Sequential Intercept Model Mapping Report for Contra Costa County

Prepared by: Policy Research Associates, Inc.

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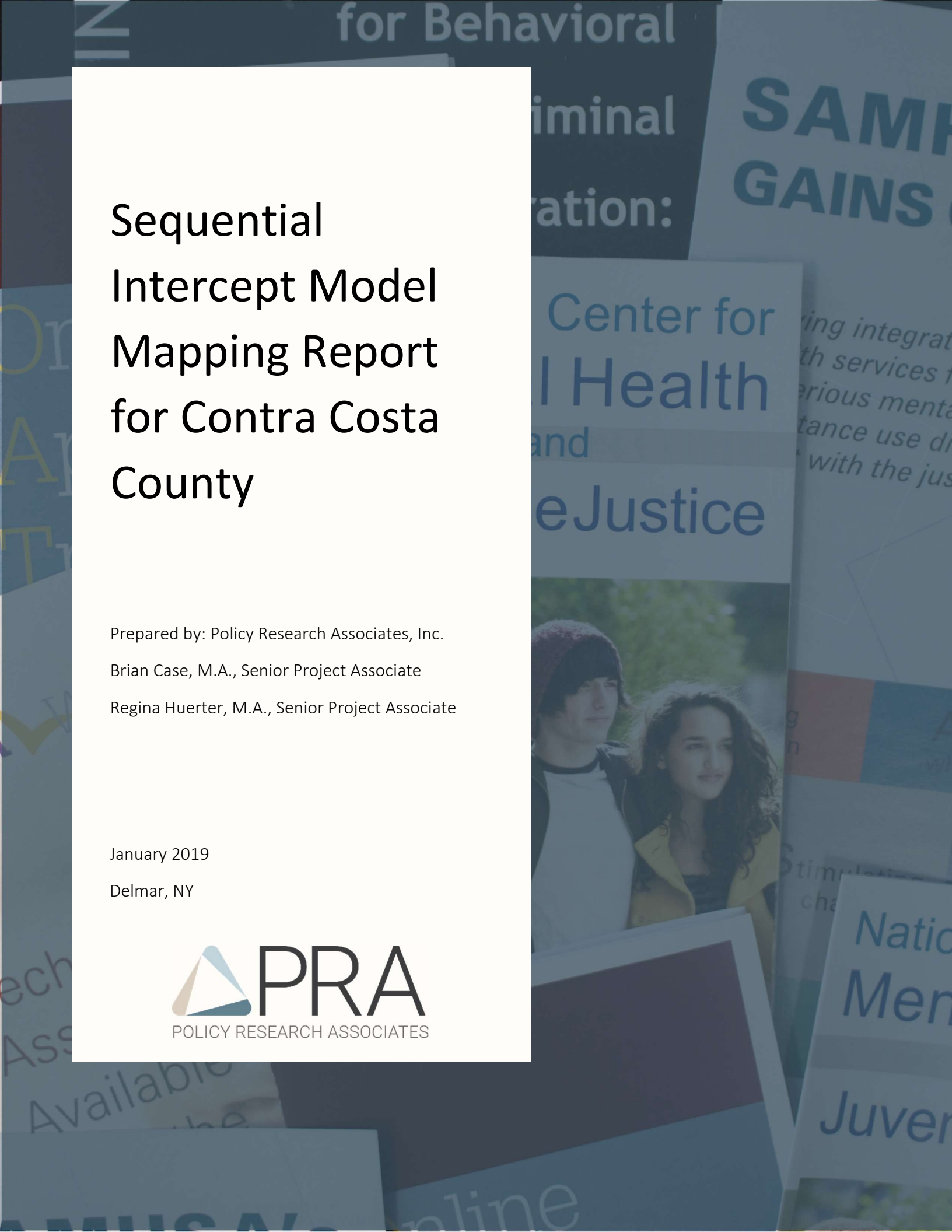
January 2019

Delmar, NY



PRA
POLICY RESEARCH ASSOCIATES

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Final Report
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ACKNOWLEDGEMENTS

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CONTENTS

BACKGROUND

The Sequential Intercept Model, developed by Mark R. Munetz, M.D. and Patricia A. Griffin, Ph.D.,[1] has been used as a focal point for states and communities to assess available resources, determine gaps in services, and plan for community change. These activities are best accomplished by a team of stakeholders that cross over multiple systems, including mental health, substance abuse, law enforcement, pretrial services, courts, jails, community corrections, housing, health, social services, peers, family members, and many others.

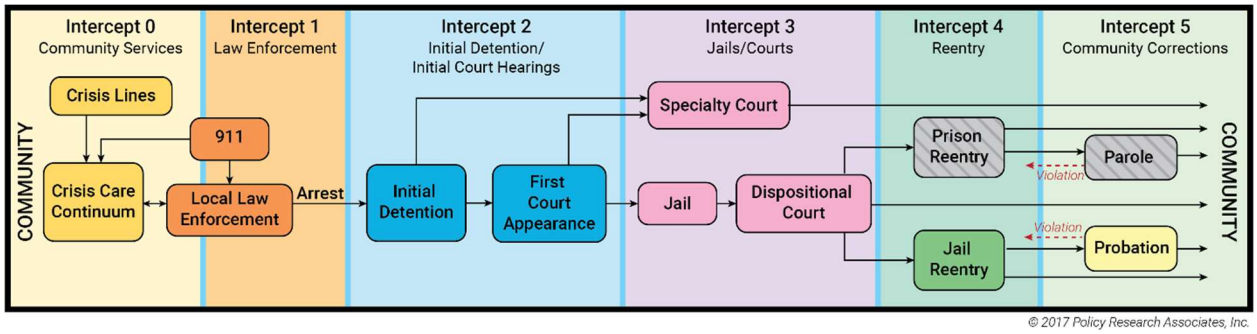
A Sequential Intercept Model mapping is a workshop to develop a map that illustrates how people with behavioral health needs come in contact with and flow through the criminal justice system. Through the workshop, facilitators and participants identify opportunities for linkage to services and for prevention of further penetration into the criminal justice system.

The Sequential Intercept Mapping workshop has three primary objectives:

1. Development of a comprehensive picture of how people with mental illness and co-occurring disorders flow through the criminal justice system along six distinct intercept points: (0) Mobile Crisis Outreach Teams/Co-Response, (1) Law Enforcement and Emergency Services, (2) Initial Detention and Initial Court Hearings, (3) Jails and Courts, (4) Reentry, and (5) Community Corrections/Community Support.

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

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



[1] Munetz, M., & Griffin, P. (2006). A systemic approach to the de-criminalization of people with serious mental illness: The Sequential Intercept Model. *Psychiatric Services*, *57*, 544-549.

REPORT SUMMARY

On September 19-20, 2018, Brian Case and Regina Huerter of Policy Research Associates facilitated a Sequential Intercept Model Mapping Workshop in Martinez, California, for the Contra Costa County Government. The workshop was organized by the Contra Costa County Administrator's Office and was hosted at the Deputy Sheriff's Association building. Approximately 55 representatives from Contra Costa County participated in the event.

Opening remarks for the event were provided by District II Supervisor Candace Andersen and Contra Costa Health Services Department Director Anna Roth. Supervisor Andersen highlighted the commitment of the Board of Supervisors of Contra Costa to the Stepping Up Initiative to reduce the number of people with mental illnesses in jails by adopting Resolution No. 2015/456 on December 8, 2015. Four hundred and sixty counties in the United States have adopted Stepping Up resolutions over the last three years, including 34 counties in California. Supported by the Council of State Governments Justice Center, the National Association of Counties, and the American Psychiatric Foundation, the Stepping Up Initiative supports counties in implementing strategies to reduce jail incarceration of individuals with mental disorders. In addition, Supervisor Andersen discussed the underutilization of Laura's Law (AB 1421), which provides for assisted outpatient treatment of individuals with mental disorders who meet criteria set forth in statute and is overseen through a civil court process.

Contra Costa Health Services Department Director Anna Roth discussed the need to address high rates of mental illness among individuals incarcerated in Contra Costa County. On any given day 15 percent of individuals incarcerated in Contra Costa County have a serious mental health need (based on 2016 data), which is comparable with national estimates of 17 percent.[2] Director Roth encouraged the workshop participants to identify strategies which could "change the narrative" for justice-involved individuals with mental disorders and to build on the County's success with improving procedures and outcomes through application of the Lean management process including recent application of Value Stream Mapping and Rapid Improvement Events within the Behavioral Health and Detention Health divisions. Director Roth encouraged participants to think from the perspectives of family members and individuals with mental and substance use disorders over the course of the Sequential Intercept Model Mapping Workshop.

The Sequential Intercept Model was developed in the early 2000s as a strategic planning model through parallel processes in Summit County, OH, and southeastern Pennsylvania.[3] Through the mapping workshop, the facilitators identify how individuals move through the criminal justice system in Contra Costa, identifying resources and gaps within the system. The workshop

[2] Steadman, H.J., Osher, F.C., Robbins, P.C., Case, B. & Samuels, S. (2009). Prevalence of serious mental illness among jail inmates. *Psychiatric Services, 60,* 761-765. DOI: 10.1176/ps.2009.60.6.761

[3] Munetz, M., & Griffin, P. (2006). A systemic approach to the de-criminalization of people with serious mental illness: The Sequential Intercept Model. *Psychiatric Services, 57,* 544-549.

culminates in priority setting by the participants who then establish action plans for addressing gaps specific to Contra Costa County.

Intercept 0 – Community Services. Intercept 0 represents the community-based and behavioral health crisis services which address individuals experiencing mental health and substance use crises as alternatives to law enforcement-based responses. Contra Costa County has an array of resources at this intercept, including Psychiatric Emergency Services, Mobile Crisis Response Teams, a crisis line with 211 integration operated by the Contra Costa Crisis Center, the Miller Wellness Center and CARE Centers. The workshop participants identified gaps in Intercept 0 including the need for intervention with frequent users of the Psychiatric Emergency Services, the mental health training for call-takers and dispatchers, and the limited availability of withdrawal management services in Contra Costa County.

Intercept 1 – Law Enforcement. Intercept 1 represents the response of law enforcement and early diversion initiatives (e.g., law enforcement –mental health co-response strategies, deflection strategies) to individuals experiencing behavioral health crises. The strengths of Contra Costa County in this intercept include the law enforcement Mental Health Evaluation Teams, with some agencies such as the Martinez Police Department having 80 percent of officers trained in crisis intervention across shifts, and the CoCo LEAD Plus program in Antioch which expands on the Law Enforcement Assisted Diversion model developed in Seattle, WA. The participants identified gaps including the need for officer training on documentation in support of the gravely disabled standard for individuals who may be placed on a mental health hold; lack of standardization across law enforcement agencies for the state-mandated, eight-hour mental health training, and the underlying housing instability and homelessness of many individuals with behavioral health conditions who come into contact with law enforcement.

Intercept 2 – Initial Detention/Initial Court Hearings. At Intercept 2, an individual has been arrested or cited. During this intercept, an individual experiences their first court hearing and may be detained or released on a citation. Contra Costa County's strengths in this area include the pre-trial services for individuals charged with low-level felonies, the use of cite and release policies to reduce overall jail bookings, and the Contra Costa Regional Medical Center as the provider of physical and behavioral health services within the detention facilities. The participants identified gaps at Intercept 2 such as need for expansion of the Failure to Appear Program, limited programming space within the Martinez Detention Facility, and need to continue examining patterns of racial and ethnic disparities among the cited and pre-trial populations.

Intercept 3 – Jails/Courts. Intercept 3 represents the dispositional courts, treatment courts, and services within the detention facilities for individuals who are detained prior to case disposition and sentencing. Resources in Contra Costa County at Intercept 3 include the Behavioral Health Court, Homeless Court, and Veterans Treatment Court as well as an outpatient competency restoration caseload for individuals charged with a misdemeanor. The participants identified gaps at Intercept 3 including treatment court eligibility criteria which may limit the reach of the

programs, and the waiting list and overall process for defendants who need to be transferred to a State Hospital for competency restoration. An opportunity for new mental health diversion programming is available through AB 1810.

Intercept 4 – Reentry. Intercept 4 provides an opportunity to examine the transition of individuals back to the community from local and state incarceration. Contra Costa County's strengths in this area include the availability of pre-release reentry planning for individuals incarcerated in the Martinez Detention Facility and the West County Detention Facility, tracking of release dates (if known) within the electronic health record, availability of a 14-day supply of medication (if enough advance notice) or a prescription to bridge the gap between release from jail and an appointment with a prescriber, Medi-Cal enrollment or reinstatement prior to release from jail, and provide jail-to-community services through two contracted service providers, Men and Woman of Purpose and Reach Fellowship. The participants identified gaps at Intercept 4 with the opt-in requirement for individuals to receive jail-based programming and reentry supports, and limited availability of gender-specific programming in the jail.

Intercept 5 – Community Supervision. Intercept 5 is the final intercept in the model. At this point, individuals may be free without supervision or on some form of community supervision such as probation or parole. Intercept 5 resources in Contra Costa County include the robust supervision and services within Contra Costa County Adult Probation for AB 109-qualified individuals, an array of specialized probation caseloads for specific needs, and the availability of Thinking for a Change cognitive-behavioral intervention for individuals on probation. Participants identified gaps at Intercept 5 including a high rate of technical violation among individuals on court probation which impacts the jail census, lack of probation integration into the jail release process, and the disparity in access to services and supervision for individuals depending on their eligibility under AB 109.

Priorities. The first day of the workshop culminates in a priority-setting activity where participants identify gaps and through a voting process to establish which priorities will be the focus of strategic planning. The participants identified 16 priorities, with the top-voted priorities being an (1) after-hours service and transportation support services; (2) a 24-hour crisis triage center; (3) standardized metrics for the criminal justice system to address data-sharing, racial and ethnic disparities, and interoperability; and (4) increased mental health diversion both pre-complaint and post-complaint. In addition to establishing strategic plans for these priorities, the participants examined next steps for formalizing leadership and oversight of the Stepping Up Initiative within Contra Costa County and planning for the implementation of mental health diversion under AB 1810.

In addition to the priorities established by the workshop participants, the facilitators offer recommendations to Contra Costa County. These recommendations address broader issues related to the justice involvement of individuals with mental and substance use disorders in Contra Costa County and specific issues for interrupting the trajectories of individuals with behavioral health conditions involved at each intercept of the Sequential Intercept Model. The

overarching recommendations from the facilitators consist of the need to establish an oversight committee to coordinate efforts related to behavioral health and criminal justice innovation and reform, the need to establish standardized metrics and data-sharing across county agencies to improve data-informed decision-making about the population, bolstering crisis mental health alternatives to the Psychiatric Emergency Services, and improved treatment and service integration across agencies and providers for the justice-involved population with mental and substance use disorders.

AGENDA

PRA

Sequential Intercept Mapping Workshop

AGENDA

Contra Costa County, CA

September 19, 2018

8:00 **Registration**

8:30 **Opening**
- Welcome and Introductions
- Overview of the Workshop
- Workshop Focus, Goals, and Tasks
- Collaboration: What's Happening Locally

What Works!
- Keys to Success

The Sequential Intercept Model
- The Basis of Cross-Systems Mapping
- Six Key Points for Interception

Cross-Systems Mapping
- Creating a Local Map
- Examining the Gaps and Opportunities

Establishing Priorities
- Identify Potential, Promising Areas for Modification Within the Existing System
- Top Five List
- Collaborating for Progress

Wrap Up
- Review

4:30 **Adjourn**

There will be a 15 minute break mid-morning and mid-afternoon.

There will be break for lunch at approximately noon.

PRA

Sequential Intercept Mapping Workshop

AGENDA

Contra Costa County, CA

September 20, 2018

8:00 **Registration and Networking**

8:30 **Opening**
- Remarks
- Preview of the Day

Review
- Day 1 Accomplishments
- Local County Priorities
- Keys to Success in Community

Action Planning

Finalizing the Action Plan

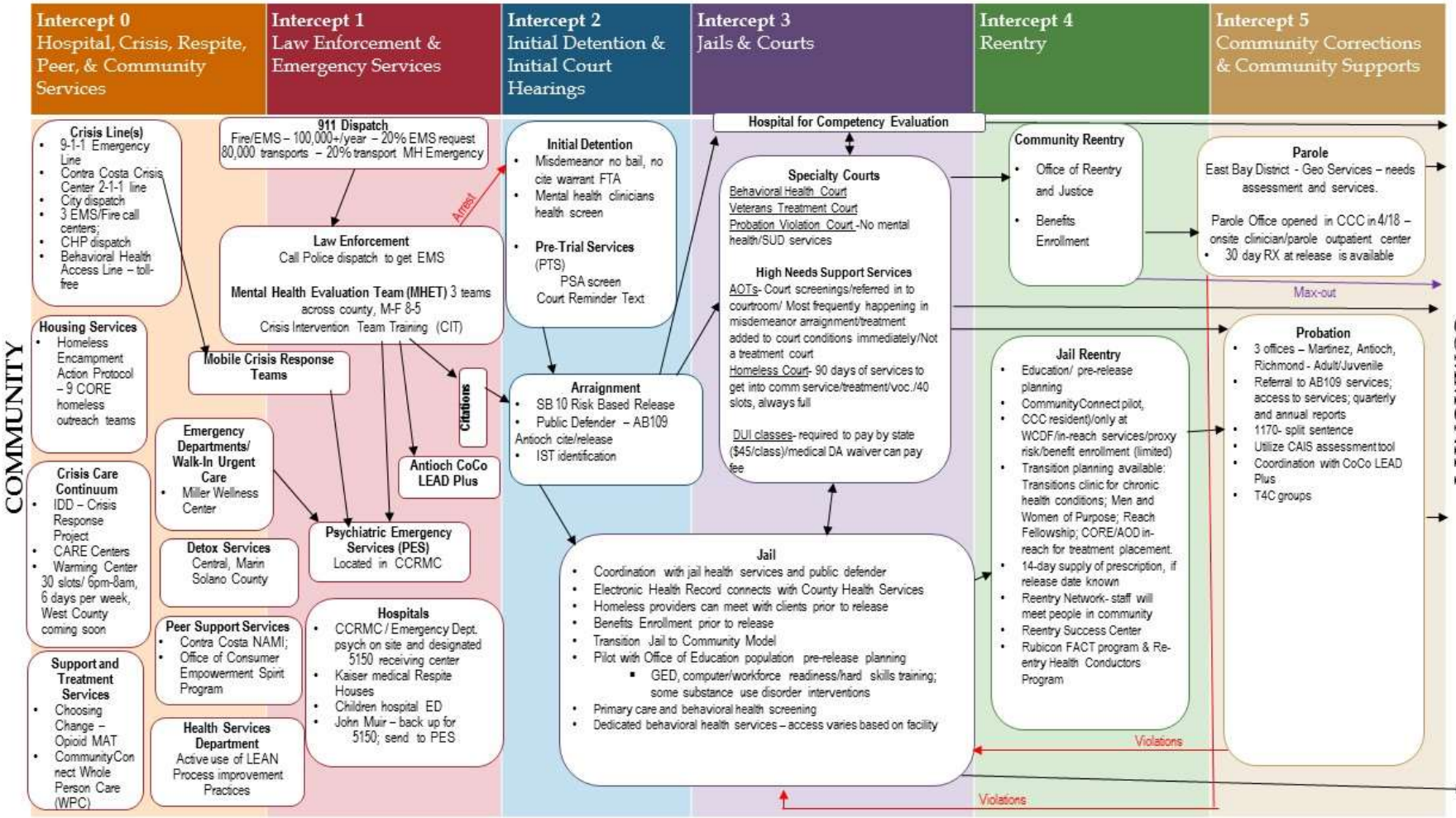
Next Steps

Summary and Closing

12:30 **Adjourn**

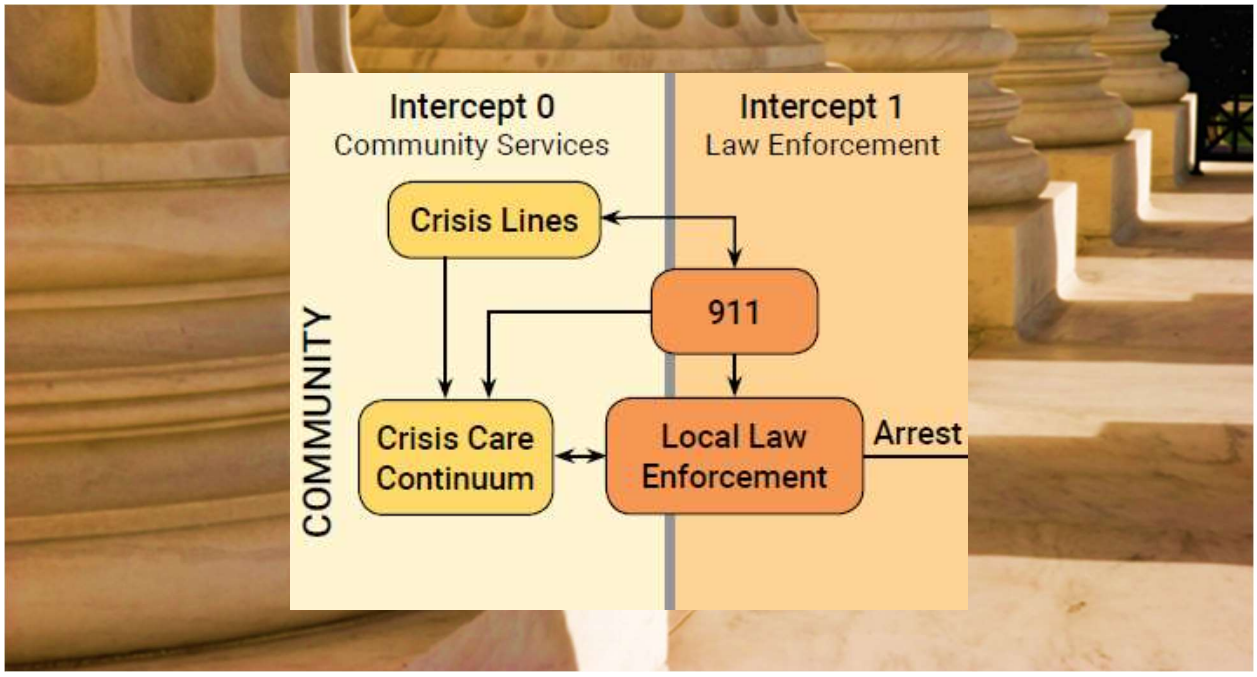
There will be a 15 minute break mid-morning.

SEQUENTIAL INTERCEPT MODEL MAP FOR CONTRA COSTA, CALIFORNIA



Resources and Gaps at Each Intercept

The centerpiece of the workshop is the development of a Sequential Intercept Model map (p. 12). As part of the mapping activity, the facilitators work with the workshop participants to identify resources and gaps at each intercept. This process is important since the criminal justice system and behavioral health services are ever changing, and the resources and gaps provide contextual information for understanding the local map. Moreover, this catalog can be used by planners to establish greater opportunities for improving public safety and public health outcomes for people with mental and substance use disorders by addressing the gaps and building on existing resources.



INTERCEPT 0 AND INTERCEPT 1

INTERCEPT 0 RESOURCES

- The Contra Costa Crisis Center operates the local mental health crisis hotline and 211 service to direct people to local resources. The Center provides resource guides for each area of the county in English and Spanish.
- National Alliance on Mental Illness (NAMI) Contra Costa also operates a crisis line, a "warm line" at (925) 942-0767.
- The Behavioral Health Access Line is a toll-free number available to clients to screen for eligibility and to help them access the most appropriate Mental Health and Substance Abuse services based on their acuity.
- Behavioral Health emergencies are one of the top three reasons for requests for 911 services in Contra Costa County. The three Emergency Medical Services (EMS)/Fire Centers routinely process over 100,000 (as of 2018 that number was 105,434) calls per year for medical assistance. Of those calls, 77.4% result in a patient transport to a hospital emergency department and 22.6% result in ambulance cancellations typically due to patient refusal, no patient found or patient condition did not warrant an ambulance transport. The County requires all dispatch agencies to process medical calls consistent with national emergency dispatch (EMD) standards. At this time, San Ramon Fire Dispatch is the only accredited EMD center and Contra Costa Fire Dispatch is working towards this effort. Compliance with EMD standards allows dispatch agencies to more precisely match EMS resources to patient need and position EMS to support future integration with other county services.

- Many cities maintain their own law enforcement dispatcher service along with the California Highway Patrol and the Contra Costa County Sheriff's Office, which handles mobile 911 calls.
- The *Mobile Crisis Response Team* started in 2018 to respond to individuals experiencing mental health crises. The service can be reached through an 800-number which can be accessed by the public as well as by law enforcement. The mobile crisis response team is linked to 211 and to local dispatch centers.
- The *Psychiatric Emergency Services* (PES) receives the majority of psychiatric transports in Contra Costa County. Estimated that nearly half of visits are a result of EMS transports. Voluntary and involuntary (i.e., 5150) transports go to the PES. EMS transports individuals to the PES on behalf of law enforcement. A pilot program within the PES embeds a substance use counselor to assist with identification and linkage to substance use treatment. The PES is located at the Contra Costa Regional Medical Center (CCRMC) and is the designated 5150 receiving center. John Muir Hospital in Concord has an inpatient psychiatric unit and serves as the secondary receiving center.
- The Warming Center serves 30 people each night, six days a week, offering triage for most vulnerable individuals around food and clothing. A shelter is co-located with the Warming Center. The CORE Outreach Team serves as an entry point.
- Family members are a major resource providing shelter and support. In addition, National Alliance on Mental Illness (NAMI) Contra Costa offers the Family-to-Family workshop as well as a Mental Health crash course in a one-day session.
- Contra Costa has invested in peer support and the leadership of individuals with lived experience. *Wellness Recovery Action Plans* (WRAP) are used throughout the service array including in Detention at MDF. The county has established an Office of Consumer Empowerment. Peer support is integrated into the PES and the Miller Wellness Center, among other places.
- Contra Costa County is participating in a 1115 Medicaid Waiver which permits expanded county services to address substance use treatment along with co-occurring disorders among Medi-Cal eligible residents.
- "Choosing Change" Opioid Medication Assisted Treatment (MAT) program, is provided by Contra Costa Health Services. The program began in 2015 and has already served 767 enrolled patients through 13 Choosing Change clinics located in 5 CCHS Health Centers; in addition, Street Outreach MAT provides services for the Homeless. Referrals are accepted through a combination of phone referrals and electronic referrals from the Access Line, Detention, CCRMC ED and inpatient and outpatient services. Choosing Change provides a daily physician on call to help write transitional prescriptions and troubleshoot issues during the intake period before patients are established with services

- *Whole Person Care* pilot program, is a statewide waiver pilot program. Contra Costa County is one of 19 counties participating in the program. It uses a risk-based algorithm to identify Medi-Cal clients who are eligible for case management services to improve their health and prevent Emergency Department visits. Case Management Teams are composed of nurses, community health workers, housing navigators, mental health clinicians and substance abuse counselors. Case managers are alerted when clients visit Emergency Rooms, are hospitalized or are released from Detention. Patients eligible for enrollment are approached for voluntary participation in the program and enrolled in one of two tiers:
    - Tier 1 – Medical Case Management, managed by a Public Health Nurse
    - Tier 2 – Social Case Management, managed by a Social Worker or Community Health Worker
- The County *Behavioral Healthcare Partnership* with Contra Costa Regional Medical Center and Health Centers (BHP) was formed in 2009 as a multi-stakeholder team of senior hospital administrators, doctors and clinicians from the County's Psychiatric Emergency Services (PES), the Sheriff's Office (which provides security services for the health centers), mental health consumers, and family members. Chaired by a consumer or consumer ally and staffed by a Patient and Family Advisory Council Coordinator, the goal of the BHP is to ensure that the hospital and psychiatric emergency settings provide effective and holistic services, include family and consumer voice, and reduce seclusion, blame, and shame. Meeting monthly, the BHP has finalized a strategic plan and operational protocol to ensure that the Health Centers provide welcoming and accessible care for all mental health consumers and their families.
- Inter-Agency Electronic Health Record: In 2012, County Health Services implemented an electronic health record (EHR) system, cc Link, based on software by Epic; this EHR is used across Contra Costa Health Services and enables information to be shared among Detention Health staff (both physical and mental health), the County's Regional Medical Center, including PES, County Health Centers (outpatient clinics), County Behavioral Health and CommunityConnect Whole Person Care case managers. In some areas, the system has been refined to include prompts related to housing status, substance use, and other psychosocial factors.
- *Homeless Encampment Action Protocol*: For the past several years, an interagency partnership (including the Health, Housing and Homeless Division (H3) of the Health Services Department, the Sheriff's Office, two police departments, and Contra Costa Public Works) has worked to develop a Homeless Encampment Action Protocol. Memorialized in a Memorandum of Understanding signed in 2013, this protocol details a coordinated and supportive response to homeless encampments. According to this protocol, upon any report of a homeless encampment, an officer notifies the H3 Director, who dispatches the Homeless outreach team (CORE) to build connections, protect and store individuals' personal property, arrange immediate alternative shelter, and provide coordinated connection to ongoing services.
    - The CORE Teams and CARE centers are working to stabilize individuals, many of which might otherwise end up in our criminal justice system. (Coordinated Outreach and Engagement/Coordinated Assessment Referral and Engagement) https://cchealth.org/h3/

- The *George & Cynthia Miller Wellness Center*, opened in 2014, is designed to improve access to integrated behavioral and physical health care, especially for people with complex challenges. Located on the campus of the Contra Costa County Regional Medical Center and technologically connected to its data systems, the Wellness Center offers a preventive and more ongoing alternative to County Psychiatric Emergency Services (PES). In addition to offering primary care, pediatrics, group medical visits, and same-day appointments, its behavioral health services include psychiatry, short-term individual and family therapy, outpatient care for substance abuse, support groups, and crisis management and referral into long-term treatment for children and adults. Located just one mile from the County's main jail, the Wellness Center is well suited to provide post-release support, an effective intervention that can prevent rapid re-incarceration. Behavioral health urgent care is available on a walk-in basis from the Miller Wellness Center. The Miller Wellness Center has limited hours and is not a bed-based service. Two peer support specialists are on staff with the Center.
- The Health Services Department use of Lean management practices including Value Stream Mapping and the Rapid Improvement Events are examples of how the system is currently working to better address the needs of its Criminal Justice and Mental Health Population.

INTERCEPT 0 GAPS

- Emergency Medical Services/Fire Dispatch Centers should be encouraged to fully utilize and participate in Medical Priority Dispatch Systems to better identify behavioral health emergencies. Identifying behavioral health emergencies will assist EMS/Fire Dispatch Centers with call triage, increased interoperability with other services, including 211 and the Mobile Crisis Team deployment.
- Psychiatric Emergency Services (PES)
    - If a patient is eligible for CommunityConnect Whole Person Care (WPC), they can voluntarily receive case management services, however, not all frequent users of the Psychiatric Emergency Services are eligible or accept CommunityConnect WPC services.
    - Law enforcement officers need options beyond the PES for individuals who don't meet 5150 criteria and refuse a voluntary admission.
- Currently there is only one Warming Center open in Central County, and no Warming Center in East or West County as yet. Although the West County Warming Center is anticipated to open in spring 2019.
- There is no CARE Center in East County.
- Withdrawal management services for alcohol are limited within Contra Costa County. The present capacity is nine beds in Central County. Additional limited number of beds are contracted through out-of-county providers. Some medically-assisted withdrawal management can be handled by local hospitals. An additional capacity of 8-9 beds and social detox services is being considered in Richmond.

INTERCEPT 1 RESOURCES

- The *CoCo LEAD Plus* program in Antioch is based on the Seattle (WA) model of Law Enforcement Assisted Diversion along with an expanded list of charges that are eligible for participation in the program. Law Enforcement Assisted Diversion (LEAD) targets individuals with substance use disorders and co-occurring substance use and mental disorders who agree to services as a form of pre-booking diversion. Currently, funding for the CoCo LEAD Plus program is provided through Prop 47 and aims to serve 200 unduplicated individuals over the course of the grant.
- *Crisis Intervention Training* (CIT): With the County's increasing attention to helping agencies differentiate between criminal behaviors and those that result from mental illness or substance use, under new leadership, the County's longstanding CIT has been enhanced over the past two years. A partnership of the Sheriff's Office, DMH, and Psychiatric Emergency Services (PES), the CIT is a four-day, 32-hour specialized mental health training, specifically intended to reduce the number of people with mental illness who are either arrested or committed on an involuntary hold, by broadening multi-agency perspectives, deepening technical understanding, and building operational partnerships. Offered by the County Sheriff's Office Training Academy twice a year to 40 people per session, the CIT is open not only to Sheriff's Deputies but to all other law enforcement agencies in the County. The Sheriff's Office is committed to ensure all of their offices are CIT certified. Martinez Police Department has achieved 80 percent of officers trained across all shifts.
- The *Mental Health Evaluation Team* (MHET) program is a partnership between Contra Costa County Behavioral Health Division and local law enforcement agencies to follow up with community members who have recently experienced psychiatric crisis. Many law enforcement agencies have a CIT officer who can consult with MHET providers. The MHET has three funded teams across the county with each team consisting of an officer and a clinician. In addition, Danville/San Ramon created their own team in partnership with the Health Services Department. The teams operate on weekdays during business hours to provide follow-up and engagement outreach for individuals and their families after the individuals have experienced a mental health crisis.
- The MHET program and newly formed Adult Mobile Crisis Response Team and newly expanded Children's Mobile Crisis Response Team have the goal of connecting individuals in crisis with supports and services to avert a 5150 if possible. https://cchealth.org/mentalhealth/crisis-adults.php
- The reorganization of our Alcohol and Other Drugs System of care through the Medi-Cal Waiver is allowing greater funding for services and programs that truly meet the needs of this population.
- Law enforcement agencies can choose to cite and release persons in the field.

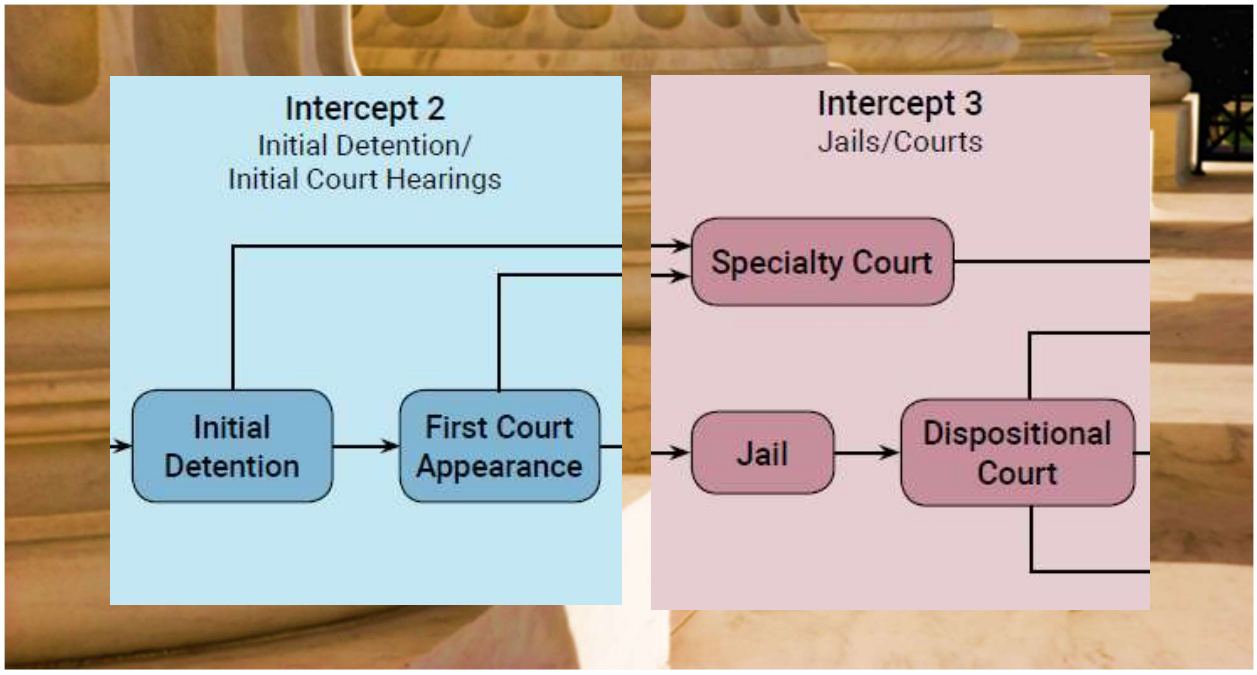
INTERCEPT 1 GAPS

- California law supports consideration of "gravely disabled" as information to be considered as grounds for a mental health hold, known as 5150. NAMI Contra Costa has developed a Survival Guide, Survival Guide Form and a Contra Costa Jail Guide. The Survival Guide Form, if completed, provides the history of the individual's mental illness and can be used as a basis for gravely disabled. Law enforcement officers are not aware of the form. Training from NAMI Contra Costa could help officers know to ask for, and how to use the form to demonstrate that an individual meets the gravely disabled standard.

- Law enforcement officers and probation officers would benefit from access to resource guides for the services available in Contra Costa. Officers are not always aware of the services that are available and when programs have ceased operations.

- The eight-hour mandated mental health training for law enforcement officers is not standardized across departments. Officers would benefit from a uniform training across agencies in Contra Costa County. The development of a state uniform curriculum is coming through legislation, but agencies would have to opt in for the training.

- An underlying need across many individuals with mental and substance use disorders who come into contact with law enforcement is housing instability and homelessness, both in terms of transition programs/beds as well as permanent supportive housing.



INTERCEPT 2 AND INTERCEPT 3

INTERCEPT 2 RESOURCES

Pre-Trial Services (PTS)

Pre-Trial Services program was implemented in Contra Costa County in 2014 through state resources provided by AB 109. The Virginia Pretrial Risk Assessment Instrument (VPRAI) is the current screening tool; eligibility is limited to low-level felony arrestees. Not all individuals arrested are screened for PTS. PTS consists of four Deputy Probation Officers, three Public Defender Legal Assistants, and support staff. Potential participants are identified based on current charges. The Public Defender Legal Assistants interview the defendants and then Adult Probation authors a report recommending either release under various conditions or pretrial detention based on their assessed risk to fail to appear for court (FTA) and/or commit a new crime. Efforts have been underway to expand the use of the VPRAI tool across all populations in Contra Costa, however, there are not resources to do so at this time.

SB 10, passed in 2018, proposes to end cash bail entirely and directs the courts to implement risk-based assessment programs to evaluate the need for individuals to remain in custody. Currently, high risk individuals could bail out while low and medium risk individuals may stay in detention due to not being screened for PTS, and/or their own indigence or inability to pay bond. A referendum to overturn SB10 has qualified for the 2020 ballot.

Contra Costa County has implemented strategies to reduce the likelihood an individual on pretrial release will fail to appear for a court appearance or commit a new crime. Strategies include text message court reminders and phone calls, various levels of Probation monitoring,

electronic home detention (EHD) and/or SCRAM devices for detecting alcohol use. Policies are under development for individuals who cannot afford the fines and fees associated with supervision, however, a person's financial situation does not, and has not precluded them from services.

- At the beginning of each day, the CCSO provides a list of those who are currently in custody and scheduled for court to the Public Defender's Office so they can determine who is eligible to be screened that day so that a pretrial services report can be provided to the court.
- The District Attorney, Public Defender and Judge are all present at arraignment and review any PTS report with recommendations from Probation regarding release or detention.

Office of the Public Defender (PD)

Many of the cite-and-release arrests for individuals charged with misdemeanors result in a failure to appear. The initial appearance in court for individuals who receive a citation is set six weeks from the arrest date and, in almost all cases, data collection has shown that charges have not been filed by that date. In cases where charges are later filed, individuals may not realize that they have a later court date and end up failing to appear in court. When this happens, a bench warrant often issues for that person's arrest. Individuals who miss this initial court appearance can later be placed in pretrial detention.

The Office of the Public Defender has partnerships with Antioch, Richmond, and Martinez Police Departments and the California Highway Patrol (CHP) to improve the use of cite and release, and to provide early legal representation as a way to both increase court appearance and to provide individuals with early intervention by connecting them with community resources. This program, called the *EarlyRep Program*, is AB 109-funded and now operates in all three regions of the county. This program has successfully increased court appearance rates in arraignment court throughout the county and lowered the failure to appear rate. Strategies to remind individuals of court and/or expediting the court hearing have been considered and are being utilized through the Early Representation Program.

Contra Costa County Detention Facilities

Contra Costa County Office of the Sheriff operates three facilities:

- West County Detention Facility (WCDF), rated capacity 1,096, is located in Richmond, is a direct supervision facility designed to operate as a co-educational, program-oriented facility, with three and a half dedicated housing units for males, and one and a half dedicated units for females. Generally, the facility operates with a population under its rated capacity.
    - Plans are in place for an additional housing unit specific for persons with high mental health and substance use needs. Construction completion is targeted for 2022.
- Martinez Detention Facility (MDF), rated capacity of 695, is a maximum security facility and the primary point of intake for all arrestees booked in Contra Costa County. It serves as both a detention facility for pre-sentenced, high risk populations, and as a post-sentenced facility for individuals who do not qualify for less restrictive settings.

    - The facility has a Mental Health housing module. In July 2017, the Sheriff's Office added a second deputy to the housing module. Health Services increased the number of structured group activities. As a result, there has been a dramatic increase in participation within the housing module.
- Marsh Creek Detention Facility (MCDF), rated capacity 188, is located in Clayton, is a minimum security facility for sentenced male offenders. Generally, the facility operates with a population far under its rated capacity.

In addition, the Sheriff's Custody Alternative Facility (CAF) provides alternatives to traditional incarceration in the form of electronic home detention (EHD), alcohol monitoring, work release program, and County parole. The number of individuals enrolled at CAF is not restricted.

Jail Snapshot: The average length of stay is 22 days. For September, 2018, the total average daily population was 1279, 35% under capacity. Approximately 15% were eligible for release and had bail amount under $50,000; 24% were not eligible for bail or had a hold; 146 had charges that included murder and serious offenses.

Book and Release

- The Sheriff's Office "book and releases" the majority of people who come into custody, including people arrested for low level felonies. Generally, 65-70 individuals are booked into the MDF each day.

Detention Health

- *Contra Costa Health Services* is the health provider for all three adult facilities. Health Services staff refers to "patients" under their care to describe those in custody.
- All persons booked into the detention facility receive a health and mental health screening where there are co-located physical and mental health staff. Patient information is entered into the county health system Electronic Health Record (EHR). Initial Screening:
    - Persons see RN at intake when entering the facility. The nurse medically clears the patient and reviews their medications and screens for other health conditions. The nurse also does a mental health screen.
    - Law enforcement completes a questionnaire as part of the booking process. The pre-booking form includes information about the interaction with the arrestee at the time of arrest.
    - If the initial mental health screening indicates a referral to mental health, then the mental health clinicians will conduct a more comprehensive mental health assessment.
    - Based on medical or mental health needs, patients may be placed in special housing modules.
- 2016 data showed a quarter of the patient inmates received a second mental health screen; 15% living with serious mental health needs and 35% screened at a moderate

level of need. About a quarter of all medications provided were psychiatric medications and a third of the appointments were mental health based.

- Nursing is available 24/7 at MDF and WCDF. Mental Health clinicians are available at MDF 24 hours/day from Wednesday to Saturday and from 6 am to midnight Tuesday to Sunday. At WCDF, Mental Health clinicians are available from 8 am to 9 pm.
- A standard ASAM screening for substance use treatment can be obtained by clients calling the Behavioral Health Access Line – Alcohol and Other Drugs.

- *Access to Medications while in Jail*
  - Psychiatrists are scheduled at MDF daily 7am -11 pm and at WCDF Monday-Thursday 8am – 6 pm;
    - Patients' medications are verified 24/7. An alcohol and opioid withdrawal protocol is in place, and medication assisted treatment is offered to patients if appropriate. Methadone is available for maintenance for pregnant patients only. Withdrawal management is handled by medical staff.
    - Education about opioid overdose and treatment are offered, including the option to be released with naloxone.
- Currently, upon release with enough advance notice, some individuals may receive a short course of medication or the Detention Health provider can send a prescription to a community pharmacy for pick up when the newly released individual returns back to their community. CommunityConnect (Whole Person Care) case manager is also alerted when someone is released from jail. Detention Health providers also refer to the Health Services Transition Clinic where providers are trained to provide culturally competent and respectful care.
  - Pre-Release Planning Pilot project is a way to ensure the continuity of transition planning with Detention Health Services.
  - Pre-Trial Services Program, which may be changing due to SB10, has been part of the County's efforts to ensure that folks are not incarcerated simply due to an inability to make bail.
  - Contra Costa County's jail enrollment process in Medi-Cal is a collaboration between the Office of the Sheriff, Detention Health Services, and the Employment and Human Services Department (EHSD). The Office of the Sheriff provides EHSD with a weekly list of detained individuals, and EHSD compares the lists to CALWIN and MEDS in order to determine current eligibility. If an individual is already enrolled in Medi-Cal, EHSD will suspend the individual's Medi-Cal status in order to preserve eligibility.
    - Additionally, Contra Costa County is establishing drop-boxes for paper health coverage applications at the Martinez, Marsh Creek, and West County detention facilities. A Behavioral Health Liaison retrieves the applications and enters the data into CALWIN. EHSD has established a specialized unit of Eligibility Workers dedicated to expedite applications.

INTERCEPT 2 GAPS

Pre-trial Services and Cite and Release

- There are no mental health services provided through the Pre-Trial Services Program; however, Probation can provide referrals, upon request of the Defendant.
- More data is needed regarding race and ethnicity disparity at pre-trial and it needs to be examined by looking at the assessment scores across demographics and decisions made based on the assessment.
- The assessment tool is not used across all populations.
- The *EarlyRep* pilot program is a partnership between Contra Costa Public Defender's Office and some, but not all, of the LEAs in the county. The *EarlyRep* team is currently working with Antioch PD, Richmond PD, California Highway Patrol, and Martinez PD. The ultimate goal would be to expand to provide *EarlyRep* services to individuals who are cited by any of the LEAs countywide, but currently the Public Defender's Office is only receiving information from the LEAs listed above and, in general, the PD is only working with individuals who have been arrested or cited by those LEAs.
- More data needs to be reviewed and analyzed for cite-and release failure to appear.

Detention Facility Programming

- All three County detention facilities were intended for short term stays and for people with sentences less than one year. Extended trial periods and jail commitments of more than one year have created an environment where people are in custody much longer than facilities were intended to accommodate. The jail system lacks sufficient high-security housing capacity.
    - MDF has various housing module sizes, layouts, and staffing based on the housed population. Modules can house 36-90 people. There is a lack of programming space within the facility and each housing module, resulting in essentially no education, program or therapeutic group spaces. With the exception of very few services, education and programs at MDF require independent study. The MDF serves as the County's behavioral health facility, inconsistent with its original intent.

Detention Health

- None of the facilities have an infirmary. However, CCRMC is available for hospitalization of patients.

General

- Public Defender currently has one social worker for 86 attorneys, but is hoping to receive additional funding to hire more social workers in the next fiscal year.
- Issues of Race and Ethnic Disparities (RED) should be reviewed for the pre-trial and cite and release process.
- Analysis of this information could benefit from data integration because information across this intercept is in multiple systems.

INTERCEPT 3 RESOURCES

Treatment Courts

- Behavioral Health Court began in 2007. The program entails 2 years of intensely supervised probation with very frequent court appearances; upon graduation, those who are successful can have their cases expunged. Participants are required to attend programming 3 days per week. Some begin with inpatient treatment and transition to outpatient and others remain outpatient treatment throughout the course of the program Participants with SUD issues almost always start inpatient.
- Veteran's Treatment Court began in 2017 as part of a court grant. VTC is an 18-month program and focuses on the treatment of mental health and substance use disorder issues that are linked to military service. The program accepts veterans whose alleged felony or misdemeanor conduct has a nexus with their military service and who have pending cases in criminal court. VTC works with VJO and the VA to provide housing, mental health, and substance abuse resources to participants in the VTC includes a robust mentor program for its participants. VTC currently has approximately 30 participants.

Mental Health Diversion

A Mental Health Diversion Program as a result of AB 1810, is being developed by Health Services, the Court, the Public Defender, and the District Attorney. Mental Health Diversion, Penal Code section 1001.36, became law in 2019. The statute allows a court to grant pre-trial diversion to a defendant suffering from a qualifying mental illness, where the mental illness was a significant factor in their charged crime, and the symptoms of the mental disorder would respond to treatment. The defendant must present a mental health treatment plan that the court determines will meet his or her specialized needs. During the diversion period, criminal proceedings are suspended. A defendant may be diverted for up to two years. After successful completion of Mental Health Diversion, the criminal charges are dismissed. There are currently 5 people on Mental Health Diversion.

Detention Facility Programming

- The Office of Education provides Drug Education Understanding Counseling Evaluating (DEUCE) to individuals in custody. DEUCE is a program that provides classes regarding substance use, anger and stress management, and job development. Psycho-education groups involve three phases: drug education, creating a plan, and understanding triggers.
- Over the past 8 months, substance use support and therapeutic groups have been offered on Monday mornings and afternoons. General populations can take advantage of AA meetings at MDF, WCDF, and MCDF.

Other Specialized Court Processes and Resources

- Laura's Law Assisted Outpatient Treatment for individuals with serious mental illnesses who meet criteria for involuntary outpatient commitment. Individuals enter AOT through a court settlement or a voluntary services agreement. The county has a capacity to serve 75

individuals through delivery of Assertive Community Treatment. Among the 70 consumers who enrolled in the AOT since program implementation, 16 enrolled with court involvement, and 54 enrolled voluntarily. The AOT program allows for pre-engagement services. Approximately 90 individuals are currently under active investigation for eligibility.

- The Probation Violation Calendar began in approximately 2000. Previously, violations were sent to each sentencing court. This is not a treatment court; but provides sanctions for technical and law violations committed by the Defendant while on Probation. Often sanctions will include jail time, residential or outpatient drug or alcohol treatment, orders to complete community service, Electronic Home Detention (EHD), Sheriff's Work Alternative Program (SWAP), participate in counseling or Forensic Mental Health or possibly a prison sentence.
- Throughout the courts, a substance use counselor is often present in all courts to make referrals. This is most consistent in pre-trial courts.
- Homeless Court is held once a month with 40 slots; only traffic tickets are heard. Participants are referred to the court by a service provider who can verify that a person has completed the requirements as part of the referral. Generally, the referred persons must complete 90 days of some type of service work as precondition to get into the court.

Incompetent to Stand Trial Process

- AB 1810 has created new challenges and opportunities to address the Incompetent to Stand Trial Process.
- The state competency law is codified in Penal Code section 1367 et seq. Problems with competency appear prior to a finding and post-finding with delays in getting people treatment after a finding of incompetency and premature or inaccurate findings of restoration after commitment to a state hospital.
- The State Hospital offers restoration services for persons with a felony; Forensic Services offers restoration services in the community for persons with a misdemeanor.
- The law now permits competency restoration in a health facility or detention facility.
- It has been helpful that there is now a dedicated Deputy District Attorney with regard to most IST cases.
- Forensic mental health oversees misdemeanor IST commitments. There are currently approximately 10 people enrolled in the program and receiving outpatient competency restoration services.
- Currently there are 65-70 persons in various stages of the competency process.
    - Outpatient can be seen at one of the clinics
    - Currently there are 25-28 committed to DSH.

INTERCEPT 3 GAPS

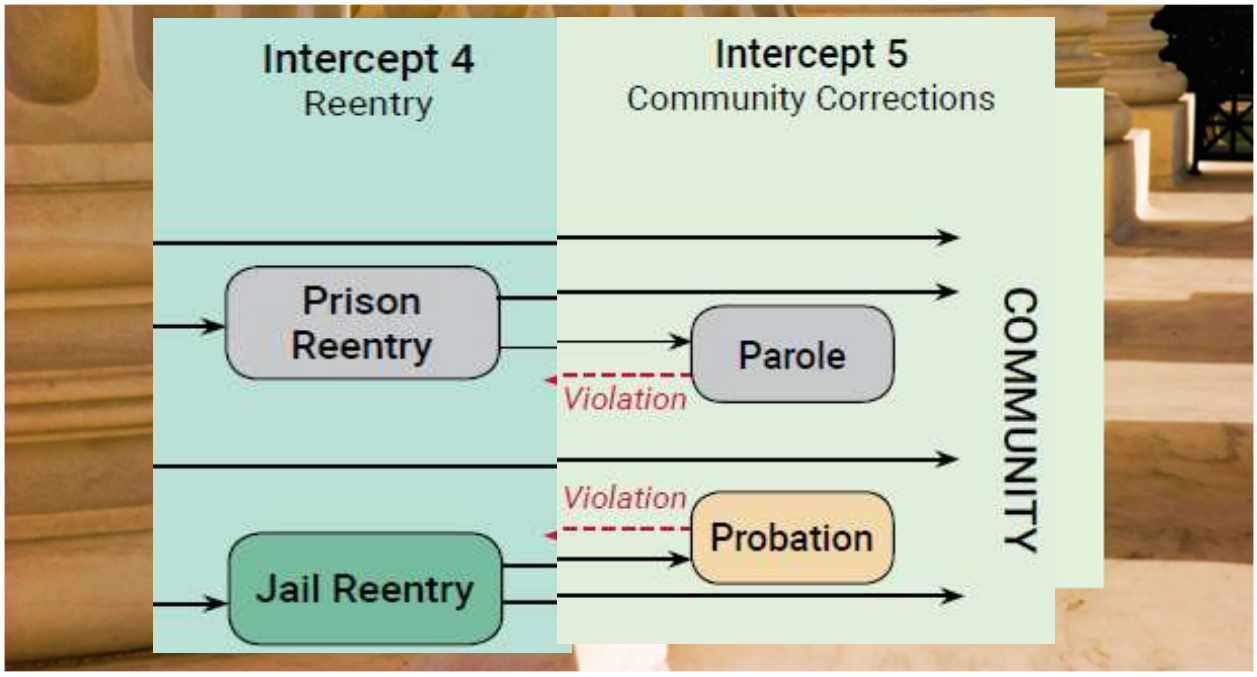
Treatment Courts

- Very few individuals who are involved in our criminal justice system participate in treatment courts. Moreover, referrals and access to treatment is not consistent throughout the system. Participation in the treatment courts is based on criteria that may prevent individuals who would really benefit from such a court. There may not be consensus on "why" and therefore "who" should be in the courts. Evaluation and process improvement need to be established.
    - The Behavioral Health Court has resumed accepting referrals in March 2019. According to the Public Defender's Office, when it is accepting referrals, often those that need these services the most are not accepted into the program due to being rejected during the screening process. The length of the program may be a deterrent for people wanting to be involved especially if they can just do a short jail stay for a minor offense.
    - Veterans Court is only available to those with an honorable discharge.
    - Contra Costa does not have a specialized drug treatment court and has not had this in the last several years. Individuals are connected with AODS services throughout their criminal cases through their attorneys. This sometime happens while they are in court. All of these cases are heard on one docket.
- Probation violation court does not include screening or services for mental health or substance use issues
- Homeless Court is for handling traffic cases only. It requires 90 days of receiving services or full compliance with a program before coming to court to have traffic cases dismissed.
- DUI clients who are diagnosed with a substance use disorder can get treatment paid for by Medi-Cal, however, people who are not covered by Medi-Cal are still required to pay regardless of ability to pay. According to State law, DUI fees must be paid by individuals who are charged with a DUI.

Incompetent to Stand Trial (IST)

- Prior to mental health diversion, the DSH invested the bulk of its resources into expanding jail-based competency treatment programs (JBCT) rather than investing in community-based treatment alternatives. For this reason, detention is used all too often to treat incompetent individuals in lieu of community-based treatment.
- Despite DSH's efforts to reduce its waitlist, individuals are still waiting in County Jail 90-100 days prior to receiving competency treatment.
- DSH is also under tremendous pressure to restore and return individuals quickly from the state hospital to the county jail thus leading to many individuals being returned to county jail as "competent" even when they have not been restored. Some returned from the state hospital are in the same condition, and others may be in worse condition.

- Special unit IST cases are not handled by the dedicated mental health Deputy District Attorney and more collaboration is needed on these cases.
- More collaboration is needed with IST cases to ensure that individuals are treated for competency after court-appointed and retained experts have opined these individuals are IST. In many of these cases, they are held up in the courts with litigation despite no mental health expert opinion to the contrary. For those whose cases are held up in courts, they can wait for periods as lengthy as 3 years for a competency trial.
- While some people are receiving outpatient competency restoration treatment through Forensic mental health, those who are homeless or lack a network support are less likely to succeed in the program. More wraparound services are needed to guarantee greater success to those undergoing this treatment and avoid a revolving door of incarceration.
- There are no available beds at Napa State Hospital: 90 -100 day wait for a bed
- State Hospital does little neuropsych testing; the Public Defender often pays for neuropsych to do the battery of testing.
- No IST restoration for felony cases in the community
- There is not a payment mechanism for a second reevaluation of a client. The Public Defender has been paying for re-evaluations.
- In many cases, it takes years to get to trial. During this time a person may again decompensate, become incompetent to stand trial, causing the process to start all over again.
- Gravely is not considered even though the law allows for it to be considered.



INTERCEPT 4 AND INTERCEPT 5

INTERCEPT 4 RESOURCES

Contra Costa County Office of Reentry and Justice

The creation of the *Office of Reentry and Justice* was a very critical component of ensuring there is a vehicle to run the Stepping Up Initiative through. Many of the County's reentry programs, funded through AB 109 dollars, are being spent to address the causes of recidivism with the goal of connecting individuals with programs and services upon reentry to avert future involvement in the criminal justice system.

Contra Costa Detention and Jail In-custody and Reentry Services

All detention facilities provide release planning; the public defender or social workers may also make referrals and request specific community services through their reentry partnership with non-profit agencies who can provide detention-in-reach and post-release support.

Pre-release planning begins inside the detention facility. There are several supportive services in place to help support persons transitioning to the community.

Health Services: In-custody

- Currently, with enough advance notice, some individuals may receive a short course of medication or the Detention Health provider can send a prescription to a community pharmacy for pick up when the newly released individual returns back to their community.

- CommunityConnect (Whole Person Care) case manager is also alerted when someone is released from jail.
- Detention Health providers also refer to the Health Services Transition Clinic where providers are trained to provide culturally competent and respectful care. In addition, he enrollment process for Medi-Cal can be initiated in detention.
- The Electronic Health Record (EHR) tracks the projected release date, if known.
- Homeless service providers can meet with clients inside the facility, prior to release. This was a recent change designed to help increase engagement.
- Alcohol and Other Drugs Division has 2 FTE Substance Abuse Counselors funded by AB109. Both counselors provide in-custody screenings and referrals to treatment. They work directly with the Access line to place clients into substance use outpatient or residential treatment. Once screened, clients have an actual admission date into treatment to prevent gaps. Part of the screening includes questions for opioids disorders to ensure a linkage to Choosing Change or our Medication Assisted Treatment (MAT) and Narcan to prevent an overdose. The counselors provide transition and recovery support services as well as system navigation. Case management services are available to clients with history of multiple relapses, high recidivism and who are medically vulnerable- the latter is only in the event that there is no other case manager in the life of a client such as Whole Person Care or mental health forensic.
- Referrals are made to Choosing Change for opioid treatment in the electronic medical record, and Choosing Change staff follows up with patients.

General Programming: In-custody

Community-based and county-based offices are working together to provide: adult-based education, GED testing, computer classes, workforce readiness and English as a Second Language (ESL). A minimum of 14 days in-custody is required; participation is voluntary and in an opt-in basis. Still in a pilot phase, the Office of Education is providing Pre-Release Planning to a limited population through a community / private collaborative services. The goal is to keep people from returning to detention and provide connection to services utilizing a warm-handoff. Ideally, participants have a release date and are returning to Contra Costa County.

- The Contra Costa County Office of Education offers a fully accredited adult school to all individuals in the detention facilities.
- The West County Detention Facility operates an engraving/sign shop and a frame shop.
- The Marsh Creek Detention Facility offers wood shop and a horticulture program.
- OSHA training is being developed for the West County facility.

Post Release Community Supports and Programs

Contra Costa's Reentry System brings together Probation, jail staff, and both jail-based and community-based services. The Reentry Network provides services in East and Central County, while the Reentry Success Center is available to provide services in West County.
Existing programs:

- Rubicon operates the Fathers Advancing Community Together (FACT) program that provides services for families, and parenting support and education. Overall a lower number have known mental health issues.
- Health Services' Health Conductors Program is a support and navigation for the formerly incarcerated. The program provides support from health conductors with a lived experience of justice involvement; Health Services' Health Conductors provide outreach, intensive support, health coverage enrollment, needs assessments and resource linkages. The Health Conductors Program also supports the Transitions clinic, specializing in correctional health care for those previously incarcerated with a chronic disease. The clinic is tailored care with medical providers experienced caring for patients with a history of incarceration.
- Probation Department's Smart Reentry grant is focused on medium to high risk 18-24 years old transition age youth (TAY) returning to East County community from county jail, providing comprehensive support with housing, mental health and substance use disorder services, education and employment development.

Some of the jail-based services continue to provide services to individuals post-release.

- The Pre-Release Planning Pilot is still accessible after release, especially to facilitate connections to local community colleges.
- Choosing Change, the opioid medication assisted treatment program, uses Buprenorphine for persons out of custody. Referrals are made to Choosing Change in the electronic medical record, and Choosing Change staff follows up with patients. This program is expanding quickly, and streamlining the referral process.
- The County is committed to getting Medi-Cal initiated or reinstated while someone is in jail through the efforts of the Employment and Human Services Department.

The Public Defender plays an important role in supporting inmate's access to reentry services. Public Defender works to coordinate resources upon release and transition individuals from jail to the appropriate community-based programs. Up to this point, communication and collaboration has worked well for getting things into place.

California Department of Corrections and Rehabilitation (CDCR)

Program services differ across CDCR. Generally, previously incarcerated individuals are able to order an ID card prior to release and initiate applications, as appropriate for SSI services. At a minimum, CDCR conducts mental health screenings for persons sentenced to CDCR and provides a 30-day supply of medications upon release.

INTERCEPT 4 GAPS

Jail Programming and Reentry

- Data and the ability to predict release date is difficult
- The process to engage in jail programming and reentry services is optional and on an "Opt-in" basis. It is not known how many medium, medium-to high or high risk individuals are participating.
- Location of services and transportation makes it challenging for clients to get to services upon release.
- Challenges continue to be the availability of housing, family issues, employment, etc. when transition individuals from jail to the appropriate community-based programs.
- The Pre-Release Planning Pilot has served more than 100 individuals since it began in 2017, however there are still some gaps in such as obtaining documents, applying for benefits, as well as issues transitioning to medical appointment, mental health appointments, and housing. Some of the organizations associated with the Pilot don't come and meet with potential clients before release. service Some patients may leave facilities without medication because release date may not be known in advance. In addition, some who have the prescription are turned away due to not having an active Medi-Cal account; stigma was also reported as an issue. Medi-Cal enrollment is inconsistent.
- "Choosing Change" is not serving all areas or all patients who need medication-assisted treatment services. There is not a consistent referral process to access this MAT program, resulting in confusion.
- The substance abuse counselor may not know the date of release making it difficult to set up appointments.

Housing

- There is a gap in the number of transitional living beds/programs, as well as permanent supportive housing specific to this demographic.
- The County currently has one evening CORE team that works between the hours of 7 pm - 3 am, Monday - Saturday. If there is a need after 3 a.m. Monday through Saturday or anytime on Sunday (currently, there is no CORE, CARE or Warming Centers operational on Sunday), no assistance is available.
- The other gap is that the Concord Warming Center only has space for 30 people. If people exiting jail are referred to the Center, they are not guaranteed a place during the evening hours. If they exit during the daytime hours, they can access the CARE center. However, there might be a barrier to transportation. Since CORE is not solely a transportation service provider, if people being released only need a ride, they are usually referred to other resources for transportation only.

- There is also a gap in people being released from jail knowing what resources are available. It might be helpful for the CORE centers to provide outreach materials to the jails. The gap comes into play when someone is aware of the CORE center resources, yet the CORE centers either don't have a team that is operational (if the call comes in after 3 am Monday – Saturday or anytime on Sunday,), and/or if there is no space at the CORE/warming centers or shelter.

Transportation

- Transportation was often identified as a barrier to accessing services. Because the County is large, individuals may have to travel across the County to receive services, or the location of services may not match the needs of the regional population.

INTERCEPT 5 RESOURCES

Probation

Contra Costa County Probation Department consists of 128 Deputy Probation Officers, 63 of those in the Adult Division, and is supervising over 4000 Adults under Probation supervision (formal probation). During probation, whether in or out of custody, work is being done to connect individuals to county mental health for services. The Forensic Mental Health Unit, who reports to the Behavioral Health Division of Contra Costa County Health Services, has an in-house Clinical Specialist who Deputy Probation Officers can refer Defendants to for screening. The Clinical Specialist interviews at the Probation Department or in jail and s/he and his/her team have approximately 45 felony or misdemeanant offenders in their program. Services may include individual therapy, group therapy or referrals out to other county services to suit the needs of the individual. AB 109 has additional funding for housing, AODS Treatment beds, and shelter beds.

The Banked Case Load (BCL)

- Probation has approximately 600 to 650 banked cases.
- BCL is for low risk clients who have completed all court ordered requirements.
- It requires persons under supervision to call in when they have status changes, such as a change in phone number or address, to report an arrest or if they are in need of a travel permit outside of California.
- Otherwise, no contact is required.

Court Probation:

- There are in excess of 7,000 persons on “court probation” (informal probation) generally used for misdemeanor cases and some felons. Generally, supervision is over the phone; if there are specific court ordered deliverables, 4 deputies monitor those cases on a rotational basis.

- Of the people held in custody on misdemeanors, 52% were on probation.
- Average 3 years on Court Probation. Most have to complete some form of community service, Domestic Violence classes, Anger Management classes, Theft classes, Parenting classes, DUI school, SWAP, etc.
- If they don't contact probation when required to do so to report the completion of court ordered deliverables, a warrant is issued.

AB 109 Probation

In response to prison overcrowding in California, the Public Safety Realignment Act (Assembly Bill (AB) 109) was signed into law in 2011, taking effect on October 1, 2011. AB 109 transferred the responsibility of supervising specific lower-level incarcerated individuals and parolees from the California Department of Corrections and Rehabilitation (CDCR) to counties, realigning three major areas of the criminal justice system. Specifically, AB 109:

- Transferred the location of incarceration for individuals incarcerated for lower-level offenses (specified non-violent, non-serious, non-sex offenders) from state prison to local county jail and provided for an expanded role for post-release supervision for these offenders;
- Transferred the responsibility for post-release supervision of individuals incarcerated for lower level offenses (those released from prison after having served a sentence for a non-violent, non-serious, and non-sex offense) from the state to the county level by creating a new category of supervision called Post-Release Community Supervision (PRCS);
- Shifted the responsibility for processing certain parole revocations from the state Parole Board to the local court system; and
- Shifted the responsibility for housing individuals whose parole has been revoked from CDCR to the County. There are three new populations for which the County is now responsible for housing and supervising, all classified under AB 109.

These populations include:

- Post-Release Community Supervisees: County probation departments now supervise a specified population of incarcerated individuals discharging from prison whose commitment offense was non-violent and non-serious.
- Parolees: Parolees – excluding those serving life terms – who violate the terms of their parole serve any detention sanction in the local jail rather than state prison. In addition, as of July 1, 2013 local courts are now responsible for parole revocation hearings for parolees who violate the terms of their parole, rather than the state Parole Board.
- 1170(h) Sentenced defendants: Individuals convicted of non-violent or non-serious felonies serve their sentence under the jurisdiction of the county instead of state prison. Sentences are now served either in county jail, on felony probation or on a split sentence

(where part of the term is served in jail and part under supervision by the county probation department).

In addition to transferring the responsibility of housing and supervising these populations from the state to the County, AB 109 also required that the County use AB 109 funding towards building partnerships with local health and social service agencies and community based services to provide supportive services designed to facilitate the successful reentry and reintegration of AB 109 individuals into the community and reduce the likelihood that they would recidivate.

- Active 482 (PRCS and 1170 Mandatory Supervision (MS) and 242 in warrant status (also including PRCS and MS clients). At any given time, there are clients that are pending entry who are in what is called "pre-release" status. On average, there are 75-81 clients in this category.
- There are two main subcategories: PRCS or Post Release Community Supervision and 1170(h) MS or Mandatory Supervision.
    - PRCS: 1-3 years of supervised probation: -Shall terminate after 1 year IF no custodial sanctions occurred (either technical violations of the terms and conditions of PRCS or new law violations). The maximum is 3 years of supervised probation for PRCS; -Varying Risk Levels based on the risk/need assessment (CAIS) completed (Low, Medium, High: Low risk are seen every other month, on average; Medium risk are seen monthly, and High risk are seen twice each month; -referrals for services are made at every stage of the supervision and are repeated to effectively engage the client.
    - 1170(h) MS: the length of mandatory supervision is determined by the Court, the length varies from 4 months to 52 months of supervised probation (as reported by Probation); -supervision is based on assessment completed, similarly to PRCS; -referrals for services are also very similar to PRCS
- Pre-release (both PRCS and 1170(h) MS): these clients are pending re-entry. Pre-release Deputy Probation Officer (DPO) is assigned to this caseload to meet with clients, in person when possible or via Pre-Release Video Conference with CDCR to conduct risk/need assessment and determine what services the client needs post release; -referrals are submitted at pre-release status.

General Supervision and Specialized Units:

- Probation currently uses the Correction Assessment and Intervention System (CAIS) to assess and reassess client needs, although it is in the process of adoption of a different tool.
- General supervision caseload is managed by 13 Deputy Probation Officers.
- Specialized caseloads include: DUI, Vehicle Theft, Sex Offender, Domestic Violence and Transitional Age Youth (TAY consists of Probationers ages 18-25). In addition, a probation officer attends Veteran Court.
- Probation staff teach a class called Thinking for a Change (T4C).

Parole

- Parole has two offices: East Bay District Alameda and Contra Costa; the office in Concord was reopened in April. As of March 2019, there are a total of 690 active parolees, 17 Parole Agents and 4 Supervising Agents in the County.
    - Licensed Clinical Social Worker is located at the Concord office. Individuals are not eligible for county services when on parole.
    - A 30-day prescription is available upon release from DOC
- GEO Reentry Services provides a treatment program in West county. Services vary based on client need but can include substance abuse programming, education/employment, anger management, life skills, parenting, women's group, MRT, domestic violence etc. Participants undergo extensive assessments within the first week of the program designed to identify specific programming needs. There are four phases of supervision with each participant starting off in the most intense phase and progressively moving through lower phases of supervision. Participants moving to lower phases of the program is contingent upon the actual behavior change. Participants can expect breathalyzer each time they report to the DRC, random urinalysis testing, groups and individual cognitive behavior treatment sessions with their case worker, periodic evaluation of progress, awards and affirmation for compliance and sanctions and reprimands for noncompliance. In addition, the DRC can also assist participants with transportation, Sober Living housing and free 52-week domestic violence classes.

INTERCEPT 5 GAPS

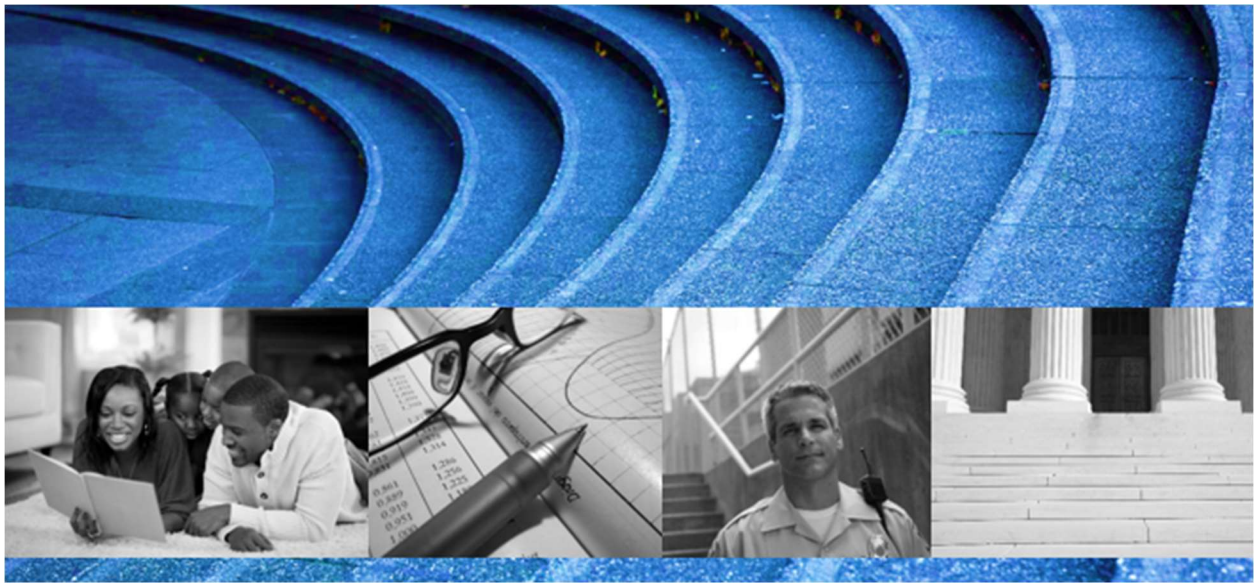
Probation Gaps

- Participation in T4C is only incentivized for AB 109 clients.
- There is not a shared definition of serious mental illness.
- Probation is not well integrated into the jail release process including lack of notification of release date. In addition, some Probationers who have been ordered to probation seem to report while others fail to report. Some who are on Probation for the first time may seem confused about what is expected.
- Probation would benefit from improved connection and coordination with community agencies who can support probationers and provide continuity of support post probation.
- There is a lack of dual diagnosis beds; general substance use treatment programs will not take people on psych medication. Also, Probation cannot get a bed for a dual diagnosis probationer, only Mental Health can apply.
- There is no formal process to screen for mental health or intellectual and developmental disabilities (IDD) issues and Probation does not receive the NAMI one-page assessment. Thus, Probation must rely on a self-report of MH condition and meds.
- Communication and coordination between the PES and Probation could improve.

- Even though prescriptions for medications are available, clients often don't receive or fill the prescription.
- Evaluation of court probation is needed. There is little information about the needs of the population. Recidivism rates could be impacted if screening and access to treatment was available.
- Insurance and the Access Line have created more roadblocks to treatment. It was reported that since Discovery House and DVR are Medi-Cal eligible, Probationers' treatment programs are getting terminated months too early. Also, if a Probationer has Kaiser, the Access Line won't help them at all; if their Kaiser does not cover substance abuse, they are left with no options.
- Some services are prioritized for AB 109 clients.
    - There may not be capacity in some services (e.g., housing) for all of Probation's clients.
    - High needs clients such as those living with IDD, have high failure rates.
    - Transportation and location of services is challenging across probation
    - AB 109 has internal data management system that is separate from the MOCHA, the one that Probation currently utilizes.
- Proposition 47, which reduced many felonies to misdemeanors, has flooded Court Probation with persons in need of connection to substance use treatment services.

Parole Services

In general, parole services are not extensive. Parolees are county residents but cannot receive county health services. Parolees are not eligible for Medi-Cal.



PRIORITIES FOR CHANGE

The priorities for change are determined through a voting process. Workshop participants are asked to identify a set of priorities followed by a vote where each participant has three votes; 16 areas of work (priorities) were identified and voted on. After a review of the vote, the group bundled priorities number 1 and 5 and broke into three groups to develop initial action plans. The group then took on two additional priorities, ranked at number 4 and 7. Following is the list of identified priority areas by rank and votes; bolded items show the areas where action plans were developed. It was noted that one of the priority areas, "family-first approach" was important across all aspects of work.

Rank	Votes	Priority
1	22	**After-hours services** **Transportation support services (rank #5 with 7 votes, was combined with after-hours services.**
2	19	**24-hour crisis triage center**
3	12	**Standardized metrics: data sharing, RED – goal of interoperability**
4	8	**Increased mental health diversion (pre-and post-complaint)**
5	7	Transportation support service – also related to after- hours services.
6	5	Sustain and expand existing pilot projects
	5	More dual diagnosis SUD residential treatment services
7	4	Create a criminal justice coordinating council
	4	Work together to identify persons where there are agreements to take action; stepping up model – shared definitions, better understanding of capacity of system
	4	Family-first approach

8	3	Coordination and communication group across all points of the system
	3	Release to services point of contact (hub and spoke)
	3	Gap analysis of housing needs for justice-involved population; and expansion of housing
9	2	Explore co-responder strategy for mental health crisis
	2	In –county step down facility (not limited to state hospital); deep dive into IS; Create a stepdown residential from state hospital.
10	1	Information carries with the person (e.g. one-page summary)

STRATEGIC ACTION PLANS

Priority #1 - After Hours Services

Objectives	Action Steps	Who	When
1. Supportive transport • Crisis vs. (e.g., co-responder model) • Non-Crisis (ex., PD model)	• Research PD model (peer based) • List of after care service providers • Connect with triage (24 crisis) • Approach reentry/natural partners to have safe place to land on exit/discharge • Follow-up co-responder	• CARE • Reentry Center • Family/advocates • PD • Faith • Library • HCH • Needle exchange • CORE • Detention • Forensic	Meet Detention Health/HS/Pat/Jail Releases/Forensics next 2 weeks • Who: David, Jenny, Marie
2. Transport services	• Uber health – research County programs using service • Referral mechanism (self-referral, forensics, PD, etc.)	• Uber Health • CCHP transport networks • CORE • Health Center	Tiombe, CCHP, Jenny, Sheriff, CSW transports, OCE • By end of October
3. Communication protocol for care coordination	• Office of Education understand pre-release plan • Identify service at both centers • Gap in communication – identify feedback loop • Spoke and wheel model • AB 210 information sharing	• Jana • Reentry networks • CORE • Health center • CARE	10/31/18
4. Person centered/family centered after care needs	• Survey • Review rapid improvement results to inform next steps	• OCE • Reuniting Families • NAMI • Center for Human Development	10/31/18

Priority #2 – 24 Hour Crisis Stabilization and Triage Center

Objectives	Action Steps	Who	When
1. Define purpose, use of triage center (function) (model). 2. Build on what's existing. Identify components that are available (i.e., Restoration Center, Reentry Center/Network, Neighborhood House [WC], Adjacent to PES as step-down) and which need to be developed. 3. Location/space determination	• Establish planning group • Engage planning effort • More learning, thinking about models (define functions) • In-depth map of current resources • Test function • Funding exploration • Leadership support/champion • BUDGET development	• BHD – AODS, Public Health, MHET, PDs • Homeless Outreach, CoCo Lead, and ORJ • BOS, HSD Director, BHD Director, PH Director	• Within 3 months

Priority #3 - Standardized Metrics: Data-Sharing, RED – Goal of Interoperability

Objectives	Action Steps	Who	When

1. Shared operational definitions	• Define shared understanding of serious mental illness (SMI) population
	  • Inclusion criteria
	  • Explore best practices
	  • Consider approach
		• Study group to evaluate best practices. Define membership.	

2. What are people already measuring? • Inventory • MOUs • Templates	• What are we trying to track? • How are we sharing that information across disciplines (pulling data -> feed measures) • Open source data vs. protected (covered entity) • Get others' methodology on high utilizers • Get Antioch PD report (vulnerability risk index)		
3. Cross walk of familiar faces	• Ranking opportunities based on number of arrests or encounters over last five years (Jail, police, health) • City/county MOUs • Include Housing First interventions		

Priority #4 – Increase Mental Health Diversion (Pre- and Post-Complaint)

Objectives	Action Steps	Who	When
1. Use the MHET Forensic Review Team to hold pre-1810 cross system discussion to determine best course of action for clients: - Multi-disciplinary review - Early intervention	a) Review and adopt the "LEAD +" Antioch model protocols and criteria as a model for case reviews. b) Determine how 5150 CORE resources should/could be involved in the process. c) Need to ensure prosecutor engagement- currently part of LEAD+	MHET, LEAD + /1810 Team, Forensic Science	
2. • Determine population eligibility by intervention level • Develop 5 levels of intervention: 1) Triage and Divert – PES / (Crisis Solution Center – Future) 2) Regular case course 3) Forensic LEAD + / MHET review 4) IST 5) Conserve	a) Review and determine definitions and criteria for each level of intervention. Use historical data to understand population definitions/needs. b) Build supportive stabilization resources to meet client needs c) Determine alternative responses for those who are not eligible (especially based on exclusions) or do not comply. d) Determine what "teeth" are needed support client. What are the reporting requirements? Time lines? Availability of treatment and options if it is not available.	MHET, LEAD+ 1810 Team	
3. Governance and Structure	a) Develop an AB 1810 implementation MOU or charter. b) Determine what information needs to be		

Objectives	Action Steps	Who	When
	shared by whom, when and how and why. c) Determine who is the keeper of this process. d) Who is on the steering committee and how will it operate.		
4. Maximize, leverage and build funds and other resources.	a) Who is eligible to apply for and manage 1810 funds? b) Build a housing and inpatient strategy		

RECOMMENDATIONS

The following recommendations have been developed in response to the SIM discussion and group's identified priorities and action plans. Action plans as developed at the SIM are included in the Action Plan section and should be considered as a recommendation to continue to move forward regardless if they are included in the recommendations below. We encourage stakeholders to review and prioritize recommendations and SIM Action Plans according to aligned interests and current county priorities. Some of the following recommendations are more general than others; none are intended to be prescriptive but, rather, suggestions of how to approach identified issues.

Most recommendations include references to websites, articles and documents, or examples of work being done across the country. Inclusion of such websites, articles, documents and work taking place across the country are only examples and not intended to be exhaustive. In addition, inclusion in this report is not endorsement from PRA or PRI, but is intended to help point those reading this document in a direction to self-explore and determine actions regarding gaps in their system. Best wishes to you in your journey to improve your system.

OVERARCHING RECOMMENDATIONS

RECOMMENDATION #1

ESTABLISH AN UBER COMMITTEE AND PROCESS THAT ALLOWS FOR SHARED LEADERSHIP, RESPONSIBILITY, COORDINATION, AND OVERSIGHT OF JUSTICE SYSTEM AND BEHAVIORAL HEALTH INNOVATION AND REFORM

The basis of this strategy came from the priority areas and Action Plan #5. Currently, the County has several planning and coordinating committees tasked with improving criminal justice and behavioral health services and infrastructure. There is a need to improve coordination, reduce duplication of work and jointly develop a plan that uses the County's resources in an efficient

and effective manner. The goal is to improve coordination and streamline the work rather than stop any one group from moving forward.

- Following are some of the current groups and advisory committees: Contra Costa Behavioral Healthcare Partnership, Office of Reentry and Justice, Racial Justice Oversight Body, Contra Costa Community Corrections Partnership (CCP), and Stepping-up Steering Committee.

Inventory and Review

Develop a matrix identifying current planning groups including: membership, reason for existing, meeting dates and attendance; goals, directives and mandates; charters, resolutions, strategic plans and other documents; budgets; contracts, and metrics and data points and gaps.

- Some of the plans and documents to include: The Homeless Encampment Action Protocol MOU, BHP Strategic Plan, Racial Justice Task Force Report, Detention Health Services Pre-Release Planning Pilot Project and the AB 109 Public Safety Realignment Plan and annual reports, presentations such as the Justice Reforms in Contra Costa County Post AB 109 Public Safety Alignment.
- Include the Reentry Strategic Plan.
- An inventory by H3 of housing by types, capacity and eligibility.

Convene and Coordinate

Consider using a "collective impact model" to align and advance the work of all the groups and results in shared vision and metrics, mutually reinforcing activities, open communication and solid backbone support to keep efforts moving forward. Use *Stepping Up Resolution 2015/456 as the bases of a "charter":*

1) Determine baseline and prevalence numbers;

2) Identify and understand current treatment and service capacity;

3) Identify and review local and state plans, policy and funding barriers to minimize justice system contact and provide community treatment and support.

4) Develop an overarching jail reduction plan with measurable outcomes including jail bookings and length of stay, connections to treatment, stabilization and recidivism; and

5) Create a process to track progress and information systems.

The Stepping Up Initiative has created resources for county leaders to guide the process of addressing these issues via the Stepping Up Toolkit and the Self-Assessment. In addition, the initiative has created resources, such as case studies and virtual presentations, to support implementation of strategies to reduce jail incarceration of individuals with mental disorders.

RECOMMENDATION #2

ESTABLISH STANDARDIZED METRICS AND DATA-SHARING ACROSS COUNTY AGENCIES TO IMPROVE DATA-INFORMED DECISION-MAKING

The basis of this strategy came from the priority areas and Action Plan #3. Cross-system data can help us improve overall system outcomes at the micro and macro level. It is essential to identify system gaps and resource utilization. It can help us understand returns on our investments and improve outcomes. Individualized data is necessary to identify and stratify potential populations for alternative processing and inform strategies to build a more responsive system. It allows you to tell your story of your success. Unfortunately, all too often criminal justice data systems are transactional or operational in nature, making them "data rich but analysis poor" with reporting functions limited to boilerplate reports. Generally, disciplinary stakeholders have their own data systems, each with unique individual identifiers making data matching very limited. Many do not capture trends, let alone allow for data integration or interface with other systems within the justice or behavioral health systems.

A review of the Contra Costa County Public Safety Realignment Annual Reports: FY 14/15 and FY 16/17 provide a strong rationale for this recommendation. Both reports, page 5, have basically the same paragraph:

"The RDA team worked with each County Department, as well as seven(*seven in FY 14/15, 11 community- based organizations (CBO's) in FY 16/17) community-based organizations (CBOs) contracted to provide AB 109 services, in order to obtain the data necessary for the following report. Because data was collected across a variety of departments who track AB 109 client measures differently, we caution against making direct comparisons from figures across department sections. Moreover, because each department has a separate data system and track AB 109 client data disparately, some measures such as the percentage of the AB 109 population under supervision with new criminal charges and/or convictions during FY 14/15 or FY 16/17 could not be calculated without tracking individuals across departments, divisions and programs."*

This recommendation intentionally dovetails with *Recommendation #1: Establish an Uber Committee*, *Recommendation #3: Deflection and Diversion* and *Recommendation #4: Familiar Faces* strategies. Each should be viewed as natural extensions of each other and necessary to improve overall cross system outcomes, resource utilization, and cost management.

Phase I

Using the plans in Recommendation #1, identify one or two data gaps and develop strategies to share information, connect data systems and define metrics.

Convene a cross-system/discipline technology (IT) and user working group, including those who enter data, to walk through their data systems:

- Take a current or recent data set and "walk" through the data for a small group of individuals to explore what is, and isn't collected. Identify what data is entered, and when, what is fixed vs free form, who is it shared with, how is it shared, who has

access, how is access provided and by whom, what is the original source of data, how is it verified; how is data pulled and pushed; what is part of a boilerplate report, etc.

- Review any data sharing memorandums of agreement. Create memorandums as appropriate.
- Define terms and definitions of each data point. Review current and adjust codebooks as needed.
- Determine who already has access to enter, read, or change each data point.
- Determine if a data point is private information or public.
- Look at both charge-based and individual-based data.
- Determine costs for each step in the process.
- Create a data dictionary that includes *shared definitions* and *defined terms* to ensure there is a common definition of what populations/issues you are trying to understand; learn from each system how that data point is collected, coded, and stored. Determine common identifiers to match populations. Sometimes, the best you will have is "name and date of birth". Some key terms to define are: serious mental illness, substance use disorder, incompetent to stand trial, pre-trial eligibility, homeless and housing status. Terms that surround tracking race and ethnicity also need to be defined.
- Add an "opt out" clause to release of information about information collection for data sharing (as appropriate) and analysis purposes.

Rather than tackle the entire system, start with integrating two or three parts of one system – such as pre-trial and detention/jail data; or emergency department, mobile crisis and triage center. After some success, look to add cross-discipline information such as jail-based mental health and substance use information and pre-trial screening and outcomes.

Phase II

- Develop a case-process flow analysis and data including race/ethnicity, gender, age, time to process each step, level of offense and risk, bond eligibility and status, average length of stay for the general population and for someone with a mental illness or a substance use disorder.
- Use data to understand trends. To the degree possible, use both charge-based and individual-based data and look historically at issues such as repeat offenders, common offense locations, system processing and access to services. Historical data can reflect trends and target or illuminate issues.
- If possible overlay access and utilization of mental health and substance use treatment and medication. Include failure to appear and lengths of stay in jail.
- Track data for racial and ethnic disparity across all programs. Examine criteria, acceptance, successful completion rates and technical violations.
- Track technical violation data to understand the impact on the jail and improve use of sanctions and incentives.
- Create cost measures that can be added to the analysis.
- Include race, ethnicity, age, and gender in data analysis.

Increase common understanding about information sharing:

- Increase cross-system understanding of HIPAA, 42 CFR Part 2, and HMIS for mental health, substance use, and homelessness information sharing. Educate stakeholders on information and data sharing between protected entities, between protected and non-protected entities, and between non-protected entities.

Current State Laws Regarding Information Sharing	
State Health Information Guidance: Sharing Behavioral Health Information in California Source: State of California Office of Health Information Integrity https://www.chhs.ca.gov/wp-content/uploads/2018/10/State-Health-Information-Guidance-January-2018.pdf	PDF
Guidance on Applicable Federal Law	
HIPAA.com	Website
Health Information Privacy Portal Source: US Department of Health and Human Services	Website
Frequently Asked Questions: Applying the Substance Abuse Confidentiality Regulations to Health Information Exchange Source: Substance Abuse and Mental Health Services Administration	PDF
Disclosure of Substance Use Patient Records: How Do I Exchange Part 2 Data? Source: Office of the National Coordinator for Health Information Technology	PDF
Confidentiality of Substance Use Disorder Patient Records, Cornell Law School	Confidentiality of Substance Use Disorder Patient Records
Dispelling the Myths about Information Sharing between Mental Health and Criminal Justice Systems	PDF
Homeless Management Information System	
HUD Exchange Homeless Management Information System Guide and Tools	Website
McKinney-Vento Homeless Assistance Act Source: HUD Exchange	PDF
Information-Sharing Guidance	
Opportunities for Information Sharing to Enhance Public Safety Outcomes Source: IJIS Institute, Urban Institute	PDF
Prioritizing Justice-to-Health Exchanges Task Team Final Report Source: Bureau of Justice Assistance	Website

Corrections and Reentry: Protected Health Information Privacy Framework for Information Sharing Source: American Probation and Parole Association	PDF
A Comparative Analysis of HL7 and NIEM: Enabling Justice-Health Data Exchange Source: National Consortium for Justice Information and Statistics	PDF
Information Sharing in Criminal Justice-Mental Health Collaborations: Working with HIPAA and Other Privacy Laws	PDF
Mental Health Information Systems Source: World Health Organizations	Website

Tracking population-specific data:

- Track *population specific* data (see also *Familiar Face* Recommendation) across a sample of cases to create a case flow process by race/ethnicity, gender and age, identify areas of redundancy such as screening and assessments, unnecessary wait times, disparity and access to services. Types of data points may include average time stamps between processes by type and level of offense, pre-trial and bond eligibility including holds (parole, other jurisdictions, and federal), time from eligibility to time of release, release volume by time of day and day of the week; sentencing outcomes, revocations by reason and outcomes, diversion utilization and outcomes, and program and jail program access, capacity and utilization.
- Identify a "familiar face" population through analysis of court data by individual first, and then by charges and address, accounting for housing instability and experiences of homelessness. From there, look at pre-trial and bond eligibility as well as jail stays. If available, look at detention/jail program service use (including medical and behavioral health) and jail stays associated with court sanctions or technical violations. This should result in the identification of low-level offenders with high-needs.

Data-sharing technology

- Terms such as interface, integrated, and interoperability are used interchangeably, however they may have different meanings. Refer to this quick guide on the differentiation between the terms. In many cases, levels of data integration can be achieved but the ability to interface systems is a tremendous leap forward. Interoperability, especially across disciplines, is often challenging and not necessary to improve system coordination and outcomes. A moto to keep in mind is "don't let great get in the way of good."

  Some counties, such as Johnson County (KS), have created their own county-wide data hub. In Johnson County, the data hub is built on a system called My Resource Connection (MyRC). Other counties are benefiting from the cumulative benefits of

open source technology which can reduce system reliance on closed, proprietary systems. Open source consortiums like the Open Justice Broker's Consortium (OJBC) (PDF and Website) specialize in cross-system data. OJBC began their work in Hawaii to connect human service and criminal justice data systems. They now have members in Pima County (AZ) and Adams County (CO) as well as the states of Michigan, Massachusetts, Maine, and Vermont. In each case, the new county or state is able to benefit from the other systems' work, resulting in expediting the process and reducing costs.

- Adams County (CO) offers the following lessons learned:

  1. Start with survey to develop and document a unified vision, mission, and goals.
  2. Establish a governance structure to set policy and technical priorities, from what kind of data makes sense to share to who will have access and where it will reside
  3. Set up the necessary protections, from data sharing and management control agreements to intergovernmental agreements and rules of access.
  4. Use project charters to align stakeholders, researchers, and technologists behind a unified set of goals and expectations for projects in development
  5. Use justice information sharing standards when possible as laid out by the National Information Exchange Model (NIEM) and Global Reference Architecture (GRA)
  6. Map data, build database, and develop research, sharing, and analytics tools

- Check with local universities to see if they can help map your data tracking and information system. Some universities have specific departments that partner with Counties and States. The Harvard School of Law, Government Performance Lab and Code for America can be helpful partners in developing strategies and connection to others who are doing similar work.

Dashboards

- Dashboard indicators can be developed on the prevalence, demographics, and case characteristics of adults with mental and substance use disorders who are being arrested, passing through the courts, booked into the jail, sentenced to prison, placed on probation, etc. Tools like Microsoft PowerBI are free and fairly easy to use.
- A mental health dashboard can also be developed to monitor wait times in hospitals for people in mental health crises and transfer times from the emergency department to inpatient units or other services to determine whether procedures can be implemented to improve such responses. These dashboard indicators can be employed by a county planning and monitoring council to better identify opportunities for programming and to determine where existing initiatives require

adjustments. Louisville (KY) and Denver (CO) are among the jurisdictions with strong jail mental health dashboards.

- The publication Data-Driven Justice Playbook: How to Develop a System of Diversion provides guidance on development of data driven strategies and use of data to develop programs and improve outcomes. See also the *Data Analysis and Matching* publications in the Resources section.

RECOMMENDATION #3

INCREASE COUNTY-WIDE DEFLECTION AND DIVERSION STRATEGIES. EXPLORE THE NEED FOR A 24 HR CRISIS STABILIZATION AND TRIAGE CENTER AND A MENTAL HEALTH-FIRST RESPONDER CO-RESPONDER STRATEGY.

The basis of this recommendation # 3 and recommendation #4 came from the SIM priority areas and Action Plan #4. This recommendation should be dovetailed with *Identify "familiar face" high-utilizer populations to help manage costs, reduce unnecessary utilization of services while increasing individual stabilization. Develop "high utilizer" strategies*.

It is recommended that the county builds on its existing resources and takes a comprehensive look, perhaps even a "mini-SIM" focusing on Intercept 0 and Intercept 1. Use data, determine gaps, lessons learned from CoCo Lead+ in Antioch and MHET across Contra Costa County as a starting point. This recommendation also has two specific priority areas

1. Explore the need for a 24-hour sub-acute crisis stabilization center; and,
2. Improvement of law enforcement-behavioral health co-response strategies.

1. Increase Deflection and Diversion Strategies

The ability to increase client stabilization through community and alternative processes is at the heart of criminal justice deflection and diversion strategies. Law enforcement based deflection requires immediate access to services, without barriers. System and public support for law enforcement discretion is critical to supporting deflection strategies. In general, "deflection" is pre-arrest or citation and refers to law enforcement utilizing non-criminal justice supports without any official criminal justice action, while "diversion" may be pre or post-arrest or pre-or post-booking. Diversion often refers to the use of an alternative criminal justice course of action. For example: police deescalating an individual, using clinical co-responders, taking an individual to a triage center, sobering center, or emergency department is seen as deflection; the addition of a citation, or other criminal justice stakeholders' involvement and offering an alternative to traditional case processing such as treatment court, deferred prosecution or judgement, or Law Enforcement Assisted Diversion (LEAD) are diversion strategies.

Document Actions to Understand Trends, Costs and Populations

The importance of documentation of "deflection" and "diversion" actions taken by law enforcement cannot be overstated. At the very least, documentation should note if the action

taken was: de-escalation, hospitalization, transportation and referral to services, citation, arrest and detained, etc.

- Determine how to identify or flag repeat/frequent individuals for law enforcement so they can initiate the deflection or diversion process. See the Familiar Face recommendation for more information.
- Create a baseline and track by deflection and diversion strategy.
- A simple "check-box" used by law enforcement, as within Fairfax County (VA) and Dade County (FL) can document actions taken.
  - Track the total number of dispatch calls to persons with behavioral health issues and sort by actions – de-escalation, cite, arrest/detained, deflect/divert, and "No Probable Arrest," "Probable Misdemeanor Arrest," or "Probable Felony Arrest."
  - Track the percentage and type of calls specialized police units/officers are responding to and prioritize calls if necessary.
  - Establish costs of various actions to determine return on deploying various strategies.

Deflection

The following strategies can improve immediate support for an individual and improve access to services, and appropriate service match.

1. Increase coordination and access to crisis services, especially psychiatric beds.
   - Strategies should be developed to streamline access to beds and increase capacity of hospital resources. Explore the development of, and use of a bed registry across the crisis triage and the hospital network. Such a registry could be helpful in tracking availability when services are needed.
   - Consider how to improve "release-to-supports" to improve stabilization and continuity of care including medication, housing, and emotional supports.
   - Coordinate with county and state crisis call centers and lines. Physically call crisis call lines and review websites, billboards, public information about crisis services. Ensure information is up-to date and access and messages are clear. Talk with Colorado Crisis Services about they developed their robust, statewide referral database.
   - Review current recipients of deflection and diversion strategies. Compile data to understand recipient needs and evaluate the match to meet the recipient needs.
   - Address the "churn" effect of persons repeatedly coming through the process without different results, and remove "constriction" issues where the system becomes clogged due to limitations in moving persons to the next step.
   - Examine the process to access services and criteria to access services; match risk and need to services; formalize referral processes; and increase knowledge of what services do and don't offer.
     - Use data and other methods to learn about current processes, and who is receiving services including their risk and needs level. Review any existing contracts or agreements to understand current expectations.
     - Develop agreements that include service match to risk and need levels. Develop outcome metrics and clarify expectations. Create strategies to streamline referral

processes. Commit to have dedicated services and "slots" for justice-involved persons with medium to high risk and needs. Address concerns of service providers in taking higher risk offenders. Routinely address issues and make adjustments.

2. Utilize co-response clinical strategies

Build on the current MHET model and explore implementing a full clinical co-response model. A joint, clinical mental health and law enforcement/first responder response is known as "co-responders or clinical co-response." Generally, once law enforcement has secured the scene and determined they do not have to make an arrest, clinicians work directly with law enforcement to help determine the best clinical response for the individual. Although co-response strategies vary from community to community, the general framework entails a licensed clinician who rides along with law enforcement or can be requested to the scene of a mental health crisis. The crux of a co-response strategy is that the licensed clinician can assist law enforcement in de-escalating the crisis, establish a warm hand-off to services, and provide proactive follow-up to improve the likelihood of long-term services engagement. Some law enforcement departments have specific teams that routinely work together, others have a more general response. In some cases, regular patrol requests a co-responder while other departments have officers and co-responders working specific areas known for "high-needs" calls. Regardless of the model, to be effective, "community-based crisis response" must be adequately staffed to respond promptly to crisis calls. More communities are coordinating mobile crisis/co-response team responses with law enforcement especially during peak call hours and co-locating services or embedding clinicians in police district headquarters. Often these services are augmented by providing telephone or videoconference consultation to law enforcement. The Crisis Now report provides a comprehensive overview of crisis services and a crisis framework. Some states with advanced crisis frameworks include Colorado, Texas, New York, Virginia and California. In addition, consider the viewpoints and experiences of individuals with lived experience and family members when designing deflection and diversion programs.

- Explore the use of virtual crisis response strategies such as video conferencing and telehealth to support law enforcement officers and other first responders responding to crisis situations. The use of videoconferencing to expand access to the mental health consultation is increasingly being used to connect law enforcement with mental health professionals. Counties with varying populations, from large counties (e.g., Harris County, TX), medium counties (Lancaster County, NE), and small counties (Yuma County, AZ), have employed this technology to improve response times of mental health co-responders. For reference, see the overview of virtual crisis response from Springfield (MO) provider Behavioral Health Response.
- Additional crisis response strategies for consideration:
    - Expand CIT training and coordinate across each of the law enforcement entities and 9-1-1 call takers in the surrounding municipalities.

- Mental Health First Aid training to first responders including EMS/Fire and other justice system stakeholders is a terrific way to build common information across the system.
- Increase coordination with Probate Court regarding guardianship and outpatient commitment.
- Explore using a Social Impact Bond. Reference the Urban Institute report on Denver's experience.
- Explore a county tax to ensure funding and increase availability of services. Some of the counties with a tax include Bernalillo County (NM) and Denver (CO).

3. Sub-acute Triage and Stabilization Services

Sub-acute triage and stabilization models vary across the United States.

- Review current program data, including Contra Costa Crisis Center, to create an understanding of who is, and who isn't accessing these services, what services are offered and gaps in need and care. Examine treatment match to client need and gaps in level of care based on population needs. Based on service needs, examine the necessity of adding new crisis service models which can allay the need for the psychiatric emergency service admissions. Before implementing a new service, explore how the service will work with existing mental health, law enforcement, and EMS/Fire responses.
- Bexar County has created a comprehensive, person centered crisis and stabilization process. Contra Costa county is well positioned to implement many of the Bexar County strategies.
- Mental health crisis services triage and stabilization units can be a tremendous asset in a community; however, any brick-and-mortar setting will be underused and without the desired outcomes unless the following conditions are met:
  - Stakeholders obtain a clear understanding of the need for a facility;
  - Stakeholders establish a formal commitment to utilize the facility;
  - Stakeholders focus efforts on integrating the existing crisis response process; and,
  - Stakeholders understand that, without pro-active follow-up, post-crisis services, and engagement strategies, the use of crisis services by an individual will continue into the future.

4. Continue Implementation of Homeless Intervention Strategies

Communities around the country including Contra Costa County have begun to develop more formal approaches to housing development, including use of the Housing First model. The 100,000 Home Initiative identifies key steps for communities to take to expand housing options for persons with mental illness. A strong housing continuum includes emergency shelters, landlord support and intervention, rapid rehousing, Permanent Supportive Housing (with or without Housing First but including supportive services such as case management, treatment, employment, etc.), Supported Housing (partial rent subsidies), transitional housing, affordable rental housing, and home ownership. In addition, consider how dependent care, institutional care, home-based services such as FACT, FUSE and ACT, halfway houses, and respite care can support specific populations needs.

- The Corporation for Supportive Housing FUSE Resource Center describes supportive housing initiatives for super utilizers (frequent users) of jails, hospitals, healthcare, emergency shelters and other public systems.
- Camden New Jersey has developed a promising collaboration of healthcare, social service, and law enforcement services to address their "complex care" populations that have frequent contact with their hospitals and, sometimes, police. They have been showing success in reducing repeated contact and improving health.
    - Work with homeless service providers and triage systems to improve coordination and access to shelter and housing providers.
- Understand and, where possible, address provider criteria that limits access of criminal justice, or persons living with mental health or substance use issues. Whenever possible, work collaboratively to improve access to housing, the environment of shelters and housing to promote safety and stabilization.
- Prioritize and coordinate access to housing, especially housing first and permanent supportive housing models. Access to coordinated housing is usually based on scores such as the Vulnerability Index and Service Prioritization Decision Assistance Tool (VI-SPDAT).
- Diversify housing options such as transitional, supportive and supported housing. In addition, a comment was made that "many shelters only provide that function but do not connect persons with longer term housing services". Discussions with shelter providers and persons who have experienced homelessness could result in expanded thinking and repurposing of some of the shelter beds.
- Similar to permanent supportive housing, consider combining affordable housing with access to supportive services to increase housing stability.
- The Doe Fund, Ready to Work models create alternatives to jail or release from jail that include housing, employment, and life skills training
- Landlord Liaison projects increase the likelihood that landlords will accept individuals with justice system involvement and higher needs.
- Coordinated entry helps communities prioritize housing resources
- Funding that supports move in costs, deposits, damage repair, etc.
- Right Home, Right Time, Right Support:
    - Learn the various housing funding streams at the municipal, county, state, federal and private levels
        - State and Federal housing vouchers and public housing options, Veterans Affairs Supportive Housing (VASH), Family Unification Program (FUP), Emergency Solutions Grants (ESG), Home Purchase Assistance Program (HPAP), Tenant-based Rental Assistance (TBRA), Permanent Supportive Housing (PSH) and PHS Bonus, PSH Shelter Plus Care (PSH(S+C))
    - Inventory who is currently in supported housing to ensure match with level of need.
- Coordinate with your local HUD CoC - Continuum of Care

- Understand U.S. Department of Housing and Urban Development (HUD) definitions to access various housing options.
- Understand HUD rules and compare to local housing authority rules
- Work to prioritize criminal justice housing under you CoC and housing authority.

- The following resources may help inform strategy development. See also *Housing* under Resources below.
  - GAINS Center. Moving Toward Evidence-based Housing Program for Person with Mental Illness in Contact with the Justice System
  - Stefancic, A., Hul, L., Gillespie, C., Jost, J., Tsemberis, S., and Jones, H. (2012). Reconciling Alternative to Incarceration and Treatment Mandates with a Consumer Choice Housing First model: A Qualitative study of Individuals with Psychiatric Disabilities. Journal of Forensic Psychology Practice, 12, 382–408.
  - Tsemberis, S. (2010). Housing First: The Pathways Model to End Homelessness for People with Mental Illness and Addiction. Center City, MN: Hazelden Press.
  - Stefancic, A., Henwood, B. F., Melton, H., Shin, S. M., Lawrence-Gomez, R., and Tsemberis, S. (2013). Implementing Housing First in Rural Areas: Pathways Vermont, *American Journal of Public Health*, *103*, 206–209.
  - Shifting the Focus from Criminalization to Housing
  - Lehman, M.H., Brown, C.A., Frost, L.E., Hickey, J.S., and Buck, D.S. (2012). Integrated Primary and Behavioral Health Care in Patient-Centered Medical Homes for Jail Releases with Mental Illness. *Criminal Justice and Behavior*, published online.
- Built for Zero (formerly Zero: 2016) is a rigorous national change effort working to help a core group of committed communities end veteran and chronic homelessness. Coordinated by Community Solutions, the national effort supports participants in developing real time data on homelessness, optimizing local housing resources, tracking progress against monthly goals, and accelerating the spread of proven strategies.

5. Review and improve client community stabilization.

Community-based supports such as Assisted Outpatient Treatment (AOT), Assertive Community Treatment (ACT) and Forensic- ACT processes and Frequent Users Service Enhancement (FUSE) are some of the core programs that can help stabilize high-needs clients in the community. It is likely that those served by these programs are all eligible for Supplemental Security Income (SSI), or Social Security Disability Income (SSDI). All of the models are staff intensive and require comprehensive support including housing, medications, case management, access to primary, mental health and substance use disorder interventions.

- Review current contracts, eligibility, number served, services, and outcomes for these services.
- Review and improve how these programs interface with Probate Court practices.

- Consider bridging ACT services with incompetent to stand trial populations and community restoration models.
- Review and create outcome-based agreements to support the implementation of AOT, ACT/FACT and FUSE with fidelity.
    - Work the state/regional SSI/SSDI Outreach, Access and Recovery (SOAR) providers to apply for SSI/SSDI entitlements. If not already enrolled, the SOAR process can be initiated for those under AOT, in the state hospital, in psych-units in community hospitals or under mental health alerts in jails and prisons. Cross system coordination will be critical to not duplicate efforts and complete the applications.

6. Create Shared Values

Deflection and diversion in the criminal justice system requires shared values and response to individuals with high needs. Routinely discuss the challenges and various points of view held by various justice stakeholders.

- Provide a way to "listen to understand" (rather than to "respond") to each other and explore concepts such as accountability, public safety, "victim" and tolerance level for various diversion options. Invite community members, providers and persons with lived experience to be part of the discussions. Use the LEAN concept of "customers" to identify impacted sectors (e.g., business, family, victims).
- Develop a process to respond to concerns about deflection/diversion. Develop a collaborative message that communicates that deflection and diversion are appropriate strategies to use in case a negative event occurs.
- Develop a cost model of the traditional system and deflection/diversion strategies.
- Consider developing a restorative justice based response to low level offenses such as shoplifting, loitering and quality of life offenses. Perhaps develop a sheriff-run work crew to support clean-up, graffiti removal, care of flower beds and gardens to offset municipal costs and provide an alternative to jail for unpaid fines and fees.

7. Post-booking stabilization

Post-booking stabilization process (not program) provides opportunities at multiple points to screen and address behavioral health, including who receives information about post booking options, who can be diverted out and to what, what is needed to stabilize individuals in jail, and what services are persons needed to be released to in the community. Essential elements can be found in the SAMHSA Monograph, "Municipal Courts: An Effective Tool for Diverting People with Mental and Substance Use Disorders in the Criminal Justice System." The monograph identifies four essential elements of arraignment diversion programs. Improving screening, clinical assessment, and behavioral health disorders who are released without referral or follow-up. The CASES Transitional Case Management and the Manhattan Arraignment Diversion Program are two examples.

RECOMMENDATION # 4

FURTHER INCORPORATE THE USE OF PEERS AND PEER SUPPORT AND RECOVERY ACROSS INTERCEPTS

Peer specialists and peer support services can assist in helping inmates with mental illness/addiction to engage in treatment. They can be instrumental as part of a re-entry team to help an inmate connect with services upon release. Peer support has been found to be particularly helpful in easing the traumatization of the corrections process and encouraging consumers to engage in treatment services. Peers can work one-on one or in a setting such as a "living room" model or as part of homeless, crisis evaluation centers, emergency departments, treatment courts, jail and reentry services, mental health and detox settings. Please review the resources below for information.

- *The 2014 SAMHSA publication* Toolkit for Evaluating Peer Respites *provides information on developing Peer Respite Centers.*
- Philadelphia's Department of Behavioral Health and Intellectual Disability Services has created a helpful Peer Support Toolkit.
- There are many other resources available such as Medicaid Coverage of Peer Support for People with Mental Illness.
- Wellness Recovery Action Plans (WRAP) are integral to individual recovery and can be integrated into probation or other case management plans.
- Living Room Living Room, Global Journal of Community Psychology Practice.pdf https://www.gjcpp.org/pdfs/2013-007-final-20130930.pdf
- Best Practices for Effectively Integrating Peer Staff in the Workplace, New York State Office of Mental Health (2017)
- Florida Peer Services Handbook, Florida Department of Children and Families, Office of Substance Abuse and Mental Health (2016)
- Peer Services Toolkit: A Guide to Advancing and Implementing Peer-Run Behavioral Health Services, ACMHA: The College for Behavioral Health Leadership (Now called the College of Behavioral Health Leadership) and Optum (2015)
- Enhancing the Peer Provider Workforce: Recruitment, Supervision, and Retention, National Association of State Mental Health Program Directors (2014)

RECOMMENDATIONS FOR INTERCEPT 0 AND INTERCEPT 1

RECOMMENDATION # 5

IDENTIFY "FAMILIAR FACE" HIGH UTILIZER POPULATIONS TO HELP MANAGE COSTS, REDUCE UNNECESSARY UTILIZATION OF SERVICES WHILE INCREASING INDIVIDUAL STABILIZATION. DEVELOP "HIGH UTILIZER" STRATEGIES

It is important to differentiate between a) identifying a "familiar face" population (which, at some level, is static); b) understanding the reasons for frequent use of jail, behavioral health, and medical services; and c) using information to inform strategies from proactive identification of people at risk to be "familiar faces." Identify strategies to objectively flag, intervene and serve these familiar faces.

Use historical data from the court, jail, or MHET to start the identification process of high utilizers. Build on efforts such as CoCo Lead Plus, mobile crisis and other deflection and diversion strategies to identify high utilizers or "familiar face" populations within and across various systems. Use the lessons learned to increase information sharing, service implementation, identify gaps and improve outcomes.

General High Utilizer Identification Process

Build relationships and establish a working group across justice and non-justice stakeholders; establish goals to improve outcomes for highly vulnerable populations. Build on existing resources such as a Continuum of Care, homeless providers, and law enforcement Crisis Intervention Team programs.

- Convene the county mental health provider, county hospital, police, fire, EMS, 9-1-1, courts, prosecutors, public defenders, sheriff, homeless providers, withdrawal management services, etc. to understand various high utilizer populations from their perspective.
  - Determine data points and seek agreements to analyze and share data at the aggregate and individual level.
  - Map current system flow, frequency, costs for various populations.
- Define, identify, stratify and create strategies to meet the needs of various high utilizing populations. Some populations to consider:
  - Emergency services such as fire, EMS and emergency rooms for non-emergency issues
  - Calls for police services where calls are based on mental health or intellectual disability
  - Incompetent to stand trial repeat individuals with low level, non-violent offenses
  - Repeated use of withdrawal management and police contact
  - Repeated overdose of substance use disorders resulting in emergency care and use of naloxone.
  - Repeated technical violators of probation services
  - Failure to appear and high court utilization for low level offenses

- Parents where child abuse/neglect has been substantiated and frequent arrest or citation for substance use or levels of mental health disorders.

- Track outcomes of police contact. The importance of documenting pre-booking actions including citation, arrest, hospitalization, de-escalation, and referral, cannot be overstated.
  - Determine how to flag individuals for police so they can initiate the deflection or diversion process.
  - Create a baseline and track by deflection and diversion strategy.
  - A simple "check-box" used by law enforcement, as within Fairfax, VA and Dade County, FL, can document actions taken.
    - Track the total number of dispatch calls to persons with behavioral health issues and sort by actions – arrest, deflect/divert, or "No Probable Arrest," "Probable Misdemeanor Arrest," and "Probable Felony Arrest."
    - Track the percentage and type of calls specialized police units/officers are responding to and prioritize calls, if necessary.
- Develop dashboard to track the prevalence, demographics, and case characteristics of adults with mental and substance use disorders who are being arrested, passing through the courts, booked into the jail, sentenced to prison, placed on probation, etc. Systems such as Microsoft Power BI allow flexibility in presenting information.
  - A mental health dashboard can also be developed to monitor wait times in hospitals for people in mental health crises and transfer times from the emergency department to inpatient units or other services to determine whether procedures can be implemented to improve such responses. These dashboard indicators can be employed by a county planning and monitoring council to better identify opportunities for programming and to determine where existing initiatives require adjustments.
- Identify top system utilizers through analysis of court data (tickets, municipal and misdemeanor) by individual first, and then by offense, address of offense, etc. Share the list with justice system stakeholders: police, 9-1-1, pre-trial/bond eligibility and LOS before release, failure to appear (FTA), warrants, risk and need scores, detention frequency and LOS, engagement in detention/jail program services (including medical and behavioral health), probation and parole, and Department of Corrections, including technical violations and outcomes, etc. Stratify the list in ascending order of arrests or jail days; create a reasonable cut off point. Copy the list and add codes for identified behavioral health issues to a separate, protected list. This should result in understanding a lower level offender with high needs.
  - Map offense locations to understand density of offenses by offense type and develop strategies to improve outcomes.
- Share the list, with full name, known alias, and date of birth (not including protected health information) with additional non-justice stakeholders: homeless systems (HMIS), hospitals, detox facilities, Human Services, Fire/EMS, community mental health, treatment providers, and other relevant community providers to understand the utilization, needs and gaps in resources.
  - Providers may not be able to provide individual information, but they can provide information by cohort regarding levels of utilization of their systems.

- Request costs of services when possible.
- Develop MOUs with appropriate stakeholders to obtain more comprehensive data.
- Work with state systems such as Medicaid and behavioral health payers to provide utilization costs.
- Develop strategies to address specific population needs.

RECOMMENDATION # 6

IMPLEMENT A COMPREHENSIVE SUBSTANCE USE DISORDER STRATEGY: POPULATION IDENTIFICATION AND TREATMENT RESOURCES IN THE JAIL AND COMMUNITY.

SIM Workshop participants identified substance use disorder treatment capacity and access as a significant gap. The facilitators note the following substance use disorder initiatives and encourage stakeholders to expand and integrate substance use disorder treatment initiatives with other initiatives described in this report.

- *Substance use disorder treatment levels:* The American Society of Addiction Medicine's ASAM criteria is the result of a collaboration that began in the 1980s to define one national set of criteria for providing outcome-oriented and results-based care in the treatment of addiction. Today the criteria have become the most widely used and comprehensive set of guidelines for placement, continued stay and transfer/discharge of patients with addiction and co-occurring conditions.
    - ASAM Criteria- Determining Severity Ratings
    - Understanding and Utilizing the ASAM Placement Criteria
- The 2016 SAMHSA publication *Screening and Assessment of Co-occurring Disorders in the Justice System* developed by Roger Peters and the SAMHSA GAINS Center (see *Screening and Assessment* section of the Resources), provides an overview of screening and assessment and treatment of individuals with co-occurring disorders in the criminal justice system. In addition, Screening and Assessment instruments for mental illness, substance use, co-occurring disorders, treatment motivation and trauma/PTSD. Recommended screening tools include:
    - Texas Christian University Drug Screen V
    - Simple Screening Instrument for Substance Abuse
    - Alcohol, Smoking and Substance Involvement Screening Test
- The SAMHSA publication, Detoxification and Substance Abuse Treatment. Treatment Improvement Protocol (TIP) Series, No. 4 SAMHSA Tip 45, provides communities with guidance on a continuum of inpatient and outpatient care for detoxification services and identifies best practices.
- Jails and prisons are increasingly utilizing Medication Assisted Treatment (MAT) at the point of reentry. The American Society of Addiction Medicine has established a National Practice Guideline to provide information on evidence-based treatment for opioid use disorder.

- The American Academy of Addiction Psychiatrists has established a clinical support system for providers, including prescribers working with justice-involved individuals. Education and training are available through the following web portal.
- The National Sheriffs' Association and the National Commission on Correctional Health Care have established promising practices and guidelines for jail-based Medication Assisted Treatment.
- The San Diego Serial Inebriate Program is a nationally recognized program to offer services to a chronic inebriate population.
- There are several curricula that can be helpful to use within the facility. See Jail Based Substance Abuse Treatment Literature Review for details.
    - General cognitive curricula such as: Thinking for a Change (TFC) and Moral Reconation Therapy (MRT) are effective, but can be lengthy to administer.
    - The SMART Recovery curriculum is shorter in length to administer.
        - InsideOut is a SMART Recovery program for substance abuse treatment in correctional settings.
    - The Matrix Model is a curriculum for persons suffering from methamphetamine use disorder.

Medication Assisted Treatment (MAT) protocols in the jail and community:

- Review current Medication Assisted Treatment (MAT) processes in the community and jail. Many jails are only giving Vivitrol, or Suboxone to women who are pregnant.
- Ensure support, especially peer support, to help persons maintain MAT and their recovery. See the *Medication Assisted Treatment* section of the Resources portion of this report.
- Strategies may include treatment on demand, police follow-up and referral to services, a resource center, harm reduction/syringe exchange, and/or first responders trained in and carrying Naloxone.
- Consider a collective impact process to bring together harm reduction, prevention, treatment and enforcement strategies. Think of both process, and individual-, policy-, and place-based strategies.
- Full jail/criminal justice facility MAT for opioid use disorder includes:
    - Screening for use and withdrawal
    - Withdrawal management on Buprenorphine
    - Maintenance dosing and induction on Methadone and Buprenorphine paired with appropriate psychoeducational classes, and
    - Peer support in the facility and upon release
    - Inmates leaving with Naloxone (Narcan)
    - Approximately 1% of the over 3000 county jails is offering a full spectrum of MAT protocols. Dr. Rai at Denver County Jail is open to discussing their model that provides all levels of MAT: maintenance, induction, withdrawal management, psych/social education and Narcan at release.

See *Jail-Based Medication-Assisted Treatment: Promising Practices, Guidelines, and Resources for the Field*, October 2018, https://www.ncchc.org/jail-based-mat., National Sheriffs' Association, National Commission on Correctional Health Care.

Trauma-informed curricula such as Seeking Safety, TREM, and M-TREM are important to offer as trauma is often underpinning substance use disorders.

- Seeking Safety is a non-clinical curriculum.
- Basic post-traumatic stress disorder assessment may be helpful to use. The Abbreviated PCL-C is a shortened version of the PTSD Checklist – Civilian version.

Clients with cognitive impairment often go undetected but may fail to comply with justice demands and fail to comprehend forms of treatment due to their impairments. Screening for cognitive impairment is important.

- Traumatic Brain Injury
  - The Ohio State University (OSU) Traumatic Brain Injury (TBI) Identification Method (OSU TBI-ID) is a standardized procedure for eliciting a person's lifetime history of TBI via a 3-5 minute structured interview.
  - SAMHSA's TIP 57: Trauma-Informed Care in Behavioral Health Services helps professionals understand the impact of trauma.
- Cognitive Impairment:
  - The Cognitive Failures Questionnaire (CFQ) was developed to assess the frequency with which people experienced cognitive failures, such as absent-mindedness, in everyday life.
  - Mini-Mental State Examination (MMSE)
  - The Saint Louis University Mental Status Examination (SLUMS) is a brief oral/written exam given to people that are suspected to have dementia or Alzheimer's disease. Instructions are found here.

RECOMMENDATIONS FOR INTERCEPT 2 AND INTERCEPT 3

RECOMMENDATION # 7

EXAMINE THE NEED FOR PRETRIAL INTERVENTIONS TO REDUCE FAILURE TO APPEAR OF INDIVIDUALS WHO ARE BOOKED AND RELEASED.

Examine the feasibility and need for alternatives to detention and pre-adjudication diversion options for people with mental disorders at Intercept 2. Defendants with mental disorders who are remanded to pretrial detention often have worse public safety outcomes than defendants who are released to the community pending disposition of their criminal cases.

Proportional Responses

Consider proportional responses based on the severity of a defendant's criminal risk and behavioral health treatment needs.

- Defendants with pending cases who are released to pre-trial services as an alternative to detention. These may be cases with moderate criminal risk but where the individuals would benefit from community-based services that are not available while in pretrial detention and pretrial failure can be avoided.
- A deferred prosecution approach where a low-risk defendant is directed to participate in a short-term community-based treatment program. Successful completion of the program results in dismissal of the charges while failure results in remand to custody and continuation of the criminal case. The Milwaukee County Pre-trial Diversion program offers diversion opportunities using restorative justice and other accountability models.
- Consider a competency court docket, such as was established by the Seattle Municipal Court, to reduce time spent in jail during the competency process. Refer to the journal article by Finkle and colleagues (2009) and the 2013 report on the Seattle Municipal Court mental health court, which houses the competency court docket.
- Explore implementing a detention Population Review Team (PRT) process similar to the one in Lucas County, Ohio. Weekly meetings are held with the prosecutor, public defender, jail representatives, mental health professionals, and others when appropriate. The team reviews a list of individuals in pre-trial custody to determine why a person is being detained and if he or she can be safely released before trial or have his/her case resolved quickly. For example, some individuals are released to mental health services as part of pre-trial conditions. In other cases, if the case during the normal course of action would result in a plea, the plea offer expedited rather than waiting to set a trial date.

RECOMMENDATION # 8

IMPROVE PRE-AND POST-ARREST DIVERSION OPPORTUNITIES FOR INCOMPETENT TO STAND TRIAL POPULATIONS

Participants discussed the Incompetent to Stand Trial (IST) population who are detained in jail while waiting transfer to a state forensic hospital. The IST issue is a challenge for states across the country, but strategies have emerged to reduce the number of individuals found IST, provide outpatient restoration alternatives and reduce IST inpatient length of stay. In addition, deflection of repeat individuals and improved coordination with Probate Court can reduce unnecessary revolving patterns of persons where competency has historically been an issue. See the American Bar Association legal standards (2016) for diversion strategies for the individuals charged with misdemeanors who are deemed incompetent to stand trial (Criminal Justice Standard on Mental Health 7.4- 8(e)).

AB 1810 Implementation

Successful implementation of AB 1810 calls for cross-system and cross-discipline coordination and collaboration at the local and state level. Developing an AB 1810 implementation strategy and developing pre-and post- booking diversion was SIM priority area #4. SIM participants identified a path forward based on the CoCo LEAD (Antioch) model. The public defender's office is taking the lead until a governance structure for AB 1810 can be established. Part of the structure includes developing a comprehensive plan, and chartering the work of the governing committee.

Some of the questions for stakeholders to examine are as follows:

1. What entities are eligible to apply for and manage 1810 funds?
2. What information needs to be shared by whom, when and how and why?
3. What should the governance structure be including who should be on the steering committee and how will it operate.
4. Metrics and a review process needs to be established. Memorandums of Agreement should be developed to support information sharing.
5. What are other States and Counties doing to manage IST issues and populations? Some states are limiting competency restoration process for misdemeanors. Minnesota, Virginia and Georgia have the shortest misdemeanor restoration terms. In Virginia and Georgia, 45 days are allowed to restore competency (misdemeanors); if not restored, the person is released or civil commitment action is taken. In Minnesota, a misdemeanor case is dismissed after 30 days unless the prosecutor files a notice of intent.

Competency: Deflect or Divert Repeat Offenders

We encourage the justice community to think proactively about how to use deflection strategies to reduce the number of individuals involved in the justice system where there are potential concerns that competency is an issue.

- Consider using a "familiar face" triage process to deflect low-level offenders to services including a triage center, housing first and supportive housing resources and ACT; work collaboratively with Probate Court, guardianship and AOT services to improve long-term community based support.
- Stable housing is critical to individuals with high needs being successful in the community. SIM participants recognize the need to build a housing strategy.
- Consider not allowing competency to be raised in cases involving a misdemeanor offense. Instead divert to services.
- Consider convening a working group to review the current state of competency and competency restoration, including frequency of raised competency over the past several years, type of charges, evaluation/restoration outcomes, and individual information including mental health and substance use history/treatment, housing status, insurance status, and natural supports, if known.

In addition to the threshold of danger to self or others, some state laws support placing an individual on a mental health hold when gravely disabled. Contra Costa NAMI has created a *Survival Guide* and form that family and providers can use to document an individual's behaviors and be used to build the case for grave disability. Improve coordination among stakeholders to increase efficacy of the *Survival Guide.*

- *Survival Guide: A Practical Plan for Supporting a Loved One with a Mental Illness* (PDF)
- *Cover Letter for Family Information Forms (AB 1424) and Authorization for Verbal Release of Information Form* (PDF)

The American Academy of Psychiatry and Law has created guidelines for competency evaluation. Stakeholder meetings from the local jurisdiction and the state to focus on this population can be helpful. Outpatient competency-related programs can also be considered.

Competency Restoration: Nationally, (Zapf and Roesch, 2011) research shows 75-90% of incompetent but restorable defendants are restored, generally, within 6 months of restoration efforts. 13-01-1901 Zapf Standard Protocols for Tx to Restore Competency.pdf Zapf, P. (2013). *Standardizing Protocols for Treatment to Restore Competency to Stand Trial: Interventions and Clinically Appropriate Time Periods* (Document No. 13-01-1901). Olympia: Washington State Institute for Public Policy.

GAINS Center (2007) Restoration Stage considerations, authored by Dr. Debra Pinals:

- Utilization Management of restoration beds – suitability for community or jail-based restoration, prompt return to court upon restoration, capacity to transfer between levels of care as needed during restoration
- Standardization across settings, reasonable statutory timeframes for restoration, jail and community-based restoration
    - Group learning Format (Noffsinger, 2001; Mossman et al., 2007)

- Education, anxiety reduction, guest lectures, mock trials, video modules, post-restoration module, current legal events.
- Potential new methodologies: Cognitive Remediation Strategies – Attention, memory, reasoning and executive functioning (Schwalbe, E., and Medalia. A. 2007)
    - The Slater Method (Wall et al., 2003), Restoration for defendants with intellectual disability. Inpatient and outpatient versions utilizing phases that build on knowledge, understanding and repetition

Restoration practices and settings vary from most restrictive inpatient, usually at a state mental health hospital or jail-based, to community-based outpatient. According to the National Judicial College, the following practices are suggested:

- Psychotropic Medication: *Sell v. United States*, 539 U.S.166 (2003) identifies conditions under which antipsychotic drugs can be administered against a defendant's wishes for the purpose of restoring competency but only in rare, limited circumstances. *Washington v. Harper,* 494 U.S 210 (1990) authorizes the involuntary medication of inmates who are dangerous to themselves or others and cannot give informed consent by use of an internal administrative process. Additional, inter-institutional medication challenges include sharing formulary information, access to and maintenance on medications once stabilized; restoration education to prescribers and medication consistency in the community.
- Frequent Status Updates to the Court, and/or Assigned Case Managers: Forensically trained case managers who access services, track progress and update court.
    - Establish protocols that preset or advance the return court date within 24 hours on a misdemeanor and 10 days for a felony.
- Forensic Telehealth –Secure video conferencing during restoration (e.g. Wisconsin); Videoconferencing for "Sell" hearings (e.g. Texas and Nevada).
- Restoration settings from most restrictive to least include: Inpatient usually at a State Mental Health Hospital, Jail Based, and Community-based Outpatient. Considerations, at the very least should include the level, type/nature of the offense (e.g., violent felony vs quality of life), patient/defendant safety related concerns for self and others, staffing and expertise of evaluators and restoration services; access to appropriate medications and is the setting conducive to restoration?
    - Outpatient Community Restoration (OPCR): WJP-5-228 Outpatient Comp Restoration.pdf; *Lookin' for beds in all the wrong places: Outpatient competency restoration as a promising approach to modern challenges;* Gowensmith, W. Neil, Frost, Lynda E., Speelman, Danielle W.,Therson, Danielle E. Psychology, Public Policy, and Law, Vol 22(3), Aug 2016, 293-305 APA PsycNET. Also see the *SAMHSA's GAINS Center's Quick Fixes for Effectively Dealing with Persons Found Incompetent to Stand Trial (2007).*
        - Often used for patients/defendants with lower level, non-violent cases
        - Housing stability and ability to pay is a consideration in some locations
        - Generally stable on medication or willing to accept medication

    - Mental Health Courts may have a "Competency Court" docket attached that is associated with OPCR
- Jail-based Competency Restoration(JBCR): Jail based Comp Restor.pdf; RISE Jail based programs A-7-Restoring-Individuals-Safely-and-Effectively-(RISE).pdf; RISE program at Arapahoe County, CO Detention Center.
- Dr. Reena Kapoor, MD, explores the question of impact of the setting on restoration in her Commentary: Jail-based competency restoration (2011). http://www.correctcarers.com/rise/ Some of the issues surrounding JBCR are: Will it increase the number of persons in jail? Is there a racial/ethnic or socio-economic issue? Does the setting impact competency restoration? Doe it let the state off the hook? Will it prevent us from taking a hard look at current practices that need to be addressed?

Additional competency resources and information:

- Florida has developed a Competency Restoration Kit: CompKit slidex.tips florida-state-hospital-compkit.pdf.
- There a few articles on long-term restoration; attached is one from the Journal of the American Academy of Psychiatry and the Law (JAAPL) JAAPL Long Term Competence Restoration Rates.pdf
- Legacy of Jackson v. Indiana How Reasonable has Become Unreasonable.pdf
- Trueblood v Washington State Joint Motion for Preliminary Approval of Settlement Agreement Exhibit A, Case 2:14-cv-01178-MJP Document 584-1 Filed 08/16/18

RECOMMENDATION # 9

REVIEW AND ADDRESS PROBLEM-SOLVING COURT CRITERIA TO ALIGN WITH NATIONAL BEST PRACTICE STANDARDS

Problem-solving courts are an integral diversion strategy that should target high risk and high needs populations. They can provide access to treatment, encourage treatment engagement and reduce recidivism. The county has several problem-solving courts all with very limited eligibility criteria. Consider a routine review and evaluation of the problem-solving courts including: eligibility criteria; population demographics of who is included, screened out, or determined to be ineligible; completion criteria and rates of completion by population demographics; client costs for involvement; technical violations; use of graduated incentives and sanctions; completion rates and recidivism for all problem-solving courts.

RECOMMENDATIONS FOR INTERCEPT 4 AND INTERCEPT 5

RECOMMENDATION # 10

INCREASE EQUITY AND ACCESS TO SERVICES REGARDLESS OF AB 109 FUNDING.

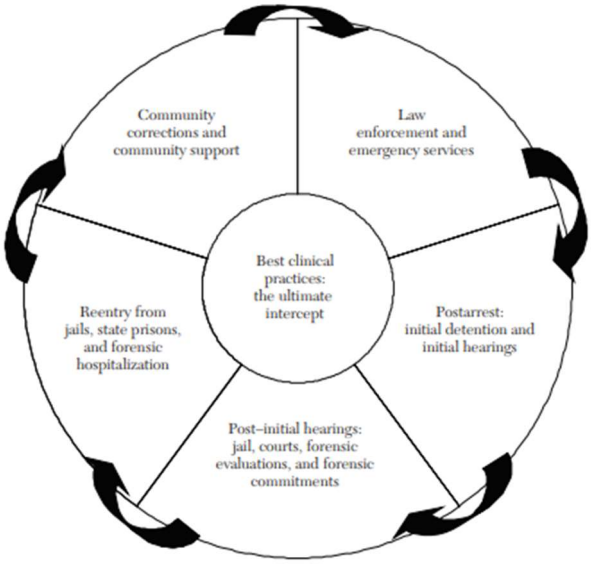
Workshop participants and the Contra Costa County Public Safety Realignment Annual Reports call out the need for improved access to services regardless if the individual is AB 109 eligible. It is our understanding that the Contra Costa County leadership recognizes this need and is working toward access to services for high needs individuals regardless of AB 109 funding.

- Attention should be given to provider capacity and performance.
- Review policies and provide equal access to incentives for participation and completion of groups, cognitive classes, treatment, etc. regardless of the funding stream.
- Non-AB 109 client access to residential treatment needs to be reviewed.
- Information-sharing with the courts regarding who is eligible for enhanced services and supervision under AB 109 should be reviewed and improved so that outcome analysis can improve.
- Increase the capacity of agencies to meet the needs of individuals with co-occurring mental and substance use disorders.
- Access, capacity, and location of opioid use disorder treatment should be reviewed.

RECOMMENDATION # 11

IMPROVE JAIL-BASED SERVICES AND TRANSITION PLANNING TO REDUCE RECIDIVISM AND IMPROVE HEALTH AND OTHER OUTCOMES FOR DETAINED OR JAILED INDIVIDUALS

Public safety and public health outcomes can be improved by providing in-jail services, transition planning and coordinated continuity of care of inmates with mental and substance use disorders. The terms “transition” and “reentry” are used interchangeably in this recommendation. It may be helpful to think of jail services and reentry in terms of a “hub-and spoke” model where the jail is the *hub* and responsible for specific actions such as identification of needs, care that increases stabilization, and coordination with *spokes* or strategies for continuation of care and access to services in the community. In addition, it is helpful to think about the intercepts as a circle rather than a linear model with resources in Intercepts 0 and 1, and 4 and 5 being interchangeable and interdependent.



Sequential Intercept Model as a Revolving Door
(Munetz & Griffin, 2006)

Therefore, this recommendation is intertwined with several other recommendations.

Specific Reentry and Transition Planning Items

- Medications at Release: a) provide inmates with at least a weeks' worth of psychotropic medication (some may not be appropriate) or a paid prescription and location where it can be filled; b) Educate on how to administer and provide Narcan (Naloxone) at release for opioid dependent individuals; c) Have posters, pamphlets and videos in the jail visitation and booking on how to administer Narcan.
- Use a standardized reentry need assessment tool (GAINS Reentry Checklist).
- Develop a multi-party, cross discipline release of information with opt-out rather than opt-in language.
- Increase probation response to mental health needs. Colorado Probation uses a brief mental health screen.
- Sort the jail population by risk to reoffend and increase jail-based programming for medium-high and high-risk individuals.
- Improve transportation, coordination, and access to services.
    - Use of Uber Health may be one possible solution.
    - Map current provider resources, hours of operation, criteria to participate, costs, number of persons served, etc.
- Maximize co-location/one-stop services and centralizing resources across the county. Use existing resources such as a triage center or the integrated care clinic.
- Inventory housing and build a housing continuum.

- Survey or hold focus groups with probationers, family members and providers to understand issues and how to improve coordinated release from jail.
- Map out the current communication (staff roles, documents, consent to release information forms, process, hours of operation, etc.) between the jail, probation, parole and community providers. Review and adjust release times to improve the likelihood that services will be open at the time of release. Make adjustments. Use "opt-out" rather than "opt-in" language on the client release of information.
- Improve universal screening of mental health, substance use disorders, cognitive impairment including traumatic brain injury and Intellectual Developmental Disabilities.
- Develop a video of programs and services that runs in the jail booking, library, dorms, etc.
- Develop a standard volunteer/provider training to provide services in the jail and letter of application to enter the jail. Create a standardized approval and review process. Convene jail-community provider meetings to discuss challenges and improve coordination.
- Track data of those who return to jail with reoccurring primary and behavioral health issues. Provide reentry, health and non-health services to inmates regardless if they are a health care member. Create specific education and intervention strategies to address re-occurring population needs.
- Review the Washington State "Pathways HUB" model in addition to the current reentry health strategies.

Some of the most challenging aspects of implementing "jail-to-community transition" is programming space, safety and contraband, access to populations, movement within the facility and availability of time/slots to deliver services. Often, secure facilities use inmate resources to operate the facility which limits "programming time". In addition, inmates in facility housing pods, units or modules are often mixed or based on classification systems that don't mirror programming needs; moving inmates requires staff and can compromise safety in the facility.

Various models are used to deliver jail transition services. Some facilities have dedicated jail staff, others use community-based providers who reach into the jail. Some facilities allow only a very limited number of non-sheriff department staff into the facility. Ideally, to build continuity of services, the same providers who provide services in jail, continue services into the community. At the very least, there should be a coordinated and streamlined process. Appropriately, most jails use volunteers to deliver some services, however, it can result in inconsistent delivery and availability of services. Generally, evidence-based programs require trained and dedicated staff to increase program fidelity.

Ideally, planning for reentry should begin as soon as the individual is incarcerated and should include risk and need assessments, targeted services in the jail, and reentry planning to meet core needs during the first day, week, month, and up to 6-9 months. The following two documents provide comprehensive information about jail to community transition:

- Guidelines for Successful Transition of People with Mental or Substance Use Disorders from Jail and Prison: Implementation Guide publication provides information reentry for 'high

needs" populations. It includes the APIC guidelines of "Assess-Plan-Identify-Coordinate". The guidelines include: Conduct Universal Screening, Follow up positive screens with comprehensive assessments, Design individual treatment plans, Develop collaborative responses that match need and risk, Identify interventions in transition planning practices, Establish policies to facilitate continuity of care, Coordinate justice system and community services, Share information to advance cross-system goals and Encourage cross training.

- The Urban Institute and National Institute of Corrections has developed the Transition from Jail to Community (TJC) Initiative and online learning toolkit. Both of these documents include an excellent framework for developing comprehensive reentry policies and practices.

Improve Access to Medicaid and Social Security Benefits

The jail health provider has been very proactive about ensuring access to health benefits. The following information is included as an outline of this issue and to identify some additional areas of work.

Medicaid suspension or cancellation while incarcerated is a barrier to recovery and stabilization. The Affordable Care Act has expanded access to Medicaid, yet communities across the country have lagged in enrolling justice involved individuals in Medicaid. A more aggressive and coordinated approach is needed to insure Medicaid benefits essential to continuing prescribed medication and accessing critical behavioral health services. Don't assume that populations are being identified - often individuals in the justice system who present with high levels of substance use disorder have co-occurring mental health or cognitive impairment.

Consider the following:

- Provide jail-based or diversion health personnel with access to the local Medicaid database to promptly identify enrollees and insure continuation of coverage.
- Social Security Outreach Access and Recovery training (SOAR) can improve successful enrollments and reduce approval times from months to as soon as 60 days. Work with your existing SOAR team and SSI/SSDI to ensure applications are completed for persons who are likely eligible and would benefit from SSI/SSDI.
- Provide a cross-discipline training on SSI/SSDI, including documentation needed for a SSI/SSDI application.
- Make sure individuals are asked what insurance they have: Medicaid, SSI/ SSDI, private, none. Review intake forms to see if that information is already collected during jail booking/medical screening and hospitals, BHD, and during CART and Mobile Crisis contacts.
- Enroll individuals who do not have insurance in Medicaid, as eligible. Everyone who has been identified as a high utilizer should be considered for SSI/SSDI application.
- Continue to address health needs of clients post release including "health home" models. Review current partnerships and make sure the jail, health care provider, and health center partnerships are maximizing what a Health Center (under Section 330, a.k.a. Federally Qualified Health Centers or FQHC) can offer.

Improve Inmate/Patient Stabilization through Medication Consistency

- Review the jail, local health center (FQHCs), community mental health, state corrections, and state hospital medication formularies to promote and coordinate medication consistency, and release with medications and an appointment to a mental health care provider.
- Ideally, inmates/patients are released with up to four weeks of medication based on ability of a new, community-based appointment date. Reentry from jail is an opportune time to create continuity of care and connect people with community-based services. A warm-hand off to the next appointment can be supported by utilizing peer support.
- Colorado has developed a state-wide criminal justice formulary across jails, community mental health, state hospital, Department of Corrections, and state Medicaid. They are willing to share the formulary and process. In addition, work with existing resources to reduce costs of purchasing medication and improve long-term health outcomes.
    - Confirm that the county, including the jail medical provider is a member of the Group Purchasing Organization, Minnesota Multistate Contracting Alliance for Pharmacy (MMCAP) to reduce the cost of medications.
    - Work with local hospitals and Federally Qualified Health Care (FQHC) centers to create primary, mental health and substance use care continuity.

<u>Broader Reentry and Transition Planning Committee</u>

Diverse stakeholders including jail administrators, volunteers, and providers representing employment, housing, education, veteran services, courts, prosecutors, public defenders, pre-trial services, human services, substance use, mental and primary health – including local representatives from a local Federally Qualified Healthcare Center (FQHC) are all important in designing and delivering reentry services. County or state *Social Security Outreach Access and Recovery (SOAR)* providers, managers of Assisted Outpatient Treatment and Wellness Recovery Action Plans (WRAP) facilitators can all be very helpful with overall coordination of mental health services. In addition, it is imperatives to include previously incarcerated individuals and recovery peers, and/or representatives from an inmate council, and inmate family members as members of the group.

Some of the core areas of work may include, but are not limited to:

- Design and improve coordination and access to comprehensive and coordinated jail-to community reentry services.
    - Inventory current policies and practices. Literally walk through the process from booking to release to identify resources and gaps.
    - Review the APIC and TJC documents identified above.
    - Inventory and strategically address the unintended or "collateral consequences" of jail and prison.
    - Review current programming staffing levels, community provider services and transition of care from one facility to another and from facilities to the community.
- Work on broad, community based issues:
    - Access to fair housing and employment through "ban the box" efforts

- Release with identification and referrals to specific services
- Educating employers on how to read and understand criminal histories.
- According to state law, ensure voting rights for incarcerated persons.
- Release times and transportation are often issues that need to be addressed.

- Increase continuity of health care:
  - Whenever possible reduce length of stay for persons SSI/SSDI to under 30 days so they do not lose this benefit.
  - Assist in the process of applying for Federal entitlements such as SSI/SSDI. SOAR providers should be used to assist with this process.
  - Ensure identification and access to veteran services. Most jails have an assigned Veteran Justice Outreach (VJO) person.
  - Ensure identification and initial enrollment of persons eligible for Medicaid.
  - Increase access to Wellness Recovery Action Plan (WRAP) plan facilitation.
  - Create a way to notify community based providers of who is in jail. Many jails simply send a daily spreadsheet to providers.

Larger issues to address by specific stakeholder groups, not necessarily the broader reentry committee identified above.

- Review the use of and availability of programming space within the jail and explore developing specific behavioral health units for mental health and substance use and program staffing as part of the plan. Some of the county jails with dedicated mental health, substance use disorder or reentry programming include jails in Denver, CO; Allegheny County, PA; Henrico County, VA; and San Diego County, CA. Talk with Denver County Jail for ideas on operating dedicated mental health, and substance use treatment units as well as mental health discharge planning and navigation from jail to community. Shane.Grannum@denvergov.org; Rhuerter@prainc.com
- Review current health care provider contracts. Review the medication formulary, access and availability of services and ensure universal screening.
- Explore models that integrate reentry programing with primary medical, behavioral health, employment, and justice system support. Programs such as the Transitions Clinic can help provide an integrated, whole health approach. Yuma County (AZ), Bexar County (TX) Bexar County, and Bernalillo County (NM) all have creative approaches to integrated justice and health care.
- Work in partnership with the municipal detention/holding facilities, county jail, and department of corrections to create a mental health unit that can serve serious offenders with serious mental illnesses.

Screening

"Universal screening" is key to sorting populations by risk and needs. Generally, detention and jail facilities have a medical/health provider that conducts basic health and some mental health screens.

For the greater, general population, transition planning services should be offered to the medium-high risk sentenced population prior to release from the jail. Consider the using risk/need assessment tools adopted by the county to identify and sort the population. Some of the common tools used include the: Level of Service Inventory- SV (LSI, there are several versions, SV stands for short version), Compas, Ohio Risk Assessment System (ORAS), Women's Risk Need Assessment (WRNA), Service Planning Instrument for Women (SPIN-W), etc. Or a simple "risk-based" tool such as the Proxy screening tool to sort jail populations by risk level and prioritize for jail reentry services.

Most jails report having over 25% of their population living with mental illness and over 60% with co-occurring mental health and substance use disorders. Recognizing the challenges of the jail booking process, short screening tools are critical to quickly identify needs. Many screening tools such as the Brief Jail Mental Health Screen, are in the public domain. Additional brief mental health screens include the: Correctional Mental Health Screen and Mental Health Screening Form III.

All too often, screening for substance use disorders and cognitive impairment is overlooked resulting in persons with these high needs left without services that can begin to address their needs. Refer to the comprehensive review of screening and assessment instruments for justice-involved individuals published by SAMHSA in 2016.

RECOMMENDATION # 12

CONTINUE TO BUILD PROBATION BEST PRACTICES, TRAINING, AND COORDINATION TO REDUCE TECHNICAL VIOLATIONS AND PROBATION REVOCATIONS.

Probation is in a pivotal position within the justice system. How probation officers are trained, supported and connected to community resources plays a critical role in client outcomes and stabilization during and post probation supervision. Contra Costa County Probation practices benefit from, and are challenged by, the regulations of AB 109 and Prop 47.

Probation and services defined by California Laws such as AB 109, Proposition 47 receive screening and access to services. Non AB 109 and Prop 47 may not receive the same access to services. In addition, Court Probation is a significant group who is unlikely to receive screening and access to services. At the very least, a data pull of persons under Court Probation should be matched with PES, ED, Jail Detention Health, and Detox data. Depending on the outcome of the data overlay, strategies should be developed to meet this populations needs.

Following are best practices to consider, some of which are already existing in the County.

- Routinely review data and appropriateness of graduated sanctions and incentives. Routinely train officers and the court (judicial officers, prosecutors and defense) on behavioral health and developmental disabilities, proximal and distal sanctions and incentives and department

policies, response polices to violations and options that consider the risk and needs of individuals.

- In addition to traditional risk/need assessments, ensure there is systematic screening for mental health, intellectual disabilities, traumatic brain injury and substance use disorders. Referrals should follow the assessment.
- Transportation to various treatment and intervention services can be challenging. Consider coordination/co-located services, scheduling and transportation options to improve probationer compliance.
- Inventory, create standards of delivery and routinely review in-house and outsourced probation programs and services. Create an evaluation process to be completed by probationers. Terminate contracts with ineffective providers.
- Develop behavioral health definitions, probation officer training and supervision standards to improve supervision of individuals living with mental health and substance use disorders.
- Consider creating a policy for screening and working with persons living with mental health disorders. Colorado has created a screening tool for probation (see embedded tool under Recommendation 9.
- Consider using a female-based assessment tool such as the Women's Risk Need Assessment or the Service Planning Instrument for Women.
- Address probation revocations and technical violations, especially those of persons with behavioral health issues:
  - Reduce caseload size, increase training, support and supervision of probation staff in managing individuals with mental health needs,
  - Provide direct access to mental health clinical services in the probation unit and in court.
  - Explore current laws such as whether the court can order an inmate to be put on involuntary medication unless the provider does not agree the medication needs to be involuntary.
- Track data and routinely review cases and supervision models of behavioral health clients.
  - Define client stabilization measures such as medication compliance, time with pro-social and productive supports such as recovery coaches and peers and, employment; housing stability, self-care/grooming, treatment compliance, etc.
  - Track stabilization, technical violations and response including use of graduated incentives and sanctions; revocations resulting in jail and length of stay.
  - Access to and level of engagement in treatment services; engagement with peers and other natural supports.
- Consider a specialized behavioral health team, working directly with county mental health provide support:
  - Improve client outcomes through community-based "day reporting". High needs clients are often out of compliance with probation requirements, resulting in technical violations. A community based, reporting opportunity staffed by recovery peers and clinical services can improve compliance and outcomes. See Denver for a model.
  - Have a clinician work from the probation office to help provide on-site support
  - Meet with clients at a mental health center or other community-based setting to improve compliance and reduce client transportation issues.

    - Ensure clients are referred to appropriate providers for FACT – Forensic Assertive Community Treatment, and that a probation officer is part of the team.
- Screening, data collection
    - Address graduated sanctions and incentives, in particular for race and ethnicity and behavioral health, including policies, uniformity and options. Response polices (sanctions and incentives) should consider the risk and needs of individuals.
    - As identified above, implement systematic screening for mental health.
    - Work to coordinate services and minimize transportation challenges to improve individual's connection with available services.

RECOMMENDATION #13

WORK WITH CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS) AND THE STATE OF CALIFORNIA TO ESTABLISH AN AGREEMENT THAT ALLOWS PAROLEES TO ACCESS MEDI-CAL AND RECEIVE COUNTY SERVICES

Work with the State of California to allow parolees to access Medi-Cal. Colorado went through a similar issue and starting making its case for inclusion of persons under parole in 2009. Attached is information regarding Colorado approach and a favorable decision from CMS.

- *Policy Statement on Medicaid Eligibility of Individuals Residing in Community Corrections Facilities (or "Halfway Houses")* (PDF)
- *Letter to the Centers for Medicare and Medicaid Services on Individuals Residing in Colorado Community Corrections Facilities are Eligible for Health Care Services Funded with Federal Financial Protection* (PDF)

RESOURCES

Competency Evaluation and Restoration

- SAMHSA's GAINS Center. *Quick Fixes for Effectively Dealing with Persons Found Incompetent to Stand Trial.*
- Finkle, M., Kurth, R., Cadle, C., and Mullan, J. (2009) Competency Courts: A Creative Solution for Restoring Competency to the Competency Process. *Behavioral Science and the Law, 27,* 767-786.

Crisis Care, Crisis Response, and Law Enforcement

- Substance Abuse and Mental Health Services Administration. *Crisis Services: Effectiveness, Cost-Effectiveness, and Funding Strategies.*
- International Association of Chiefs of Police. *Building Safer Communities: Improving Police Responses to Persons with Mental Illness*.
- Suicide Prevention Resource Center. *The Role of Law Enforcement Officers in Preventing Suicide*.
- Saskatchewan Building Partnerships to Reduce Crime. *The Hub and COR Model.*
- Bureau of Justice Assistance. *Engaging Law Enforcement in Opioid Overdose Response: Frequently Asked Questions.*
- International Association of Chiefs of Police. Improving Police Response to Persons Affected by Mental Illness: Report from March 2016 IACP Symposium.
- International Association of Chiefs of Police. One Mind Campaign.

- Optum. In Salt Lake County, Optum Enhances Jail Diversion Initiatives with Effective Crisis Programs.
- The Case Assessment Management Program is a joint effort of the Los Angeles Department of Mental Health and the Los Angeles Police Department to provide effective follow-up and management of selected referrals involving high users of emergency services, abusers of the 911 system, and individuals at high risk of death or injury to themselves.
- National Association of Counties. Crisis Care Services for Counties: Preventing Individuals with Mental Illnesses from Entering Local Corrections Systems.
- CIT International.

Data Analysis and Matching

- Data-Driven Justice Initiative. Data-Driven Justice Playbook: How to Develop a System of Diversion.
- Urban Institute. *Justice Reinvestment at the Local Level Planning and Implementation Guide.*
- The Council of State Governments Justice Center. *Ten-Step Guide to Transforming Probation Departments to Reduce Recidivism.*
- New Orleans Health Department. *New Orleans Mental Health Dashboard.*
- Pennsylvania Commission on Crime and Delinquency. *Criminal Justice Advisory Board Data Dashboards.*
- Corporation for Supportive Housing. *Jail Data Link Frequent Users: A Data Matching Initiative in Illinois* (See Appendix 3)
- Vera Institute of Justice. *Closing the Gap: Using Criminal Justice and Public Health Data to Improve Identification of Mental Illness.*

Housing

- Alliance for Health Reform. *The Connection Between Health and Housing: The Evidence and Policy Landscape.*

- Economic Roundtable. *Getting Home: Outcomes from Housing High Cost Homeless Hospital Patients.*
- 100,000 Homes. *Housing First Self-Assessment.*
- Urban Institute. *Supportive Housing for Returning Prisoners: Outcomes and Impacts of the Returning Home-Ohio Pilot Project.*
- Corporation for Supportive Housing. *NYC FUSE – Evaluation Findings.*
- Corporation for Supportive Housing. Housing is the Best Medicine: Supportive Housing and the Social Determinants of Health.
- Corporation for Supportive Housing. Guide to the FUSE Model.

Information Sharing

- American Probation and Parole Association. *Corrections and Reentry: Protected Health Information Privacy Framework for Information Sharing*.
- Legal Action Center. *Sample Consent Forms for Release of Substance Use Disorder Patient Records.*
- Council of State Governments Justice Center. Information Sharing in Criminal Justice-Mental Health Collaborations: Working with HIPAA and Other Privacy Laws.

Jail Inmate Information

- NAMI California. *Arrested Guides and Inmate Medication Forms*.

Medication Assisted Treatment (MAT)

- American Society of Addiction Medicine. *The National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use.*
- American Society of Addiction Medicine. *Advancing Access to Addiction Medications.*
- Substance Abuse and Mental Health Services Administration. *Federal Guidelines for Opioid Treatment Programs.*
- Substance Abuse and Mental Health Services Administration. *Medication for the Treatment of Alcohol Use Disorder: A Brief Guide.*

- Substance Abuse and Mental Health Services Administration. *Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction (Treatment Improvement Protocol 40)*.
- Substance Abuse and Mental Health Services Administration. *Clinical Use of Extended Release Injectable Naltrexone in the Treatment of Opioid Use Disorder: A Brief Guide*.

Mental Health First Aid

- Mental Health First Aid.
- Illinois General Assembly. *Public Act 098-0195: Illinois Mental Health First Aid Training Act*.
- Pennsylvania Mental Health and Justice Center of Excellence. *City of Philadelphia Mental Health First Aid Initiative*.

Peers

- SAMHSA's GAINS Center. *Involving Peers in Criminal Justice and Problem-Solving Collaboratives*.
- SAMHSA's GAINS Center. *Overcoming Legal Impediments to Hiring Forensic Peer Specialists*.
- NAMI California. *Inmate Medication Information Forms*.
- Keya House.
- Lincoln Police Department Referral Program.

Pretrial Diversion

- CSG Justice Center. Improving Responses to People with Mental Illness at the Pretrial State: Essential Elements.
- National Resource Center on Justice Involved Women. Building Gender Informed Practices at the Pretrial Stage.
- Laura and John Arnold Foundation. The Hidden Costs of Pretrial Diversion.

Procedural Justice

- Legal Aid Society. *Manhattan Arraignment Diversion Program*.

- Center for Alternative Sentencing and Employment Services. *Transitional Case Management for Reducing Recidivism of Individuals with Mental Disorders and Multiple Misdemeanors.*
- Hawaii Opportunity Probation with Enforcement (HOPE). *Overview*.
- American Bar Association. Criminal Justice Standards on Mental Health.

Reentry

- SAMHSA's GAINS Center. *Guidelines for the Successful Transition of People with Behavioral Health Disorders from Jail and Prison*.
- Community Oriented Correctional Health Services. *Technology and Continuity of Care: Connecting Justice and Health: Nine Case Studies*.
- The Council of State Governments. National Reentry Resource Center.
- Bureau of Justice Assistance. Center for Program Evaluation and Performance Management.
- Washington State Institute of Public Policy. *What Works and What Does Not?*
- Washington State Institute of Public Policy. *Predicting Criminal Recidivism: A Systematic Review of Offender Risk Assessments in Washington State.*

Screening and Assessment

- Center for Court Innovation. Digest of Evidence-Based Assessment Tools.
- Steadman, H.J., Scott, J.E., Osher, F., Agnese, T.K., and Robbins, P.C. (2005). Validation of the Brief Jail Mental Health Screen. Psychiatric Services, 56, 816-822.
- The Stepping Up Initiative. (2017). Reducing the Number of People with Mental Illnesses in Jail: Six Questions County Leaders Need to Ask.
- The Stepping Up Initiative. (2017). Reducing the Number of People with Mental Illnesses in Jail: Six Questions County Leaders Need to Ask.

Sequential Intercept Model

- 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*, 544-549.
- Griffin, P.A., Heilbrun, K., Mulvey, E.P., DeMatteo, D., and Schubert, C.A. (2015). *The Sequential Intercept Model and Criminal Justice*. New York: Oxford University Press.
- SAMHSA's GAINS Center. *Developing a Comprehensive Plan for Behavioral Health and Criminal Justice Collaboration: The Sequential Intercept Model*.

SSI/SSDI Outreach, Access, and Recovery (SOAR)

Increasing efforts to enroll justice-involved persons with behavioral disorders in the Supplement Security Income and the Social Security Disability Insurance programs can be accomplished through utilization of SSI/SSDI Outreach, Access, and Recovery (SOAR) trained staff. Enrollment in SSI/SSDI not only provides automatic Medicaid or Medicare in many states, but also provides monthly income sufficient to access housing programs.

- Information regarding SOAR for justice-involved persons.
- The online SOAR training portal.

Transition-Aged Youth

- National Institute of Justice. Environmental Scan of Developmentally Appropriate Criminal Justice Responses to Justice-Involved Young Adults.
- Harvard Kennedy School Malcolm Weiner Center for Social Policy. Public Safety and Emerging Adults in Connecticut: Providing Effective and Developmentally Appropriate Responses for Youth Under Age 21 Executive Summary and Recommendations.
- Roca, Inc. Intervention Program for Young Adults.
- University of Massachusetts Medical School. Transitions RTC for Youth and Young Adults.

Trauma-Informed Care

- SAMHSA, SAMHSA's National Center on Trauma-Informed Care, and SAMHSA's GAINS Center. *Essential Components of Trauma Informed Judicial Practice.*
- SAMHSA's GAINS Center. *Trauma Specific Interventions for Justice-Involved Individuals.*
- SAMHSA. *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach.*

- National Resource Center on Justice-Involved Women. *Jail Tip Sheets on Justice-Involved Women*.

Veterans

- SAMHSA's GAINS Center. *Responding to the Needs of Justice-Involved Combat Veterans with Service-Related Trauma and Mental Health Conditions.*
- Justice for Vets. *Ten Key Components of Veterans Treatment Courts.*

APPENDICES

Appendix 1	Sequential Intercept Mapping Workshop Participant List
Appendix 2	Texas Department of State Health Services. *Mental Health Substance Abuse Crisis Services Redesign Brief.*
Appendix 3	Corporation for Supportive Housing. *Jail Data Link Frequent Users: A Data Matching Initiative in Illinois.*
Appendix 4	Dennis, D., Ware, D., and Steadman, H.J. (2014). Best Practices for Increasing Access to SSI and SSDI on Exit from Criminal Justice Settings. *Psychiatric Services, 65,* 1081-1083.
Appendix 5	100,000 Homes/Center for Urban Community Services. *Housing First Self-Assessment: Assess and Align Your Program and Community with a Housing First Approach.*
Appendix 6	Remington, A.A. (2016). *Skyping During a Crisis? Telehealth is a 24/7 Crisis Connection.*