Diversion

Diversion: Overcoming Barriers to Build Capacity for Effective Interventions

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

Investigate: Study the Problem and Assess Challenges

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Finding: Know the problem that needs fixing when building capacity

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

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

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

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

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

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

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

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

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

Finding: Provide guidance and confidence to support data-sharing

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

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

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

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

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

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

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

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

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

Identify: Recognize and Examine Existing Opportunities

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

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

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

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

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

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

California Whole Person Care Pilot Applications

Figure 2

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

Source: Department of Health Care Services, November 2016

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

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

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

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

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

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

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

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

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

Source: Department of Health Care Services, November 2016

*indicates that Implementation Plan is only available in draft form

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Text Box D

No Place Like Home

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

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

Key features of the program:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Text Box E

Investment in Mental Wellness (IMHW) Act of 2013

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

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

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

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

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

Text Box F

21st Century Cures Act

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

Medicaid Coverage, Delivery and Administrative Changes:

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

Mental Health Parity and Protected Health Information (PHI):

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

Mental Health Authorizations:

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

Text Box F (cont.)

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

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

For more information and analysis visit:

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

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

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

Text Box G

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

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

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

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

For more information on the MIOCR Grant Program visit

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

Text Box H

Proposition 47: Safe Neighborhoods and Schools Act

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

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

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

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

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

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

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

For more information on the Safe Neighborhoods and Schools Act visit:
http://bscc.ca.gov/s_bsccprop47.php.

For the full text of AB 1056, visit:
http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520160AB1056.

Text Box I

Law Enforcement Assisted Diversion (LEAD) Grant Program

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

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

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

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

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

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

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

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

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

Santa Clara County and the Jail Diversion and Behavioral Health Subcommittee

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

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

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

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

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

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

Urgent Care Centers (UCCs)

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

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

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

Additional services on the campus are expansive including:

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

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

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

San Diego County's Project One for All

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

Los Angeles County's Flexible Housing Pool

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

Miami-Dade County Pre and Post Booking Diversion

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

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

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

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

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

Peer Navigator and Support Programs

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

Re-entry Pre and Post Release Programs

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

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

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