prevent juvenile delinquency through evidence-based prevention and early intervention mental health programming. The committee continued this work by reaching out to 23 entities such as the California Parent-Teacher Association to encourage support of programming such as:

- Nurse-Family Partnerships <http://evidencebasedprograms.org/1366-2/nurse-family-partnership>,
- Cognitive-Behavioral Intervention for Trauma in Schools (CBITS) <http://www.promisingpractices.net/program.asp?programid=145>,
- The Incredible Years <https://www.crimesolutions.gov/ProgramDetails.aspx?ID=194>,
- Positive Parenting Program Triple P <http://www.promisingpractices.net/program.asp?programid=272>,

Throughout 2016 COMIO saw further evolution of the Juvenile Justice Committee through both a change in leadership and a growing understanding of the needs of the changing population of youth involved in the juvenile justice system. COMIO heard from programs and experts who spoke to one or more of four distinct aspects of the juvenile justice system, which are:

- Prevention, targeting youth who are not yet in the system,
- Diversion, targeting youth who have had a law enforcement contact and instead are redirected to alternative services,
- Detention, targeting the small percentage of youth who need to go into custody and remain there or are committed to a period of time to custody, and
- Probation, targeting those youth who have penetrated the system and efforts focus on reducing recidivism risk.

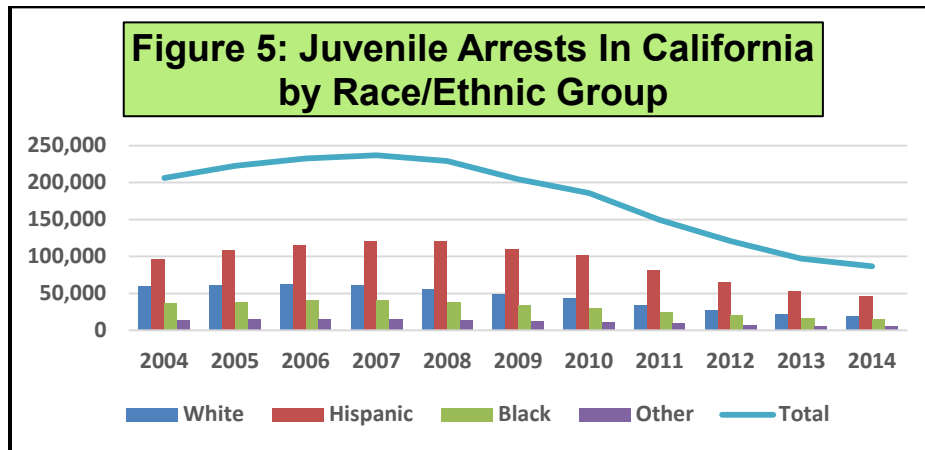
COMIO seeks to prevent juvenile delinquency, support diversion efforts, reduce the number and duration of detention, and increase the effectiveness of programs for youth who are justice-involved or at-risk of becoming so. To support this, the committee will acknowledge programs for accomplishments in one or more of these four distinct aspects of the juvenile justice system.

As the committee conducted its work, they also recognized the substantial impact of significant policy changes, such as the implementation of Continuum Care Reform (CCR), would have on this population in the future. In this section of the report the categories of *investigate*, *identify*, and *promote* are used to examine what is known about this changing population and their needs, recognize existing opportunities for progress, and encourage the future adoption of programs and strategies that are making a difference.

Investigate: Study the Problem and Assess Challenges

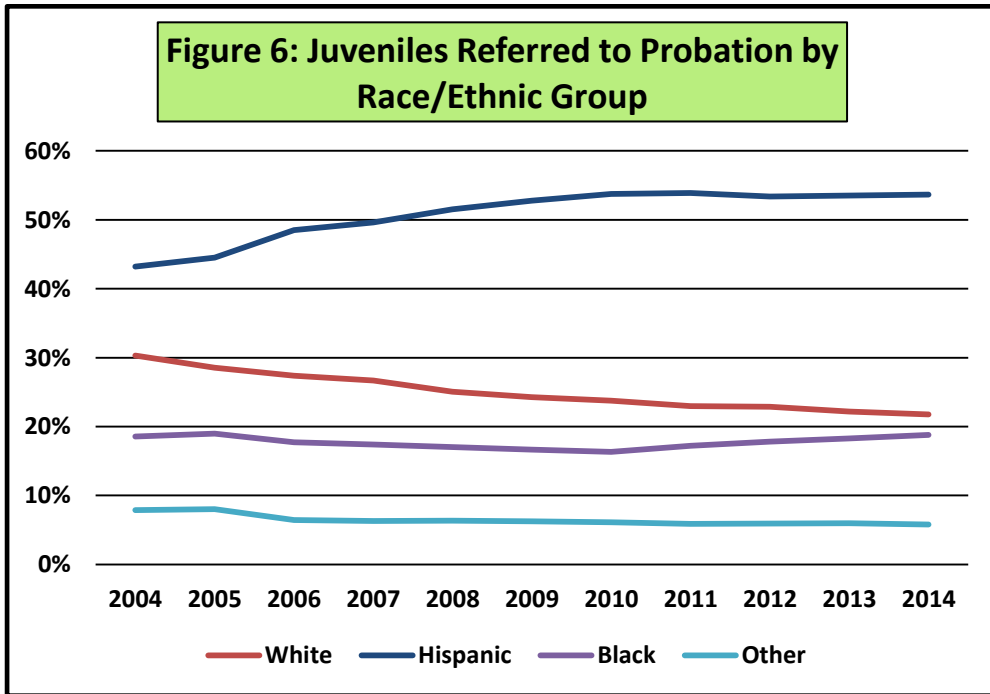
Finding: The juvenile justice population has changed significantly over the last decade

Although the total number of youth involved in the juvenile justice system has dramatically decreased, the changing demographics of the juvenile justice population demonstrate an increase in racial and ethnic disparities. There is also a disproportionality of mental health cases in juveniles in detention.¹⁰⁹ Similar to patterns among adults, juvenile arrests for youth age 10-17 have fallen to a multi-year low, representing a 54 percent decline since 2006.¹¹⁰ Figure 5 shows data over a ten-year period demonstrating reduction in juvenile arrests, but increased representation from youth of color. In 2014 White youth represented 27.1 percent of the juvenile population from ages 0-17 but only 22.2 percent of arrests while Hispanic youth represented 51.4 percent of the population and 54 percent of juveniles arrested. Strikingly, Black youth represented only 5.4 percent of the population, yet represented 18.1 percent of juvenile arrests.

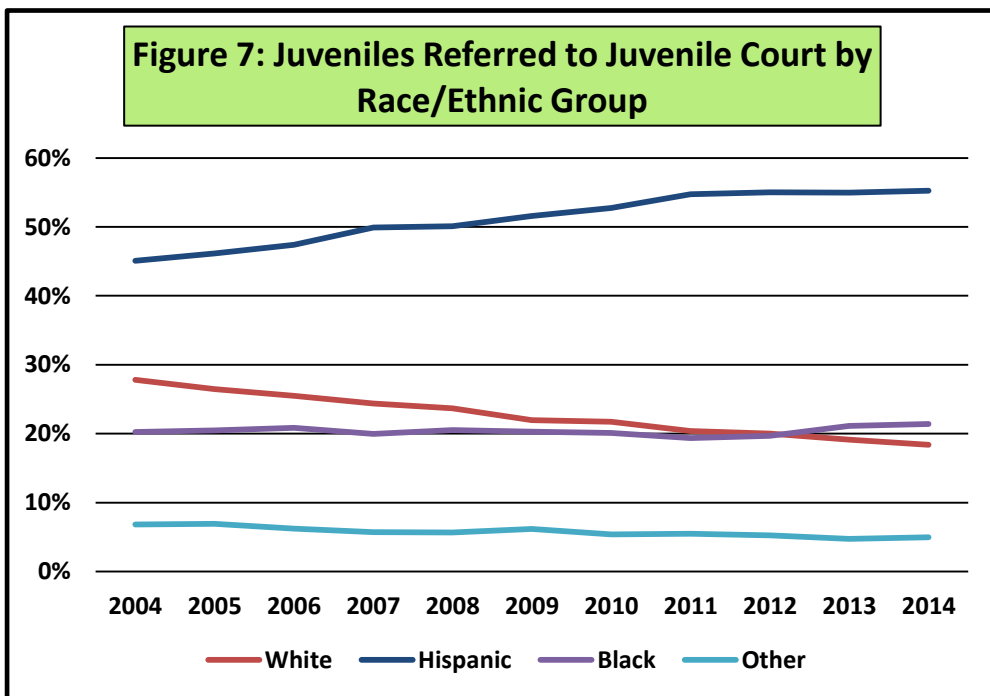


Source: California Department of Justice, Juvenile Justice in California, 2014

The demographics of juveniles arrested in California are consistent with referral to both probation and juvenile court. Figure 6 and 7 illustrate that as youth move through the juvenile justice system, racial disparities remain constant with 54 percent of youth referred to probation and 55 percent of those referred to juvenile court being Hispanic. Twenty percent of the number of juveniles referred to both probation and juvenile court were Black, roughly three times higher than their proportion of the population. These disparities are critical to consider when determining how to address the needs of the system-involved youth.

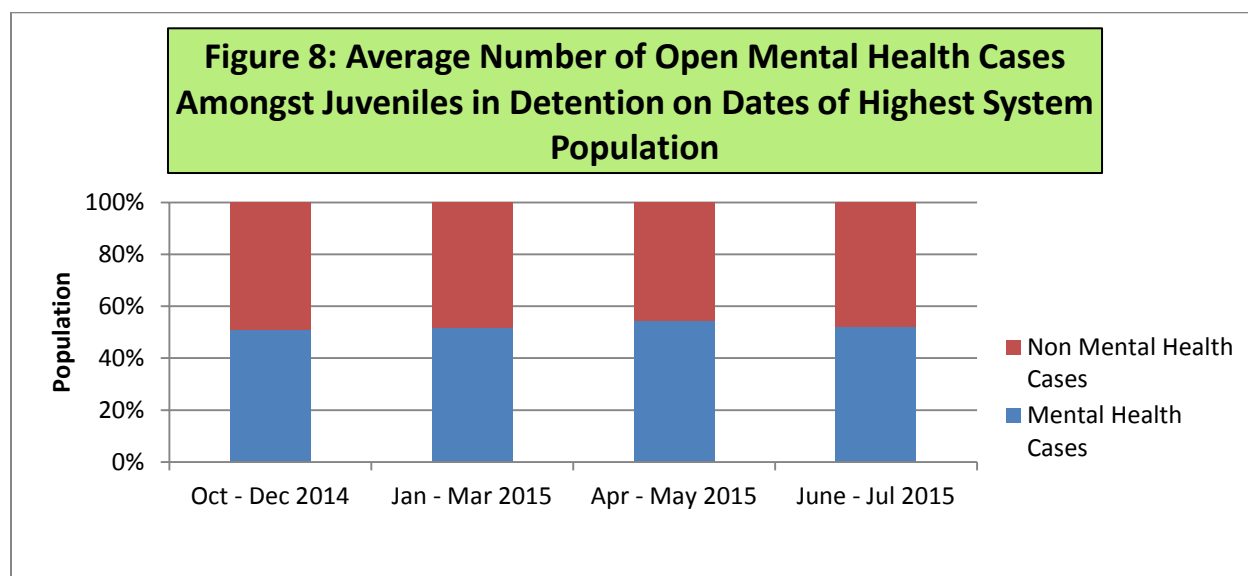


Source: California Department of Justice, Juvenile Justice in California, 2014



Source: California Department of Justice, Juvenile Justice in California, 2014.

In addition to increasing racial and ethnic disparities, more justice involved youth are experiencing mental health challenges. The high rates of mental health issues in juvenile detention have been identified previously. For example one meta-analysis found that youth in detention facilities were about 10 times more likely to suffer from psychosis than the general youth population. Girls were more often than boys to be diagnosed with major depression, (about 30 percent), and both were diagnosed with high rates, (over 50 percent), of conduct disorder.¹¹¹ COMIO heard several times this year from behavioral health providers, probation staff, and advocates who are concerned about the growing number of youth with serious mental health needs who are in detention. Figure 8 displays data on the number of open mental health cases among juveniles in detention in California. According to the most recent data from BSCCs' Juvenile Detention Profile Survey, over the course of one year, the number of open mental health cases among juveniles in detention on the dates in which the system population was at its highest, was over 50 percent. This means that over half of the youth in detention were experiencing a mental health issue.



Source: Board of State and Community Corrections, Juvenile Detention Profile Survey

While the goal should be to address mental health needs prior to detention or even involvement with the juvenile justice system, interaction with the system offers an important opportunity to aggressively and effectively treat unmet needs. This is necessary because it appears that youths' significant mental health needs do not dissipate drastically post detention. In other words, these youth grow up to become un-well adults. A recent study looking at the mental health status of juveniles 5 years after detention concluded that "substantial efforts are needed to address the many needs of delinquent youth so that they can thrive in adulthood."¹¹² The study found that 5 years after detention, when participants were 14 to 24 years old, almost 27 percent of males and 14 percent of females had two or more mental health disorders. Substance use plus behavioral disorders were the most common comorbid profile among males, affecting 1 in 6.¹¹³

It also came to the attention of COMIO that concerns remain high regarding the growing rates of youth who were deemed incompetent to stand trial and the lack of clear guidance about how to best address this situation. COMIO's role here is to ensure that appropriate stakeholders are aware that experts are working on these issues. As part of the final work from the Mental Health Issues Implementation Task

Force staffed by the Judicial Council of California, a joint workgroup was formed to comprehensively review and offer clarifications regarding juvenile competency.¹¹⁴ According to the report, the workgroup will provide recommendation on the following:

- Setting clear standards for determination,
- Clarifying the procedure for the competency hearing,
- Attributing to the minor the burden of establishing incompetence,
- Clarifying what is expected when evaluating a minor,
- Requiring minors who are found incompetent to receive appropriate services, and
- Requiring the Judicial Council to outline what training and experience is needed for juvenile competency evaluators.

In 2016 Assembly Bill 2695 attempted to address some of the recommendations but the bill did not move forward.¹¹⁵

Recommendation 1d. Continue to investigate the root cause of increased severity and acuity of mental illness in juvenile detention in support and partnership with CPOC, CBHDA, Judicial Council and other appropriate expert partners. Specifically explore how best to advance efforts to improve competency restoration for juveniles in the justice system.

Finding: There are significant reforms underway that will impact justice-involved youth

Efforts to improve outcomes for children and youth at high risk of out of home placement have been underway for several years in California under the direction of the Department of Social Services (DSS). After nearly three years of working with experts, providers, administrators, and advocates a 2015 legislative report outlined how the system of care would be transformed through *continuum of care reform* which will improve the experience and outcomes of children and youth in foster care.¹¹⁶ “CCR” refers to the spectrum of care settings for youth in foster care, from the least restrictive and service-intensive to the most restrictive and service-intensive. The existing system will be replaced by two broad levels of service. The lower level will be home-based family care (HBFC) which will rely on family members, county licensed foster family homes and certified resource and foster families. The higher-level system, short-term residential treatment programs (STRTP), will replace congregate care for high need and high risk youth. To read more about CCR please see Text Box J. Changes to this system are directly related to the issues and needs of the juvenile justice system because the children, youth, and families involved are often the same. Referred to as “cross-over” youth (experiences maltreatment and engages in delinquency) or “dual-system” youth (involved in both the child welfare and juvenile justice systems) these youth have placement instability, educational challenges, and an absence of pro-social bonds.¹¹⁷

Text Box J

Continuum of Care Reform (CCR)

After multiple years and a series of reform efforts, AB 403 (Chapter 773, Statutes of 2015), was signed by the Governor in 2015 and aims to improve outcomes for youth in foster care. The bill combines both new and existing reforms to child welfare services to address the need to provide children who are not able to live with their biological parents with nurturing, stable, and permanent families. "Continuum of Care" refers to the spectrum of care settings for youth in foster care, from the least restrictive and the least service-intensive to the most restrictive and most service-intensive."

The law stipulates that "reliance on congregate care should be limited to short-term, therapeutic interventions that are just one part of a continuum of care available for children, youth and young adults" and creates the statutory and policy framework to achieve this. The bill established a new community care facility category called the short-term residential therapeutic programs (STRTP), which are residential facilities operated by a public agency or private organization that provides an integrated program of specialized and intensive care and supervision, services and supports, treatment, and short-term 24-hour care and supervision to children and non-minor dependents. The new requirements put in place the law take effect on January 1, 2017 and are designed to increase capacity for providing home-based family care, residential treatment and core services, and to evaluate provider performance.

For more information on the CCR, visit the following links:

<http://www.cdss.ca.gov/cdssweb/PG4869.htm>

http://www.cdss.ca.gov/cdssweb/entres/pdf/AB403_FactSheet.pdf

COMIO's purpose here is to ensure that the unique needs of probation youth with mental health issues, especially those at risk of delinquency and criminal behavior, are understood and incorporated. The committee identified the following concerns to share with participants involved in CCR implementation:

- Youth and family voice should be the central component of all planning, implementation, and performance monitoring efforts. Efforts to support the use of family partners as system navigators for both the child welfare and juvenile justice systems should be prioritized.
- The lack of a comprehensive system of substance use treatment services for youth, similar to adults, is a significant contribution to justice-involvement. A clear understanding of substance use disorders should be integrated into all services and "abstinence" as a condition needs to be revisited. Efforts to develop and pay for such treatment should be prioritized.
- Similar to gaps in the adult system of diversion, crisis stabilization and community-based alternatives to incarceration are either full or not available at the local or even regional level. Investments to build adequate stabilization services for youth are necessary for diversion and reentry of juveniles in detention with mental health needs. Doing so also supports federal reimbursement for treatment.
- Without adequate planning and support, the removal of congregate care that is able to provide services to the highest risk and highest need youth may result in an increased reliance on incarceration. STRTPs will need resources to provide integrated behavioral health and core

correctional services. Efforts to monitor and quickly assess whether policy and practice changes are increasing juvenile incarceration are needed.

- Rural and small counties will need additional creativity in planning due to significant distances, as well as reduced numbers of youth in population centers, that will challenge the standard STRTP and foster care family operational model.

Recommendation 2d. COMIO will continue to monitor the implementation of CCR so that alternatives for high risk and high need justice-involved youth are adequate including strengthening training, support, and resources that include substance use and correctional services.

Finding: Sufficient data collection, performance measures, and outcomes are needed to monitor effective programs

The National Institute of Justice (NIJ) has a resource called www.crimesolutions.gov that uses research to rate the effectiveness of programs and practices to inform practitioners and policy makers about what works, what doesn't, and what's promising in criminal justice, juvenile justice, and crime victim services.¹¹⁸ This resource has analyzed 266 juvenile justice programs, classifying 59 as effective, 156 as showing promise, and 51 as not effective. Knowing which program is more effective than another, under certain conditions and for particular target populations, is critical, but the ability to implement such programs requires an expansion of data collection capacity and analysis to apply what is learned from performance and outcome monitoring. In 2016 the California Juvenile Justice Data Working Group issued a report to the Legislature that included recommendations to improve data collection, performance measures and ultimately outcomes for California youth.¹¹⁹ After extensive assessment the working group narrowed and prioritized recommendations based on essential need, timeliness, and efficient use of resources. The following are the key recommendations of the workgroup:

- Replace the juvenile court and probation statistical system currently housed at the California Department of Justice because it lacks capacity and flexibility to capture the range of data needed for today's system,
- Consolidate all state-level juvenile justice data collection and reporting responsibilities into a single state agency,
- Expand the range of caseload and outcome data collected and reported at the state and local level,
- Make improvements to the juvenile detention profile survey managed by the BSCC;
- Establish a web-based California juvenile justice data clearinghouse, and
- Establish a juvenile justice data development taskforce or commission with responsibility for implementation of these recommendations.

COMIO strongly supports prioritizing investments in building data-driven practices statewide, and identified two areas where state priorities could be effective:

- Collect only the data that is needed to monitor performance, which could support local capacity to retain the ability to do further research and evaluation on best practices, and
- Support data infrastructure that can monitor trends and patterns to inform policies and practices.

Recommendation 3d. Support the work of the BSCC and the Juvenile Justice Data Working Group to improve data collection, performance measures, and outcomes for California’s youth offender.

Identify: Recognize and Examine Existing Opportunities

Finding: Seize opportunities to develop a continuum of crisis care for children and youth

Similar to adults, the lack of a continuum of crisis services for children and youth can result in ill-equipped first responders, unnecessary or over-reliance on emergency rooms and other in-patient care settings and even incarceration. The availability of these services is essential to youth diversion. In 2015-16 the MHSOAC embarked on a project to gain a greater understanding of what services exist for children and youth in crisis, document challenges, identify effective service delivery models, and advance specific policy, funding, and regulatory changes to improve service quality and outcomes.¹²⁰ This important and timely project has brought together the expertise of counties, providers, families and advocates. Together they can provide helpful insight to CHFFA regarding the administration of grants specific to children’s crisis services as part of the larger Investment in Mental Health Wellness Grant Program for Children and Youth (IMHWG-CY).

The 2016-17 budget provided \$27 million in funding for a competitive grant program to develop services for children and youth in crisis with an emphasis on providing early intervention and treatment, expanded community-based services, mobile crisis support teams, crisis residential and stabilization beds and expanded family respite. Funds from the grant will support facility acquisition, construction/renovation, equipment acquisition and start-up costs. Counties would be responsible for providing necessary behavioral health services. Funds must be appropriated by 2019.¹²¹

COMIO is pleased to see that one of the objectives of the IMHWG-CY grant program is to reduce recidivism and wait times experienced by law enforcement. In addition to measuring recidivism, best practices in crisis services for training, mobile response, and assessment should accompany such infrastructure investments. Some examples are provided in the section below.

Recommendation 4d. COMIO will encourage counties to use best practice models in responding to children and youth in crisis and monitor how this investment is supporting diversion and contributing to reduced recidivism.

Finding: Strengthen efforts to support on-going program investments that show promise and innovation to prevent youth justice involvement

Programs for youth to avoid justice involvement or re-involvement are becoming equipped to treat the unique needs of at-risk youth with mental health needs. In a presentation to COMIO from CPOC representatives, there was acknowledgment that there has been growth in the use of evidence-based practices in California. More youth are being diverted from the system on the front end, and for those that remain who have higher risks and needs, the use of assessments and monitoring fidelity of evidence-based programs have played an important role in preventing continued justice-involvement. Furthermore, CPOC noted how partnerships with judges, attorneys, behavioral health providers, and schools has led to improved community responses to delinquency and cross-system interventions that address recidivism risk and behavioral health and educational challenges.¹²²

The purpose of the National Council on Crime and Delinquency (NCCD) is to help practitioners and policymakers improve outcomes for young people by using research to make better decisions.¹²³ Through their work they have identified common themes and core elements of effective programs with empirical research findings that suggest using the following approaches:

- Use of valid assessments,
- Focus resources and target interventions only to youth likely to re-offend or be re-arrested;
- Ensure effective interventions are implemented as intended,
- Reduce the use of corrective sanctions and placement in secure settings, and
- Serve youth in the community and focus on positive youth development.

Several strategies and programs that are showing promise are described below.

Positive Youth Development (PYD) is a policy perspective that emphasizes providing services and opportunities to support all young people in developing a sense of competence, usefulness, belonging and empowerment. While there are individual PYD programs, such as diversion, restorative justice, and mentoring, the approach works best when the entire community, including young people, is involved in creating a continuum of services. PYD programs operate within the multiple aspects of the juvenile justice system from prevention to probation. Some of the key elements to the Youth Development approach include policies and programs focusing on the evolving developmental needs and tasks of adolescents and families, schools and communities working together to develop environments that support youth.¹²⁴

In 2012 the Sierra Health Foundation launched the *Positive Youth Justice Initiative (PYJI)* and positive youth development was one of four distinct elements that counties were to use to build new approaches to serve the most difficult juvenile justice populations. Other design elements included trauma-informed care, wraparound service delivery, and improved operational capacity. With additional support from the California Endowment and the California Wellness Foundation four counties, Alameda, San Diego, San Joaquin and Solano, were funded to implement reform plans.¹²⁵ For example, the San Joaquin County Probation Department focused on training and building capacity to expand mental health services that treat adverse childhood experiences for foster care youth also involved in the criminal justice system (crossover youth). The department also used the PYD approach to support programs to train crossover youth to be leaders and mentors and trained parent partners to bridge gaps between families and probation. The county created data-sharing agreements across several agencies and departments and plans to measure whether or not these efforts are associated with reduced justice involvement by analyzing probation violations, arrests and length of stay in detention.¹²⁶

Positive Behavioral Intervention and Supports (PBIS) is a framework that typically is used in school settings for prevention purposes but is now being used in detention facilities to organize the use of evidence-based practices and their implementation, and to maximize health, academic, and social behavior outcomes for justice-involved youth.¹²⁷ At the foundation of this approach is cultural change grounded in the use of positive reinforcement. At CDCR's Division of Juvenile Justice (DJJ) the approach is referred to as the *Integrated Behavioral Treatment Model* that includes youth, staff, family and community to reduce recidivism and increase and promote success by teaching, modeling and reinforcing pro-social skills.¹²⁸ Key ingredients for the model include following the principles of risk-need-responsivity, evidence-based interventions, individualized plans, and quality assurance. Lessons learned so far include:

- The importance of leadership setting the tone for change,
- The principles of positive reinforcement used with the youth also needs to be used with the staff,
- Mental health staff need to take the lead and focus beyond just a diagnosis but how to change behavior, and
- Learning how to use incentives rather than punishment and sanctions to manage behavior.

While DJJ is still undergoing improvements the organization is experiencing a true shift in culture, but changing attitudes takes time and diligence in enforcing policy. In 2016 a lawsuit from 2003 was dismissed when a judge agreed that DJJ had succeeded in making a number of improvements, including improving mental health treatment and deterring future criminal behavior. Similar efforts to shift to systems of positive reinforcement are taking place across California (e.g. Los Angeles) and the nation (e.g. Georgia and Florida).

Crisis Intervention Teams for Youth (CIT-Y) are programs similar to the standard CIT model discussed in section three of this report, but with an emphasis on enhanced understanding of the adolescent brain and behavior, youth response to substance use, the impact of trauma and adverse childhood experiences, and how to work with schools, families and juvenile courts. Two types of CIT-Y are emerging with one being an additional 8 hours of training beyond CIT's standard 40 hours and the other being 40 hours of CIT training specific to youth.¹²⁹ In the best case scenario, a CIT-Y trained officer is able to connect youth and their families with the behavioral health services they need, and prevent involvement with the justice system. The National Center for Mental Health and Juvenile Justice recently developed a CIT-Y like training geared towards school resource officers called Adolescent Mental Health Training for School Resources Officers.¹³⁰ Locally a similar model is used in Alameda County where behavioral health staff embedded in the sheriff's department train school and campus police officers through the county. Similar work and curriculum has also been developed in San Antonio, Texas.¹³¹

Crisis Response Programs are programs that provide crisis response to support law enforcement, schools, families and other agencies that need immediate response and connection to behavioral programs, rather than emergency rooms or the justice system.¹³² Trained case workers respond quickly by phone or in-person to assess the situation and determine the best course of action. In Illinois they created a crisis response program to reduce police officers reliance on arrest and detention as the best way to keep youth and families safe during a family crisis. Protocols were amended to allow police to make referrals to a designated community social service provider and parents can also do the same if the youth is not already involved with law enforcement. Services available through the provider include crisis counseling, mediation, counseling, recreation, and linkage to other services. Early evaluation shows that 80 percent of youth demonstrate improvement on assessments from the time of intake through program exit.¹³³

Juvenile Assessment and Resource Centers serve as "diversion" hubs similar to the Urgent Care and Restoration Centers discussed previously in this report. Here, police officers, families, and school personnel can bring youth who need a safe place to go or are engaging in minor misbehavior. These centers have trained professionals that can conduct assessments and then connect youth and families to the appropriate service. Police and school personnel can return quickly to their work, and many of these models are open 24 hours 7 days a week. Last year city and county leaders in Gresham, Oregon developed a youth crisis reception center modeled on a center that was in Portland, but due to the distance it was not feasible for Gresham officers. By garnering political support they were able to develop their own center.¹³⁴

Recommendation 5d. COMIO can promote primary prevention programs with an evidence-base to prevent delinquency in the future and increase opportunities for cross collaboration between education, child welfare, criminal justice and behavioral health sectors. Efforts should include a focus on the entire family and not just the youth. The BSCC, through its State Advisory Committee on Juvenile Justice and Delinquency, could be an effective venue for fostering this collaboration.

Recommendation 6d. COMIO can promote examples of cross-system collaboration (Probation, Behavioral Health, Education, Juvenile Courts) that are grounded in shared resources and outcomes through the website and newsletter. Such partnerships can blend resources (MHSA, Medi-Cal, Education, Child Welfare, and Juvenile Justice) to be responsive to emerging issues like the need for a trauma informed system of care.

Recommendation 7d. Continue to monitor and promote for opportunities for youth diversion programs under Prop 47 and promote the use of evidence-based prevention and early intervention programs for youth who are justice-involved or at risk of justice-involvement.

Promote : Effective Practices in the Juvenile Justice System

In 2016 COMIO did not have the opportunity to visit and take testimony from as many juvenile justice programs as other committees, but here are two that the committee strongly endorses.

The W. Haywood Burns Institute for Juvenile Justice, Fairness and Equity (Burns Institute)

The disproportional over-representation of youth of color in the juvenile justice system is a critical issue that nearly all systems have a role to play in addressing. As such with this complex issue it is difficult to know where or how to begin making changes. The Burns institute seeks to eliminate racial and ethnic disparities by building a community-centered response to misbehavior that is equitable and restorative. Because the Burns Institute is dedicated to working at the grassroots level by developing relationships and solutions locally, they are well equipped to assist California's local-controlled, administered justice, and behavioral health systems. The institute has 11 sites in California in small, rural and urban counties and they provide assessment, consultation, training and evaluation services. The Burns Institute operates under the guidance of the following values:¹³⁵

- The culture and history of people of color is valuable and central to healing,
- Systems should use the least restrictive options to address youthful misbehaviors,
- Children are best served by caring adults in their communities,
- All young people and their families deserve to be treated justly,
- Youthful misbehaviors must be addressed through a process that is restorative and equitable,
- Child well-being can only be achieved when adults are working relentlessly and urgently,
- The perspective of young people, family, and communities is central to the collaborative data-driven process,
- Systems must be accountable and share decision-making power with the communities most impacted in order to reach their maximum potential toward child well-being,
- Systems must collect, analyze, and utilize data to reduce racial and ethnic disparities and achieve justice, and
- The existence of racial and ethnic disparities is evidence of injustice.

Skills and approaches enhanced can target improvements in all four distinct aspects of the juvenile justice system – prevention, diversion, detention, and probation. COMIO will promote the Burns Institute’s resources, include training and technical assistance and will reach out to the BSCC’s Reducing Racial and Ethnic Disparities subcommittee to learn more about how we can support their efforts and the dissemination of best practices.

San Diego County Probation Department – Trauma Responsive Unit (TRU)

In November 2016 the San Diego County Probation Department and TRU were honored with a COMIO Best Practices Award for a commitment to evidence-based practices that make a difference in people’s lives. The unit was developed as part of a larger response team, to the changing juvenile justice population, consistent with what was described at the beginning of this section.¹³⁶ In 2009 San Diego had roughly 800 youth in detention and today they have less than half of that number. Of those remaining, 97 percent are medium to high risk youth with 70 percent meeting the criteria for a mental health diagnosis. These youth also have high levels of trauma exposure, multiple traumas, and nearly a third meet criteria for PTSD. TRU was developed as part of a trauma-informed continuum care of services that the county is in the process of implementing.

TRU is a cross system collaboration that involves probation, education, health and human services and correctional counselors. It uses TARGET (trauma affect regulation for education and therapy) to skill build to improve regulation and behavioral control and intends to enable youth to gain control of trauma related reactions triggered by current daily life stressors. TRU has shown to have significant impact on behavior, reducing assaults and suicidal behavior and 77 percent of youth that complete the program report reduced trauma symptoms. The program requires rigorous quality assurance and fidelity monitoring which is aiding implementers to identify where to focus improvements. Efforts associated with TRU successfully target reducing the duration of detention and achieving improved outcomes for youth who have penetrated the system. COMIO will continue to follow and share lessons learned from TRU.

¹⁰⁹ The Board of State and Community Corrections (2016). Juvenile Detention Profile Survey and on-line querying available at: http://www.bscc.ca.gov/m_data&research.php

¹¹⁰ California Department of Justice, 2014 Juvenile arrests for all youth age 10-17.

¹¹¹ Fazel, S., Doll, H., Langström, N. (2008). Mental disorders among adolescents in juvenile detention and correctional facilities: a systematic review and meta-regression analysis of 25 surveys. *Journal of American Academy Child and Adolescent Psychiatry*. 47(9):1010-9.

¹¹² Abram, K., Zwecker, N., Welty, L., Hershfield, J., Dulcan, M., & Teplin, L. (2015). Comorbidity and Continuity of Psychiatric Disorders in Youth After Detention. *JAMA Psychiatry*, 72(1): 84–93.

¹¹³ *ibid.*

¹¹⁴ Judicial Council of California (2015). Mental health issues implementation task force: final report. Available at: <http://www.courts.ca.gov/documents/MHIITF-Final-Report.pdf>; For more information about juvenile competencies recommendations for policies and practices visit http://www.njjn.org/uploads/digital-library/NJJN_MfC_Juvenile-Competency-to-Stand-Trial_FINAL-Nov2012.pdf

¹¹⁵ To review the text of the bill see:

https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201520160AB2695

¹¹⁶ California Department of Social Services (2015). California’s child welfare continuum of care reform: legislative report available at: http://www.cdss.ca.gov/cdssweb/entres/pdf/CCR_LegislativeReport.pdf.

¹¹⁷Office of Juvenile Justice and Delinquency Prevention (2012). Improving Outcomes for Multi-System Involved Youth Who Cross Over Between Child Welfare and Juvenile Justice, webinar available at:

<https://www.nttac.org/index.cfm?event=trainingCenter.traininginfo&eventID=27&from=training&dtab=1>

¹¹⁸For more information visit: www.crimesolutions.gov

¹¹⁹The California Juvenile Justice Data Working Group was established by statute enacted in 2014 and was attached to the Board of State and Community Correction (BSCC) with the purpose of producing a report to the Legislature that provided analysis and recommendations for comprehensive juvenile justice data system improvement. The full report is available at: <http://www.bscc.ca.gov/downloads/JJDWG%20Report%20FINAL%201-11-16.pdf>

¹²⁰To learn more about the MHSOAC and any updates regarding this work on children's crisis services visit:

<http://www.mhsoac.ca.gov/childrens-crisis-services-0>

¹²¹For more information visit the CHFFA website at:

<http://www.treasurer.ca.gov/chffa/staff/2016/20161110/7.pdf>

¹²²To learn more about CPOC visit: <http://www.c poc.org/about-cpoc>

¹²³For more information about NCCD, research, and resources for technical assistance visit:

<http://www.nccdglobal.org/>

¹²⁴Positive Youth Development, National Clearinghouse on Families and Youth (LADMH), 2001, available at:

www.ncfy.com

¹²⁵For more information visit: www.sierrahealth.org/assets/pubs/SHF_RJJ_Report_Final.pdf

¹²⁶This information was presented at NCCD's annual conference in October 2016 in Orange County. For more information visit: https://www.sigov.org/beta/department/prob/youth_justice

¹²⁷For more information about PBIS visit: <https://www.pbis.org/>

¹²⁸DJJ presented to COMIO in June 2016 and information about their programs can be reviewed at:

<http://www.cdcr.ca.gov/COMIO/Uploadfile/pdfs/2016/June15/Evolution%20of%20DJJ%20Presentation.pdf>

¹²⁹Tamis, K., Fuller, C. (2016). It takes a village: diversion resources for police and families. Vera Institute for Justice available at: https://storage.googleapis.com/vera-web-assets/downloads/Publications/it-takes-a-village/legacy_downloads/it-takes-a-village-report.pdf

¹³⁰See the National Center for Mental Health and Juvenile Justice at Policy Research Associates, "Adolescent Mental Health Training for School Resource Officers," <https://perma.cc/8C2X-WAK3>.

¹³¹For more information about this curriculum, COMIO staff has received a copy from the San Antonio Police Department, please email michelle.grant@cdcr.ca.gov for assistance.

¹³²Tamis and Fuller, It takes a village.

¹³³*Ibid.*

¹³⁴*Ibid.*

¹³⁵To learn more about the W. Hayward Burns Institute for Juvenile Justice, Fairness and Equity visit:

<http://www.burnsinstitute.org/our-work/>

¹³⁶Information about the Trauma Responsive Unit from San Diego County was presented to COMIO in September and presentation materials can be accessed at: <http://www.cdcr.ca.gov/COMIO/meetings-2016.html>

Appendix A

Opportunities and Challenges

	Finding: Address the challenges stigma presents to building capacity and alternatives to incarceration
1a	Recommendation. COMIO will continue to support and collaborate with stakeholders to dispel myths about mental illness, justice-involvement, and the prevalence of co-occurring substance use among two-thirds of this population. COMIO can provide information regarding best practices in diversion and be available to provide referrals to experts in the field. Communicate the message that both criminal justice and behavioral health systems have joint responsibilities with shared resources over this population and its diversion from incarceration.
2a	Recommendation. COMIO will use workshops, educational site visits, local outreach, the website and newsletter to further identify and disseminate effective strategies, and to raise awareness to combat stigma-based decision-making.
3a	Recommendation: COMIO will include Board of Supervisors (BOS), Chief Administrative Officers (CAO), and other decision-makers in educational efforts about people with mental health and substance use disorders who are justice-involved and the barriers they face due to their criminal background.
4a	Recommendation. COMIO will encourage diversion stakeholders to participate in the local Mental Health Services Act (MHSA) planning process to encourage that MHSA resources support efforts to prevent and reduce the incarceration of people with mental illness. One of the primary goals of the MHSA is to prevent incarceration. Counties already have several efforts underway with MHSA funds. Explore what else can be done, especially through leveraging other funding opportunities for diversion (e.g. Prop 47 and Public Safety Realignment).
5a	Recommendation. Promote the implementation of DRC’s NIMBY reduction policy recommendations, especially efforts to ensure that local governments are complying with land use/planning, fair housing and anti-discrimination laws. Ensure that people with disabilities are not discriminated against based on their criminal background, and that they receive reasonable accommodations from landlords and municipalities that make land-use decisions.

Diversion

	Finding: Explore a new paradigm to support effective practices to reduce recidivism and prevent incarceration among individuals with mental illness
1b	Recommendation. Core competencies to provide effective integrated correctional and behavioral health services to better promote recovery and recidivism are significantly needed – both in custody and in the community. For resources to support necessary training and technical assistance, counties can explore the flexibility of existing funding sources or use technical assistance resources available through the MHSA state administration funds, which is appropriate because reducing incarceration (including recidivism) is one of the primary goals of MHSA.
2b	Recommendation. Promote the use of peers who are formerly justice-involved as an essential element of the service team. Encourage counties to support the hiring and training of the formerly incarcerated. All efforts to expand the use of peers in the workforce, including strategies that support Medi-Cal reimbursable services, should include the formerly incarcerated.
	Finding: More data and information is needed to support planning and effective practices
3b	Recommendation. Researchers, including PPIC as part of the 12county study, could include questions that are specific to behavioral health impact when investigating correctional reforms, particularly public safety realignment.
	Finding: Know the problem that needs fixing when building capacity
4b	Recommendation. Counties can use a standard definition of mental illness, substance abuse, and recidivism across the state in community corrections so that comparisons and trends across counties and statewide can be drawn. COMIO recommends the use of BSCC’s definition of recidivism and the statutory definition of mental illness (MI) and substance use disorder (SUD) as guidance for inclusion in Medi-Cal programs.
5b	Recommendation. Counties can better understand the prevalence of mental illness in the jail population by using validated screening and assessment tools at booking, including a brief screen for MI and SUD to determine treatment needs. Tools should be gender specific but simple enough anyone can administer them.
6b	Recommendation. Counties can then also screen for recidivism risk pre-trial to determine eligibility for diversion or alternative community supervision. The use of validated assessment tools can prioritize high risk, high need, and difficult to serve populations. The court can then consider when alternative treatment and services are appropriate.
7b	Recommendation. Support the counties to know their populations. Through projects like CA FDW’s J-SCI counties can learn how to use data to make informed decisions about services and funding. Counties need baseline data to know who is in their jails and why. They also need support to develop projections as to what kinds of service alternatives they need and where to develop a system wide approach to diversion. Measuring the problem is essential in making arguments for behavioral health resources to BOS, CCP, and/or MHSA stakeholder bodies.
	Finding: Provide guidance and confidence to support data-sharing
8b	Recommendation. The California Office of Health Information Integrity (CalOHII) based in the Health and Human Services Agency is working with stakeholders to produce a non-mandatory guidance document about the use, disclosure, and protection of sensitive health data. Guidance for when and how data can be exchanged with criminal justice partners, including law enforcement, corrections and the courts should be included in the effort.

9b	Recommendation. Further investigate what counties have uniquely done to overcome barriers both in building relationship and data systems such as the innovative ways LA County Department of Mental Health shares information with the LAPD and LASD. Promote the exchange between counties of tools like sample interagency agreements and other local protocols. Help disseminate the results from the White House’s Data-Driven Justice Initiative of which Los Angeles, Oakland, San Diego, San Francisco, and Santa Clara are participating in currently.
	Finding: Support counties to address the growth in the number and percentage of offenders booked into and held in jails with mental illness and substance use disorders
10b	Recommendation. Mental illness as a basis for diversion could be expanded. A review of which offenses could be additionally considered for authorization of diversion should be undertaken and recommendations made. As precedent, in 2015 Military Diversion was created as an option to support former military experiencing mental illness, substance use, traumatic brain injury (TBI) or sexual trauma to elect treatment over other action by the court.
11b	Recommendation. The state and relevant stakeholders, including the counties and the Department of State Hospitals (DSH), are examining the reasons behind the growing numbers of Incompetent to Stand Trial (IST) cases. A thorough review is of critical importance, including an assessment of why more community treatment alternatives are not being utilized in the face of this growing and persistent dilemma. COMIO requests to participate in such examinations at the state level and to offer assistance in generating a list of solutions.
	Finding: Build capacity for community alternatives with effective and integrated behavioral health and correctional services
12b	Recommendation. COMO to monitor the progress of the WPC pilots, reaching out to county implementers, when appropriate, to hear about challenges that need to be addressed to support targeting the justice-involved with mental illness, particularly those with co-occurring disorders. Encourage more counties to apply and take advantage of the second round of WPC pilots.
13b	Recommendation. Work with CBHDA and DHCS to identify strategies to increase the number of Drug Medi-Cal certified providers who serve the reentry population, what barriers exist to licensing drug providers, identifying actionable steps to take forward to increase numbers.
14b	Recommendation. Work with partners to better understand resources at the federal, state, and local levels for workforce development. Explore whether the California Office of Statewide Health Care Planning (OSHP) has any recommendations for strategies we could be pursuing.
	Finding: Maximize every opportunity to use Medi-Cal to cover the needs of the justice-involved
15b	Recommendation. California can examine this direction provided in CMS Letter 16-007 to consider the benefits of community supervision versus incarceration for individuals with mental illness and substance use. The faster individuals with these needs can move to the community to access treatment for recovery and stabilization the better. Not only will they be in an environment where they are far more likely to get well but federal reimbursement, in most cases, will cover the majority of the costs.
16b	Recommendation. Work with partners providing community-based services for the justice-involved, including CBHDA, to identify some of the major gaps or challenges with maximizing Medi-Cal funds. Are there alternatives to residential treatment that begin with harm reduction and engagement?

17b	Recommendation. Support aggressive Medi-Cal enrollment strategies in jails, using assessment and screening tool to identify high need/high risk populations like those with co-occurring behavioral health issues. Support further analysis and identification of best practices in enrollment.
18b	Recommendation. Eliminate the practice of Medi-Cal terminations for individuals who are incarcerated for more than a year and replace the practice with suspension during incarceration (regardless of length) and exiting incarceration with benefits intact.
19b	Recommendation. Explore the usefulness of a waiver currently requested by New York State that would allow federal Medicaid matching funding to provide care management and other supportive services to incarcerated individuals in the 30 days prior to their release. In California this would aid in supporting the continuity of care transfer from jails and prisons to community-based providers.
	Finding: Address building capacity challenges for housing and facilities beyond Not In My Backyard (NIMBY)
20b	Recommendation. Opportunities for Housing First initiatives must not exclude people based on justice status, explicitly or implicitly. COMIO will monitor and participate in the to be established Homeless Coordinating and Financing Council that will oversee the implementation of Housing First Initiatives. COMIO can help explore how conditions of probation and parole and Housing First initiatives may be able to work together to provide more housing opportunities for the justice-involved.
21b	Recommendation. COMIO supports the California Department of Housing and Community Development (HCD) inclusion of criteria for those who are “at risk” of chronic homelessness in the administration of the NPLH Initiative. The sole use of the definition “chronic homelessness” could exclude those exiting incarceration. This is because it requires having to meet the criteria of homelessness prior to incarceration, but it is incarceration that causes the loss of independent housing. The inclusion of “at risk” of chronic homelessness should be included in HCD programs and initiatives.
22b	Recommendation. Housing and service providers could further explore opportunities to expand group housing options as an alternative to single family units. Group housing not only could be more accessible and affordable but might be a better fit for individuals with behavioral health challenges.
23b	Recommendation. Prioritize housing for the most vulnerable – high risk and high need individuals with mental illness, substance use, and justice involvement. The Los Angeles County uses a coordinated entry system which is now available throughout the County. http://ceslosangeles.weebly.com/about-ces.html
24b	Recommendation. Educate local PHA, providers, and advocates about the recent clarifications of the application of fair housing act standards to the use of criminal records. Arrest records cannot be the basis for denying admission, terminating assistance, or evicting tenants. Review local policies and ensure they are consistent with the law. Support Californians to know their housing rights and file grievances when they are denied.
	Finding: Maximizing existing initiatives by leveraging resources, disseminating lessons learned, and facilitating exchange of practices
25b	Recommendation. The State and/or state-level partners (e.g. associations, foundations, and universities) should support counties with resources to take advantage of the Stepping Up Initiative and its technical assistance. Resources could bring counties together and facilitate the exchange of knowledge, tools and resources. The state can listen and help address barriers to aid county level strategies and interventions. COMIO is eager to support such activities in the future.

26b	Recommendation. Applicants for the CSI program could be required to leverage with existing efforts or enhance by additional sustainable funding for diversion services within a capitol project. Provide needed tailored assistance to smaller counties with unique challenges. Support efforts that use cost effective or evidence-based practices.
27b	Recommendation. HCD could ensure that parolees are eligible for NPLH placements by supporting screening for fitness for supportive housing due to mental illness to determine eligibility rather than justice-status.
28b	Recommendation. HCD could consider streamlining zoning procedural requirements as part of the implementation of NPLH in part to help ease the burden on interested providers who already will be operating in an extremely expensive market and burdensome regulatory environment.

Training

	Finding: Seize opportunities to expand crisis intervention training and models, learn more about what works and does not work
1c	Recommendation. Encourage the Center for Behavioral Health Excellence at UC Davis who has already begun to assess the effectiveness of Police-Mental Health Collaborations, to identify what are the critical ingredients for the most measurable impacts among various crisis response programs. Such an analysis could be helpful to direct investments in training and programs statewide and locally.
2c	Recommendation. COMIO can work with partners in the field and researchers to develop recommendations regarding what competencies are critically needed for which populations (i.e. dispatcher vs emergency room technician) and help identify how training and skill-building can be resourced.
	Finding: More could be done to understand the challenges law enforcement and community corrections professionals face in the field.
3c	Recommendation. COMIO will seek opportunities to raise awareness about the impact of trauma and stress on law enforcement and correctional professionals to increase understanding and support collaborative criminal justice-behavioral health partnerships.
	Finding: More resources are needed for law enforcement and community corrections professionals to support their wellness and improve outcomes for those they interact with who have mental illness
4c	Recommendation. Invest in a comprehensive review of best practices in Officer Wellness and Peer Support Programs, including models from other states and countries. Investigate whether there is evidence to suggest that officer wellness is linked to improved outcomes for the justice-involved, like reduced critical incidents, use of force, and improved behavior.
	Finding: By building relationships and providing resources, current opportunities to strengthen skills for law enforcement and community corrections can achieve outcomes
5c	Recommendation. Request that CDCR share lessons learned from the Commission on Correctional Peace Officer Standards and Training (C-POST) revision of curriculum to include 24 hours of crisis de-escalation into existing training with BSCC or other community correctional systems that are in the process of strengthening this type of training.
6c	Recommendation. Encourage POST and/or BSCC to explore the use of an application process for cost reimbursement to law enforcement and community correctional entities for enhanced crisis intervention and mental health training that can document a need and commitment to maximize training opportunities.
7c	Recommendation. COMIO will encourage criminal justice constituencies to visit mental health programs and vice versa for mental health constituencies to better understand each other's perspectives and leverage resources. COMIO can use workshops and educational site visits to support such cross-system collaboration.
	Finding: Invest in the criminal justice and behavioral health workforce, especially the nexus between the two
8c	Recommendation. COMIO will share the findings from the 2016 report with key professional guilds and educational institutions, and request further dialogue about strategies that can support the need for skill building for core correctional services among behavioral health providers.

Juvenile Justice

	Finding: The juvenile justice population has changed significantly over the last decade
1d	Recommendation. Continue to investigate the root cause of increased severity and acuity of mental illness in juvenile detention in support and partnership with CPOC, CBHDA, Judicial Council and other appropriate expert partners. Specifically explore how best to advance efforts to improve competency restoration for juveniles in the justice system.
	Finding: There are significant reforms underway that will impact justice-involved youth
2d	Recommendation. COMIO will continue to monitor the implementation of CCR so that alternatives for high risk and high need justice-involved youth are adequate including strengthening training, support, and resources that include substance use and correctional services.
	Finding: Sufficient data collection, performance measures, and outcomes are needed to monitor effective programs
3d	Recommendation. Support the work of BSCC and the Juvenile Justice Data Working Group to improve data collection, performance measures, and outcomes for California’s youth offender.
	Finding: Seize opportunities to develop a continuum of crisis care for children and youth
4d	Recommendation. COMIO will encourage counties to use best practice models in responding to children and youth in crisis and monitor how this investment is supporting diversion and contributing to reduced recidivism.
	Finding: Strengthen efforts to support on-going program investments that show promise and innovation to prevent youth justice involvement
5d	Recommendation. COMIO can promote primary prevention programs with an evidence-base to prevent delinquency in the future and increase opportunities for cross collaboration between education, child welfare, criminal justice and behavioral health sectors. Efforts should include a focus on the entire family and not just the youth. BSCC, through its State Advisory Committee on Juvenile Justice and Delinquency, could be an effective venue for fostering this collaboration.
6d	Recommendation. COMIO can promote examples of cross-system collaboration (Probation, Behavioral Health, Education, Juvenile Courts) that are grounded in shared resources and outcomes through the website and newsletter. Such partnerships can blend resources (MHSA, Medi-Cal, Education, Child Welfare, and Juvenile Justice) to be responsive to emerging issues like the need for a trauma informed system of care.
7d	Recommendation. Continue to monitor and promote for opportunities for youth diversion programs under Prop 47 and promote the use of evidence-based prevention and early intervention programs for youth who are justice-involved or at risk of justice-involvement.

Appendix B

2016 COMIO Stakeholder Engagement Log

January	<p>Meeting with Steinberg Institute Legislative Visits with COMIO members engaging with key offices San Diego Probation Program(s) Visit Presentation - California Coalition for Mental Health</p> <p>COMIO Council Meeting</p> <ul style="list-style-type: none"> • Amy Jarvis, California Department of Finance - 2016-2017 State Budget Update; Governor Brown’s Priorities for Criminal Justice and Behavioral Health: Implications for COMIO • Sara Rogers, California Department of Social Services - Overview of California’s Child Welfare Continuum of Care Reform (CCR); Opportunities for COMIO’s Involvement • Katie Howard, Executive Director; Helene Zentner, Field Representative, Board of State and Community Corrections (BSCC)- Update on BSCC Activities of Interest to COMIO • Brant Choate, Director, Division of Rehabilitative Programs, CDCR - Update on Community-Based Re-Entry Programs/ State Budget Proposal
February	<p>San Francisco Jail Mental Health Services and Probation Day Reporting Center Visit Meeting with the Council of State Governments Justice Center (CSG) Presentation - Mental Health Association in California (MHAC) Board</p> <p>COMIO Committee Meetings</p> <ul style="list-style-type: none"> • Diversion <ul style="list-style-type: none"> ➤ Lisa Heintz, Chief Clinical Program Administrator – Adult Parole Mental Health Services, Case Management Reentry Pilot and other Updates from the Division of Adult Parole Operations ➤ Sheree Lowe, Vice President, Behavioral Health, California Hospital Association – Capacity Issues for Alternative Community Based Services • First Responder Training <ul style="list-style-type: none"> ➤ Rodney Slaughter, Deputy State Fire Marshall Specialist – Firefighter Training Strategies ➤ Janna Munk, Senior Consultant Training Program Services Bureau - Peace Officer Standards and Training (POST), Update on POST activities including SB 11 and SB 29

<p>March</p>	<p>County Behavioral Health Directors Association Of California (CBHDA) Housing Summit Forensic Mental Health Association of California (FMHAC)</p> <p>COMIO Council Meeting</p> <ul style="list-style-type: none"> • Carrie Zoller, Supervising Attorney, Judicial Council of California - “The Work of the Mental Health Issues Implementation Task Force: Advancing the Progress” • Toby Ewing, Executive Director, The Mental Health Services Oversight and Accountability Commission (MHSOAC) - “Update on the Investment in Mental Wellness Act and Other Opportunities to Work Collaboratively on Policy Issues Regarding the Intersection of Criminal Justice and Behavioral Health” • Helene Zentner, Field Representative; Board of State and Community Corrections (BSCC) and Select Mentally Ill Offender Crime Reduction Grantees (MIOCR) - Informal update on how MIOCR implementation is going in the field <p>Presentation – Criminal Justice Research Association-California (CJRA) Conference Meeting with California District Attorneys Association (CDAA)</p>
<p>April</p>	<p>Los Angeles Police Department and Los Angeles Sheriffs – site visit and interviews USC School of Law and Saks Institute – Symposium on Law Enforcement, Policing & Mental Illness</p> <p>COMIO Committee Meetings</p> <ul style="list-style-type: none"> • CBHDA • American Civil Liberties Union (ACLU) • Disability Rights California (DRC) • Corporation for Supportive Housing (CSH) • Steinberg Institute <p>Presentation - Mental Health Planning Council Meeting with California Public Defenders Association Site Visit Modesto Juvenile Justice/Mental Health Programs</p>
<p>May</p>	<p>Presentation - Division of Rehabilitative Programs (CDCR) Director’s Stakeholder Advisory Group (DSAG) Presentation - UC Davis Sociology/Criminology Department California State Association of Counties (CSAC) Legislative Conference</p> <p>COMIO Council Meeting</p> <ul style="list-style-type: none"> • Jennifer Skeem, PhD, University of California at Berkeley School of Social Welfare and Goldman School of Public Policy – Best Practices and Policy Implications for Addressing the Criminogenic Needs of Justice-Involved Persons with Mental Illness in Community and Institutional Settings • Guillermo Viera Rosa, Director, Division of Adult Parole, CDCR - Welcome, Introductions and Building Relationships • Hallie Fader-Towe, Program Director – Courts, and Deanna Adams, Senior

	<p>Reentry Fellow, The Council of State Governments Justice Center - Update on the Stepping Up Initiative and Discussion on How COMIO can Collaborate and Support Efforts</p> <ul style="list-style-type: none"> • Amy Jarvis, Principle Program Budget Analyst, California Department of Finance – Update on State Budget and May Revise <p>COMIO Committee Meetings</p> <ul style="list-style-type: none"> • Diversion <p>Brian Hansen, Health Program Specialist II, Department of Health Care Services (DHCS) – Whole Person Care Pilots and Individuals with Mental Illness that are Justice-Involved</p>
<p>June</p>	<p>Presentation - California Police Chiefs Participation in POST SB 11/SB 29 - Mental Health Training Objectives Subject Matter Expert Team Site Visit CDCR C-POST Academy</p> <p>COMIO Committees Meetings</p> <ul style="list-style-type: none"> • Diversion <ul style="list-style-type: none"> ➤ Tom Pinizzotto, Alameda County, Drug Medi-Cal ODS Consultant - Building Capacity for Community Integration of Individuals who are Justice-Involved with Behavioral Health Needs – Service Capacity Opportunities, Part II • First Responder Training <ul style="list-style-type: none"> ➤ Stacy Lopez, Associate Director, California Department of Corrections and Rehabilitation (CDCR), Peace Officer Selection and Employee Development - Overview of CDCR training relevant to COMIO and discussion of lessons learned and future directions ➤ Karen Moreno, Associate Director, California Department of Corrections and Rehabilitation (CDCR), Office of Employee Health and Wellness - Over of CDCR employee wellness efforts for sworn officers and discussion of lessons learned and future directions • Juvenile Justice <ul style="list-style-type: none"> ➤ Heather Bowlds, <i>Ph.D.</i> California Department of Corrections and Rehabilitation (CDCR), Division of Juvenile Justice - Lessons Learned/ Reforms to Improve Services for Youth with Mental Health Needs ➤ Rosie McCool, Deputy Director, Chief Probation Officers Association of California (CPOC) - Changing Landscape and Needs of Justice-Involved Youth, Further Directions and Areas of Focus <p>Supportive Housing/Corporation of Supportive Housing (CSH) site visit Mercy Housing Sacramento San Diego Jail Mental Health Services and Amity Ranch (DRP Program) site visit MHSOAC Criminal Justice Workgroup Participation</p>

July	<p>LA site visit – five programs/45+ attendees</p> <ul style="list-style-type: none"> • Amistad de Los Angeles – Amity Foundation • Housing Strategies – Los Angeles Department of Health Services • Participate in the ODR’s Permanent Steering Committee Meeting/Present COMIO Best Practices Award • Los Angeles Police Department – Mental Evaluation Unit and Crisis Response • Exodus Eastside Urgent Care Center
August	<p>Meeting with the California Correctional Peace Officers Association (CCPOA) – Discussed Employee Wellness Strategies</p> <p>COMIO Committees</p> <ul style="list-style-type: none"> • Diversion <ul style="list-style-type: none"> ➤ Geoff R. Twitchell, PhD, Director of Treatment and Clinical Services, San Diego Probation - The Correctional Program Checklist and Promoting Effective Practices for Justice-Involved Youth and Adults with Mental Illness ➤ Kellen Russoniello, ACLU San Diego – Update Coalition Recommendations on Medicaid Suspension for Incarcerated Individuals ➤ Brenda Grealish, COMIO/Department of Health Care Services (DHCS) – Update Service Capacity Expansion Opportunities • Juvenile Justice <ul style="list-style-type: none"> ➤ Sheridan Merritt, the Mental Health Services Oversight and Accountability Commission (MHSOAC) - Children and Youth Crisis Services ➤ Carroll Schroeder, Executive Director, California Alliance of Child and Family Services – Q and A Justice involved youth with mental health needs and the Continuum of Care Reform (CCR) process • Training <ul style="list-style-type: none"> ➤ Olivia Lowey Ph.D., Executive Director - Clinically Supporting Resilience in the Formally Incarcerated, A Training Project of the American Association for Marriage and Family Therapy ➤ Kathleen Howard, Executive Director, Board of State and Community Corrections (BSCC) - Board of State and Community Corrections Mental Health Training Revisions for Probation Officers, Juvenile Correction Officers, and Adult Corrections Officers <p>National Alliance on Mental Illness (NAMI) – California Conference</p>

<p>September</p>	<p>Sacramento County Jail Psychiatric Services / Triage Services, site visit California Rehabilitation Oversight Board (C-ROB) / Participate in Quarterly Meeting Board of State and Community Corrections State Advisory Committee and JJDP</p> <p>COMIO Council Meeting</p> <ul style="list-style-type: none"> • Ryken Grattet, PhD, Research Fellow, Public Policy Institute of California (PPIC) - Update on the 12 County Study with Board of State and Community Corrections (BSCC) • Scott MacDonald, Retired Chief Probation Officer, Santa Cruz County with California Forward - Justice System Change Initiative – Jail Utilization Report • Denise Allen, Chief of Research, CDCR - CDCR 2015 Evaluation Outcome Research Report • Geoff R. Twitchell, PhD, Director of Treatment and Clinical Services, San Diego Probation - San Diego Probation Department’s Trauma Responsive Unit (TRU) • Carolyn S. Dewa, Ph.D., Director, Behavioral Health Center of Excellence’s, Outcomes and Evaluation Core, University of California at Davis - Evidence-Base for Pre-Booking Diversion Strategies with Law Enforcement <p>County Behavioral Health Criminal Justice Innovation Panel</p> <ul style="list-style-type: none"> • Meredith Evans, MFT, and Megan Ginilo, MPA, Sutter-Yuba Behavioral Health - AB109 Innovations Project • Sophia Lai, J.D., Esq., Manager, Innovations in Reentry Project and Janet Biblin, MPP/MPH, Program Manager, Alameda County Behavioral Health Care Services - Case and Care Management: Pathway to Reentry • Armando Sandoval, BART Police CIT Coordinator, Community Outreach Liaison - County Collaboration <p>Presentation - Chief Probation Officers of California (CPOC) Presentation - Mental Health Services Oversight and Accountability Commission (MHSOAC) National Institute of Corrections (NIC) Sponsored site visit – San Antonio – Miami Dade Florida</p>
<p>October</p>	<p>Participation in National Council on Crime and Delinquency Youth and Families Conference Presentation - California State Sheriff’s Association (CSSA) Participation in CBHDA’s Forum on Behavioral Health Needs of Justice Involved People of Color (COMIO member Mack Jenkins was one of the keynote speakers) Presentation on Health Care Reform and Impact to Justice-Involved – Reentry Solutions Conference</p>
<p>November</p>	<p>Participation in the Words to Deeds Conference Presentation to the Prison Crimes Council Participation in the BSCC’s Local Selection and Training Standards Revisions Project – Mental Health Subject Matter Expert Meeting</p>

*Prison Visits: California State Prison (CSP) – Sacramento, CSP – Solano, Mule Creek State Prison, California Health Care Facility, Deuel Vocational Institute, Department of State Hospitals – Vacaville, CSP – San Quentin

Appendix C

COMIO
The Council on Mentally Ill Offenders

DEPARTMENT OF CORRECTIONS AND REHABILITATION
STATE OF CALIFORNIA

The Barriers of Having a Criminal Background

Challenges that former offenders face

"It's a very corrosive system that's way bigger than just locking people up and returning them home with criminal records." -Alice Goffman, urban ethnographer and University of Wisconsin-Madison assistant professor

Mental Illness Rates: 1,2
In 5 state jails: In society:
Men: **14.5%** Men: **3.2%**
Women: **31%** Women: **4.9%**

In state prisons, prevalence of mental illness is 2-4 time higher than in the community. ²
What happens to them when they reenter society?

72% of those in jails or prisons suffering from a serious mental illness also have **substance abuse disorders.** ³

Social Welfare:

- Federal welfare reform in 1996 denied access of public assistance programs to drug felony offenders. California has modified but not eliminated this ban, meaning that felony drug offenders will not be denied CalWORKs or CalFresh benefits, but they must be in compliance with parole/probation to receive it. ^{4,5}
- If an offender is receiving SSI, payments are suspended while in prison. If confinement lasts for 12 months, eligibility for SSI benefits terminate. Former offenders are not automatically deemed eligible for social security or SSI payments after incarceration (depends on their specific situation). ⁶
- Justice involved veterans with disabilities may have their compensation reduced by 10% if they are convicted of a felony and incarcerated for 60+ days. ⁷

Health:

- The medical and mental health needs of the incarcerated (and reentry) population are significantly higher than those of the general population. ⁸
 - 50% in prison or jail report a chronic condition
 - 20% report an infectious disease
 - Over 50% face mental health problems
 - 53% of state and 45% of federal prisoners meet the criteria for drug dependence
- For offenders facing mental health and/or substance use problems, less than 20% who need treatment get it while incarcerated. This % is even lower for individuals reentering the community. ⁸
- Research shows that care within the first few days/weeks after reentry is most crucial to the health and recidivism status of former offenders. ⁸

Relationships:

- Having been incarcerated puts offenders at risk of losing relationships that could have prevented recidivism later on. ⁹
- Married men who have been incarcerated are 3 times more likely to divorce than men who were not. ⁹
- Formerly incarcerated men who were married or in long term relationships were 1/2 as likely to report committing a new crime 8 months after release than those who were not involved in relationships. ⁹

Housing:

- Often times, parole departments impose conditions of supervision (ie. not associating with others who have criminal records), which makes it harder for former offenders to find permanent housing. Parolees are more likely to wind up in shelters or other temporary housing. Sometimes, even families who want to take their relatives with former offenses back, can't because of these policies. ¹
- Nationwide, more than 10% of former offenders end up homeless upon reentry to society. In urban areas, this amount can be as high as 50%. ¹⁰
- 80% of private landlords use background checks nationally to weed out prospective tenants with former offenses.
- Not In My Backyard (NIMBYism) negatively impacts development of new housing facilities and increases discrimination against former offenders trying to obtain housing. ¹¹

Employment:

- Nearly 90% of employers conduct criminal background checks on prospective employees. ¹²
- Having any kind of arrest diminishes an individual's chance of employment more than any other "employment related stigma" like long-term unemployment, receipt of public assistance, or having a GED as opposed to a high school diploma. ¹³
- Employers often miss out on hiring well-qualified individuals because they put too much emphasis on criminal background. ⁴

Education:

- About 37% of people coming out of state prisons do not hold a high school diploma or a GED. ¹⁴
- 86% of people coming out of state prisons have no postsecondary education. ¹⁴
- The American Opportunity Tax Credit (AOTC), which is a \$2,500 per year complement to Pell Grants, is denied to those with any sort of felony drug conviction. ⁴
- Not having access to financial aid decreases the # of those with drug convictions enrolling in college. This impact is far greater for offenders of color. ⁴
- Poor education and/or lack of educational options makes navigating the job market much harder. ⁴

Restitution:

- A restitution order can never go away until it is paid in full. Even if an individual declares bankruptcy, it will still be owed and sent to the Franchise Tax Board (FTB) for collection. ¹⁵
- Adult misdemeanor convictions – \$150 to \$1,000 ¹⁵
- Adult felony convictions – \$300 to \$10,000 ¹⁵
- If former offenders do not pay restitution fines, money can be directly transferred from their paycheck(s) or bank account(s). Failure to pay off restitution can in some cases be considered a violation of probation, which could lead to further justice involvement or fines. ¹⁵
- If parole or probation is revoked, the fine amount doubles, as offenders are now responsible for the original fine and revocation fine. ¹⁵

COMIO: Building bridges to prevent incarceration <http://www.cdcr.ca.gov/COMIO/>

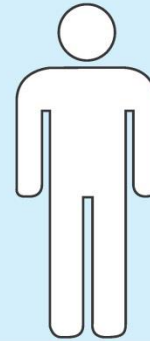


Breaking Down the Barriers

Programs and Strategies that work

"By investigating strategies that lead to prevention of incarceration or recidivism, identifying problems and creating solutions, and promoting efforts that have positive outcomes – we will make a difference."

-Stephanie Welch, COMIO Executive Officer



The Bay Area Community Services - Forensic Reentry & Empowerment (FREE) Program provides sustainable employment for the formerly incarcerated as peer providers.¹⁶

Specialty probation **improves** mental health treatment access and **protects** against violations.¹⁷

Offenders who received in-prison treatment for substance abuse and completed aftercare **recidivated 15% less** than offenders who did not.¹⁸

Social Welfare:

SOAR, funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), is a program operating on a national level to broaden the access to disability income benefit programs administered by the Social Security Administration (SSA). This program specifically targets eligible adults who are experiencing or at risk of homelessness and have a mental health illness, medical impairment, and/or a co-occurring substance use disorder.¹⁹

Health:

The Whole Person Care Pilot is part of the 1115 Medicaid Waiver (2016-2020) in California. It focuses on achieving seamless care delivery for the highest risk Medical beneficiaries - "high users" of multiple systems. Therefore, this pilot opens opportunities for counties to target justice involved individuals with high mental and medical health needs.²⁰

Relationships:

The federally funded Friends Outside in Los Angeles County offers the Dads Back program for incarcerated and reentering fathers of any age. The program provides classes on the topics of responsible fatherhood, job readiness, healthy relationships, and financial literacy.²¹

Housing:

The modification of the Housing Authority of Los Angeles' policies will reallocate resources to those who need them most, such as those who suffer from mental illness. It will eliminate any and all provisions of screening applicants out of the Housing Choice Voucher and Public Housing programs due to probation or parole status.²²

Employment:

Effective July of 2014 in California Assembly Bill 218 bars public sector employers from asking about criminal records on employment applications. The legislation stipulates law enforcement positions are exempted from the requirements, as are other positions that require a criminal background check by law.²³

Education:

The US Department of Education launched a Second Chance Pell Pilot Program for Incarcerated Individuals. This program began in July 2015. This program is being tested during the 2016-17 school year. It allows incarcerated individuals who meet all Title IV requirements and who are eligible for release to have access to Pell grants to use towards postsecondary education and/or training while in custody.²⁴

Veterans:

The Veterans Reentry Search Service (VRSS) is a fast and efficient program that identifies incarcerated individuals with a record of military service so that reentry planning and connection to Veteran services can start early on. VRSS is now active in 214 jurisdictions across 30 states and the District of Columbia, including California.²⁵

Employment:

As of January 1, 2014 California Senate Bill 530 prohibits employers from asking an applicant to disclose, or from utilizing as a factor in determining any condition of employment, information concerning a conviction that has been judicially dismissed or ordered sealed. The legislation adds protection for criminal convictions that have been expunged or judicially set aside but there are exceptions based on the conviction.²⁶

Education:

In 1998, an education ban was amended to make sure that any offender with a misdemeanor or felony drug conviction was ineligible to receive federal financial aid. The ban was since modified in 2006 to only prevent the distribution of financial aid to those who committed a drug offense while already receiving federal financial aid. The Free Application for Federal Student Aid (FAFSA) was also modified so that it no longer asks about past criminal convictions.⁴

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GLOSSARY

AB	Assembly Bill
ACA	Affordable Care Act
ACO	Adult Corrections Officers
ACSO	Alameda County Sheriff's Office
APPA	American Probation and Parole Association
ASAM	American Society of Addiction Medicine
BJA	Bureau of Justice Assistance
BJMHS	Brief Mental Health Screen
BOS	Board of Supervisors
BSCC	Board of State and Community Corrections
Burns Institute	W. Haywood Burns Institute for Juvenile Justice, Fairness and Equity
CA FWD	California Forward
CalOHII	California Office of Health Information Integrity
CAMHPRO	California Association of Mental Health and Peer run Organizations
CAMP	Case Assessment Management Program
CAO	Chief Administrative Officers
CBHDA	County Behavioral Health Directors Association
CBI-CC	Cognitive Behavioral Interventions Comprehensive Curriculum
CBI-EMP	Cognitive Behavioral Interventions for Offenders Seeking Employment
CBITS	Cognitive-Behavioral Intervention for Trauma in Schools
CBT	Cognitive-Behavioral Therapy
CCP	Community Correctional Partnerships
CCR	Continuum Care Reform
CDCR	California Department of Corrections and Rehabilitation
CHFFA	California Health Facilities Financing Authority
CHP	California Highway Patrol
CIT	Crisis Intervention Team
CIT-Y	Crisis Intervention Teams for Youth
CMHS-M	Correctional Mental Health Screen for Men
CMHS-W	Correctional Mental Health Screen for Women

CMPH	11th Judicial Circuit Mental Health Project
CMS	Centers of Medicare and Medicaid Services
COLA	Cost-of-Living Adjustment
COMIO	Council on Mentally Ill Offenders
COMPAS	Correctional Offender Management Profiling for Alternative Sanctions
CPC	Correctional Program Checklist
CPOC	Chief Probation Officers of California
C-POST	Commission on Correctional Peace Officer Standards and Training
C-ROB	California Rehabilitation Oversight Board
CSH	Corporation for Supportive Housing
CSI	Community Services Infrastructure
CSJ	Council on State Governments Justice Center
DHCS	California Department of Health Care Services
DHS	Los Angeles County Department of Health Services
DJJ	Division of Juvenile Justice
DMC-ODS	Drug Medi-Cal Organized Delivery System
DRC	Disability Rights California
DSH	California Department of State Hospitals
DSS	Department of Social Services
EAP	Employee Assistance Programs
FFP	Federal Financial Participation
FHSP	Flexible Housing Subsidy Pool
FTO	Field Training Officers
FUSE	Frequent Service Enhancement
HBFC	Home-Based Family Care
HCD	California Department of Housing and Community Development
HHS	U.S. Department of Health and Human Services
HUD	U.S. Department of Housing and Urban Development
IMHW	Investment in Mental Health Wellness Act of 2013
IMHWG	Investment in Mental Health Wellness Grant Program
IMHWG-CY	Investment in Mental Health Wellness Grant Program for Children and Youth
IMPD	Indianapolis Metro Police Department

IPHEP	Inmate Peer Health Education Program
IST	Incompetent to Stand Trial
JCO	Juvenile Corrections Officers
JSAT	Jail Screening Assessment Tool
J-SCI	Justice System Change Initiative
LACDMH	Los Angeles County Department of Mental Health
LAO	Legislative Analyst's Office
LAPD	Los Angeles Police Department
LASD	Los Angeles County Sheriff's Department
LEAD	Law Enforcement Assisted Diversion
LS-CMI	Level of Service – Case Management Inventory
LSI-R	Level of Service Inventory-Revised
MEU	Mental Evaluation Unit
MHAC	Mental Health America of California
MHSA	Mental Health Services Act
MHSF-III	Mental Health Screen form III
MHSOAC	Mental Health Service Oversight and Accountability Commission
MI	Mental Illness
MIOCR	Mentally Ill Offender Crime Reduction
MIRP	Mental Illness Response Program
MIST CBR	Misdemeanor Incompetent to Stand Trial Community-Based Restoration Program
MOST	Maintain Ongoing Stability through Treatment
MOU	Memorandum of Understanding
MRT	Moral Recognition Therapy
NACo	National Association of Counties
NAMI	National Alliance on Mental Illness
NCCD	National Council on Crime and Delinquency
NCFY	National Clearinghouse on Families and Youth
NHA	Neighborhood House Association
NIC	National Institute of Corrections
NIJ	National Institute of Justice
NIMBY	Not in My Backyard

NOS	Neighborhood Outreach Scheme
NPH	Non-profit Housing Association of Northern California
NPLH	No Place Like Home Initiative
ODR	Office of Diversion and Reentry
OMHT	Operation My Home Town
ORAS-CST	Ohio Risk Assessment Community Supervision Tool
OSHP	California Office of Statewide Health Care Planning
PBIS	Positive Behavioral Intervention and Supports
PHA	Public Housing Authorities
POST	Commission on Peace Officer Standards and Training
PPIC	Public Policy Institute of California
PSH	Permanent Supportive Housing
PSP	Peer Support Program
PTSD	Post-Traumatic Stress Disorder
PYD	Positive Youth Development
PYJI	Positive Youth Justice Initiative
R2MR	Road to Mental Readiness
R & R	Reasoning and Rehabilitation
RNR	Risk-Need-Responsivity
SAMHSA	Substance Abuse and Mental Health Services Administration
SB	Senate Bill
SMART	Systemwide Mental Assessment Response Team
SOAR	Solution: SSI/SSDI Outreach, Access, and Recovery
SSA	Social Security Administration
SSI	Supplemental Security Insurance
STRTP	short-term residential treatment programs
SUD	Substance Use Disorder
T4C	Thinking for Change
TARGET	Trauma Affect Regulation for Education and Therapy
TBI	Traumatic Brain Injury
TCUDS V	Texas Christian University Drug Screen V
TNC	Transitions Clinic Network
TRU	Trauma Responsive Unit

UC	University of California
UCC	Urgent Care Centers
VI-SPDAT	Vulnerability Index Service Prioritization Decision Assistance Tool
WPC	Whole Person Care
WRAP	Wellness Recovery Action Plan