



Together We Can

REDUCING CRIMINAL JUSTICE INVOLVEMENT FOR PEOPLE
WITH MENTAL ILLNESS

**SECOND DRAFT TO THE COMMISSION DURING ITS MEETING ON
OCTOBER 26, 2017**

**FIRST DRAFT APPROVED WITH REVISIONS BY THE SUBCOMMITTEE ON
SEPTEMBER 29, 2017 SUBCOMMITTEE MEETING**



ABOUT THE MENTAL HEALTH SERVICES OVERSIGHT AND ACCOUNTABILITY COMMISSION

The Mental Health Services Oversight and Accountability Commission, an independent state agency, was created in 2004 by voter-approved Proposition 63, the Mental Health Services Act. The 16-member Commission is composed of one Senator, one Assemblymember, the State Attorney General, the State Superintendent of Public Instruction, and 12 public members appointed by the Governor. By law, the Governor appointees are people who represent different sectors of society including individuals with mental health needs, their family members, law enforcement, education, labor, business, and the mental health profession.

California voters created the Commission to provide oversight, accountability and leadership to guide the transformation of the California mental health system. The Commission fulfills this charge by advising the Governor and Legislature, conducting research and evaluation, administering mental health triage personnel grants, and reviewing and approving county innovation projects.

Other Commission responsibilities include:

- Ensuring public mental health funds are spent in the most cost-effective manner and that services are provided in accordance with recommended best practices
- Developing strategies to eliminate the stigma associated with mental illness
- Ensuring that the perspectives of California’s diverse communities, as well as people suffering from mental illness and their families, are included in all Commission deliberations and actions
- Undertaking special research projects to document problems with California’s mental health care delivery system and produce recommendations for reform

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October 12, 2017

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One of the greatest public policy failures of our time has been the dismantling of our state mental health care institutions without the provision of adequate community-based treatment in their stead. As a result, we have seen marked increases in severely mentally ill persons – often suffering from co-occurring substance abuse disorders and homelessness – coming into contact with law enforcement. These confrontations are frequently disruptive, dangerous and, sometimes, deadly. More often than not, these encounters serve as a gateway for mentally ill persons to enter the criminal justice system.

Provided here for the review of law enforcement executives, mental health leaders, county executives, members of boards of supervisors, state legislators, the governor and interested persons alike is the Final Report, Findings and Recommendations of a Sub-Committee of the State of California's Mental Health Services Oversight and Accountability Commission that looked at the intersection of mental illness and the criminal justice system. We believe this report, which we wanted to be succinct enough to be actually read and acted upon, encapsulates the problem and contains a creative and achievable plan to reduce the number of mentally ill persons entering California's jails, and a roadmap to providing better mental health care and treatment for those who must be kept in custody.

We recognize that fiscal and human resources in all forms of government are in short supply, and that in many cases they are stretched to the limit. But we have seen how communities facing similar challenges came together to solve parts of this vexing problem. Their approaches were varied, but what they had in common was a collaborative spirit of good will and a resolve to combine forces, share their resources and solve the problem collectively.

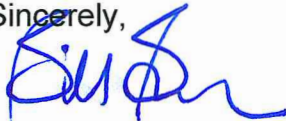
We strongly believe that now is the time to implement these recommendations. While not every county can do everything suggested in this report, we recommend taking a strong look at three priorities:

- *Collaborating and combining resources to effectively address the problem.* The Stepping Up Initiative is a proven vehicle that can help communities come together to facilitate these efforts.

-
- *Provide crisis services and other alternatives to custody for mentally ill persons.* This requires having appropriate places and/or programs that people suffering from mental illness can be diverted to.
 - *Expand jail-based and community-based restorative services for persons found Incompetent to Stand Trial (IST).* This is a state-wide problem that congests our courts and overcrowds our jails.

Lastly, I want to thank my fellow Commissioners, Committee Members and the many mental health stakeholders who provided valuable input to this project. I also want to extend my appreciation to MHSOAC Executive Director Toby Ewing and his talented staff – especially Senior Researcher Ashley Mills, whose yeoman effort on this report was at the forefront – for the hard work, collaborative spirit and positive attitudes that they invested into this worthy project. They exemplified the title of this report and the means to achieving collective success in this quest: *Together We Can.*

Sincerely,



BILL BROWN

Sheriff, Santa Barbara County & Commissioner, MHSOAC
Committee Chair

Acknowledgements

The Mental Health Services Oversight and Accountability Commission is grateful for the invaluable contributions and support it received throughout this project. From the launch of this initiative in May 2016, a wide range of people and organizations committed time and resources to produce a plan for reducing the number of people with mental health needs who enter California's criminal justice system – and better serving those who do become incarcerated.

These contributors include mental health consumers, their family members, advocates, researchers, elected officials, educators, law enforcement officials, and people from the mental health profession. This project would not have been possible without their extensive knowledge, experience, and commitment to improving the lives of one of California's most vulnerable populations.

The Commission also recognizes and thanks senior researcher and project lead Ashley Mills, whose dedication to this initiative pushed it across the finish line. Also instrumental in producing this report were contributions from Commission staff members Cynthia Burt, Wendy Desormeaux, Katherine Elliott, Ph.D., and Kayla Landry.

Although the Commission benefitted from the contributions of many individuals and organizations, the conclusions and recommendations in this report are the Commission's own.

This report is dedicated to the men and women with mental health needs who are unnecessarily caught in the criminal justice system, as well as their families and the professionals on the front lines of a national crisis.

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No one expected it – not his parents, not his brother, not his friends. One day, David (fictitious name) was a straight-A high school student who loved sports and had tons of friends. The next, a switch flipped and David was hearing voices and behaving erratically – a completely different kid. Therapists prescribed tough love, and his parents obliged. But while he managed to graduate and land a job as an EMT, David’s mental health needs intensified, and soon he was using recreational drugs to quiet the voices in his head.

Next came a suicide attempt. That opened doors to the mental health system, but help was elusive. Finally, his parents were encouraged to have David arrested, a desperate move that authorities hoped might clear a path to a treatment bed. Frantic and out of options, his family consented, but jail made everything worse. David told a psychiatrist he was contemplating suicide, a fact other inmates confirmed. And soon after, he took his own life, alone in his cell.

Executive Summary

For decades, communities have struggled with a vexing question: how to reduce the number of people with unmet mental health needs who enter the criminal justice system, at times to tragic end. Inspired by heartbreaking incidents, professionals and advocates have advanced innovative approaches and promising practices. But despite their good intentions and earnest efforts, the inmate population, violent street encounters with police, and the costs – in human and fiscal terms – continue to increase.

There is little disagreement about the need for change, or even the preferred direction of that change – in California and nationwide.

Bryan Desloge, a commissioner from Leon County, Florida, and president of the National Association of Counties, could have been speaking for county supervisors in California when he said:

“We all need to be working toward lowering the number of people in our jails and looking at our laws to identify options other than jail for low-level offenders [with mental health needs]. It’s a huge, huge crisis for our country today.”

In response to this crisis, California’s Mental Health Services Oversight and Accountability Commission in 2016 launched a review of current policies and practices and an exploration of emerging approaches. The goal was to develop an action agenda for reducing the number of, and improving outcomes for, mental health consumers involved in the criminal justice system.

Under the leadership of Commissioner and Santa Barbara County Sheriff Bill Brown, the Commission sought input from national and local leaders and convened public hearings and community forums where consumers and family members shared stories and insights alongside public officials and practitioners.

Details of the Commission’s yearlong investigation are outlined in the pages ahead. But overall, the commission concluded that California’s response must match the scale of the crisis. Californians must no longer accept the reality that a person’s unmet mental health needs too often lead to a downward spiral toward time behind bars.

While jail can be a traumatic experience for anyone, imagine the impact of incarceration on Californians with unmet mental health needs – people like David. Despite the best efforts of administrators, jails are

often crowded, chaotic, and understaffed, resulting in dangerous environments. In many cases, jails and the dedicated people who staff them also are ill-equipped to effectively manage inmates with mental health and substance use needs. Most jails in California were built to provide short-term (less than one year) custody and were never designed to hold people suffering from mental illness. Not surprisingly, interruptions in medication and other treatment are common, symptoms intensify, and profound suffering – for the incarcerated as well as their loved ones – is often the tragic result.

Release from jail should bring relief, but that is often not the case. Many people with mental health needs fail to receive transitional assistance with housing, treatment, and other community services that can help them find stable footing outside jail walls. As a result, many struggle, run afoul of the law again, and cycle back into custody. And the costs – to individuals, families, and taxpayers – multiply.

To resolve this wrenching dilemma, California must make a bold commitment. Specifically, the Commission recommends that the state undertake a concerted and coordinated effort that aligns resources and services in a strategic and sustained way to prevent people with mental health needs from getting into the criminal justice system in the first place – and effectively treating those who do.

As part of its review, the Commission took a close look at people with mental health needs in the justice system. Above all, one impression stood out: this is a group with complex and challenging needs. Frequently homeless, their lives are often complicated by longstanding physical health and mental health needs, along with chronic addictions to drugs and alcohol. Some do not believe they have a mental health need or have struggled to find appropriate care. Thus, they have difficulty with treatment – or the treatment that is available.

While recovery for many of these Californians - if not all - is possible, it often requires substantial resources and time. In a system with misaligned or inadequate resources, a jail bed is often the only solution available.

It should not take a tragedy to promote policies and practices that lead to better outcomes. Nevertheless, suicides in jails and costly lawsuits over conditions of confinement have prompted several counties to make investments and program changes to prevent incarceration where possible and provide quality in-custody care when required.

Nationally, innovative practitioners have developed effective private-public partnerships and co-located services, leveraging the expertise of those with lived experience in both mental health and criminal justice systems. The result is an inventory of promising practices that, if deployed system wide – through the management of data, integrated services, and cross-professional training – could be transformative.

The Commission's recommendations were developed through engagement with consumers, families, counties, and state agencies. In tackling this project, the Commission made a deliberate effort to model the collaboration needed to develop a shared understanding of the challenge before us and the effective responses needed to meet it.

In releasing its recommendations, the Commission acknowledges that the challenges facing California are historic, chronic, and seemingly intransigent. The problem is daunting and complex, and we may never have all the answers. Yet as the crisis grows, so does the potential for new approaches and new technologies to fuel a renewed effort.

To take reforms to a fully operational and statewide scale – to move from work arounds and “one-offs” to full system change – state and county leaders must unite to align programs and objectives, integrate services, leverage funding, and use data and other technologies to improve decisions and assess performance. Holistic, lasting change will require a sustained effort to develop the capacity and culture for continuous improvement. Just as importantly, moving forward will require candid confrontation of preconceived notions and honest assessments of whether our allocation of resources is producing the best possible results.

Criminal justice involvement can be devastating to people and their families, but it can be deadly for those living with unmet mental health needs. Reforming our approach to better serve these Californians, both in custody and in the community, won’t be easy. But failing to do so will perpetuate the tragedies that characterize our system today.

And, as many have expressed throughout this project, “It’s just the right thing to do.”

Recommendation 1

California’s mental health agencies, in partnership with law enforcement and others, should have a comprehensive, prevention-focused plan that reduces the incarceration of mental health consumers in their communities.

Too many mental health consumers, particularly those from diverse communities, end up in jail because of unmet needs and system inequities. A robust, prevention-oriented system can reduce this unnecessary harm. The commitment to diversion should continue but there also must be a focus on preventing contact with the criminal justice system. Local services should be aligned through comprehensive planning to address unmet needs before they reach the attention of law enforcement. Community-based programs and facilities must be available and accessible to support diversion.

Recommendation 2

The Board of State and Community Corrections should facilitate a collaborative effort with counties to identify, develop, and deploy services and strategies that improve outcomes for mental health consumers in jail, including universal screening for mental health needs at booking and enhanced training for custody staff.

California’s jails are not equipped to serve mental health consumers. Diversion should be prioritized but counties need more effective in-custody options to ensure they can provide appropriate and necessary services for those who cannot be diverted.

Recommendation 3

To reduce the backlog of people found incompetent to stand trial, California must maximize diversion from the criminal justice system. For people who cannot be diverted and are found incompetent to stand trial, the state and counties should expand options for restoring competency.

A large and growing number of people found incompetent to stand trial because of unmet mental health needs are forced to spend months in jail awaiting services necessary for their cases to proceed. The state and counties should have an array of options to provide competency restoration services to people found incompetent to stand trial so that these Californians do not wait unnecessarily in jail.

Recommendation 4

The Council on Criminal Justice and Behavioral Health should fortify its efforts to champion collaboration among state agencies to support local prevention and diversion of mental health consumers in the criminal justice system.

California has not put in place a statewide, systemic approach for prevention and diversion to reduce criminal justice involvement for mental health consumers and improve outcomes. California's counties are well-positioned to develop more effective responses to the increased number of people with unmet mental health needs in jails. Yet the state should clear the path for more effective responses, by providing clarity regarding state and federal law, facilitating information sharing, promoting best practices, and identifying and addressing barriers to innovation, among other tasks.

Recommendation 5

The California Health and Human Services Agency should reduce or eliminate barriers so that data and information technology are used to drive decision-making, identify service gaps, and guide investments in programs to reduce the number of people with mental health needs in the criminal justice system.

Data is a critical tool in decision-making and service delivery, but state and local agencies are not effectively harnessing its power to improve outcomes for those in need. The state should develop solutions that allow agencies to integrate and leverage data to build responsive systems, provide better case management, and continuously improve services.

Recommendation 6

The State, in partnership with the counties, should expand technical assistance resources to improve cross-professional training, increase the use of data and evaluation, and advance the dissemination of best practices, including community-driven and evidence-based practices.

To build effective prevention and diversion systems, professionals in the criminal justice and mental health fields will need new knowledge, skills, and abilities to better serve mental health consumers and their communities. The state and counties should jointly improve training and technical assistance to ensure professionals are trained and cross-trained to provide appropriate responses and quality services reflecting the needs and diverse cultures of clients. Evaluation and dissemination of effective practices are essential to continuous quality improvement.

About the Project

The Criminal Justice and Mental Health Project began in spring 2016. The goal of the initiative was to reduce the number of adults with mental health needs who become involved with the criminal justice system while improving outcomes for those in custody and upon release to the community. To achieve its mission and develop recommendations, the Commission created a project subcommittee. This subcommittee is chaired by Commissioner and Santa Barbara County Sheriff Bill Brown, Commission Chair Tina Wooton, and former Commissioner Richard Van Horn, whose term ended just as the project neared completion. The subcommittee consulted with local, state, and national experts on barriers and best practices, solicited input from diverse communities, and reviewed current mental health research, policy, and practice.

Community Engagement and Site Visits

To develop a shared understanding of the problem, the subcommittee held a series of meetings, public hearings, and community forums around the state over a period of 10 months. These gatherings allowed commissioners to hear from community members, people with lived experience, experts in the fields of mental health, public safety, and social services, as well as from state and county leaders, service providers, and other Californians. The meetings were generally open to the public and sought to incorporate a broad range of perspectives and experiences to support the development of shared knowledge, ensuring that any proposed recommendations address the needs and interests of affected communities throughout California.

Special efforts were made to include the perspectives of diverse communities, including people with lived experience who belong to communities of color and LGBTQ communities. Members from communities disproportionately represented in jails were invited to provide testimony about their experiences as people with mental health needs interfacing with the criminal justice system. Project staff reached out to leaders and cultural brokers from diverse communities to conduct additional meetings that were specifically aimed at providing a safe and welcoming environment for people from diverse communities to share their experiences.

Subcommittee Meetings

The first subcommittee meeting was held in Sacramento on June 30, 2016, to introduce the project to stakeholders and solicit feedback on the proposed project framework and scope. This meeting clarified that the project would focus on community mental health and local corrections, and that it would focus on Californians 18 and older.

The second subcommittee meeting was held in Los Angeles on September 21, 2016, to explore current and former efforts to address the intersection of mental health and the criminal justice system, discuss how these efforts should shape future policy choices, and identify gaps requiring further exploration.

Public Hearings

Public hearings before the full Commission were scheduled to support the Commission's understanding of challenges and opportunities for diverting people with mental health needs from the criminal justice system. Hearings included people with lived experience, subject matter experts, and policy leaders to

provide the Commission with a breadth of knowledge and first-person experiences. The agenda included time for discussions between presenters and Commissioners.

The Commission held its first project-related public hearing in Los Angeles on September 22, 2016. The session explored service needs and gaps, how the Commission could help improve outcomes, and the proper roles of the state and counties in reducing the number of people with mental health needs who become involved in the justice system.

The Commission held its second project-related public hearing in San Diego on March 23, 2017, to hear presentations on best practices in custody and reentry and how local leaders are initiating systems-wide change to connect people with services to prevent or reduce incarceration.

Community Forums

The subcommittee held two open community forums to engage clients, family members, professionals, and other stakeholders in a dialogue about the intersection between the criminal justice and mental health systems. Presentations and breakout sessions were held to explore local challenges and barriers as well as solutions and innovative strategies. Driven by public comments made during subcommittee meetings and hearings, the subcommittee organized the community forums to explore two areas: 1) service needs and gaps in local communities, and 2) racial/ethnic disparities.

The subcommittee held its first community forum in Modesto on December 9, 2016, gathering testimony from residents of Stanislaus County as well as those who work in public safety, behavioral health, and related fields. The forum highlighted needs and service gaps, prevention efforts that could reduce the number of people with mental health needs in the justice system, and proposals to break the cycle of incarceration by promoting recovery.

The subcommittee held its second community forum in San Francisco on April 29, 2017. The forum was organized by members of the African American community to focus on cultural barriers and a path toward a more equitable system featuring less incarceration and more community-based treatment and support.

Site Visits

To enhance information gathered through its research and public meetings, the Commission visited several sites in California and other states.

In July 2016, the subcommittee and project staff traveled to Los Angeles County to examine several innovative programs and hear presentations organized by the Council on Criminal Justice and Behavioral Health, including:

- A presentation by Amity Foundation on the Amity Model to Support Community Reintegration
- A presentation on housing strategies by the Los Angeles County Office of Diversion and Reentry
- A meeting with the Los Angeles Police Department's Mental Evaluation Unit and Crisis Response team
- A visit to Exodus Eastside Urgent Care Center

In August 2016, Commissioner Brown traveled to Allegheny County, Pennsylvania, to meet with representatives of a variety of programs, including those that improve housing and service coordination, use administrative data to identify people for supportive services, provide benefits coordination in the jail, and improve the process for dispensing medication upon release from jail. Allegheny County was

recommended to the Commission by representatives of the National Association of Counties during a meeting in Washington, D.C.

On September 21, 2016, the Commission toured the Twin Towers Correctional Facility in Los Angeles, often referred to as the largest mental health facility in the United States.

The Commission was invited by the National Institute of Corrections to send a delegation of California leaders to visit sites in Bexar County, Texas, and Miami-Dade County, Florida, from September 26-30, 2016. The tour provided information on strategies to enhance local agency collaboration and strategic planning. Also covered on the tour were strategies for developing alternatives for people who are experiencing a behavioral health crisis and are detained by law enforcement, expanding crisis intervention training, using peers to support treatment and recovery, improving the use of data and technology, and developing and using public and private partnerships to improve access, care, and outcomes.

On March 22, 2017, the Commission and representatives from the National Institute of Corrections and the Substance Abuse and Mental Health Services Administration toured sites in San Diego, including the Community Transitions Center and Vista Balboa Crisis Center. The visit included a meeting with representatives from psychiatric emergency response teams.

Project staff traveled to Santa Clara County in July 2017 to tour sites and hear presentations organized by the Council on Criminal Justice and Behavioral Health, including:

- Presentations on diversion efforts and housing by Santa Clara County leaders
- A visit to the Santa Clara County Behavioral Health Court
- Presentations on San Mateo County diversion efforts and the Drug Medi-Cal Organized Delivery System
- A visit to Santa Clara County's Crisis Stabilization Unit and Crisis Residential Center

Local and National Initiatives

The Commission also participated in local and national efforts to reduce the number of people with mental health needs who become involved in the criminal justice system. These included the Stepping Up Initiative, the Data-Driven Justice Initiative, and Words to Deeds, a project of the Forensic Mental Health Association of California.

Commissioner Brown and project staff participated in workshops in Washington, D.C., hosted by the Data-Driven Justice Initiative, a project of the White House Office of Science and Technology Policy that focused on local data exchanges, diversion, and data-driven risk assessment tools. The Commission sponsored a convening of California counties engaged in the initiative during the November 2016 Words to Deeds Conference, held in Sacramento. Words to Deeds holds an annual conference to promote best practices for ending the criminalization of mental illness and improving collaboration among courts, criminal justice agencies, mental health professionals, and governmental and nongovernmental organizations.

Commissioner Brown participated in the National Stepping Up Summit in April 2016 in Washington, D.C., and participated in a focus group to develop a Stepping Up Technical Assistance Needs Self-Assessment supported by the Bureau of Justice Assistance and the National Institute of Corrections in July 2017. Commissioner Brown and project staff participated in the Stepping Up Initiative during California's Summit in Sacramento on January 18 and 19, 2017. The Summit was designed to provide support to

government officials and others committed to reducing the number of people with mental health needs in jail. Approximately 400 people attended, representing 53 counties and other entities.

Small Group Discussions

At the start of the project, Commission staff consulted with cultural brokers and conducted a literature review, which highlighted the need to address communities affected by disparities in mental health and criminal justice, most notably African Americans, Latinos, Native Americans, and LGBTQ communities, particularly transgender people.

Members of diverse communities often may mistrust government agencies and may be reluctant to participate in stakeholder and public engagement meetings due to histories of oppression. From December 2016 through April 2017, the Commission organized small group discussions with people identifying as members of African American, Latino, Native American, and Transgender communities. Through existing relationships with community leaders, staff identified community-based organizations working in these communities to host meetings, recruit participants, and coordinate conversations.

Each of these targeted group discussions had between seven and 12 participants. To keep them informal and focused, Commissioners were not present. These discussions were based on methods used to conduct focus groups, and were not open to the public. A discussion of the findings can be found in the “Diverse Communities and System Inequities” section of this report.

Filling in Data Gaps

Throughout this project, the Commission sought to leverage state-level data describing criminal justice involvement of those with mental health needs. The Commission intended to link criminal justice and mental health data to conduct a series of analyses, including providing foundational information on the justice involvement of people receiving community mental health services. Unfortunately, the Commission was not able to access such data in time for the material to be included in this report. More information about opportunities to better use existing data can be found in the “Findings and Recommendations” section of this report.

Incorporating Previous Assessments

To supplement its public process, the Commission reviewed numerous studies and data sources. Project activities and discussions were based on recommendations from past efforts, such as the California Judicial Council’s Task Force for Criminal Justice Collaboration on Mental Health Issues, the Criminal Justice / Mental Health Consensus Project led by the Council of State Governments, annual reports by the Council on Criminal Justice and Behavioral Health,¹ a report authored by the former California Corrections Standards Authority, and the California Reducing Disparities Project.² Local and national experts from mental health, substance use, and public safety agencies also provided invaluable guidance throughout the project.

Background

***“Jails are not good for the mentally ill
and the mentally ill are not good for jails.”***

- Dr. Aris Alexander, Psychiatry Professor Emeritus, University of Wisconsin at
Madison, and Clinical Consultant, Wisconsin Division of Corrections

Public concern about the inappropriate incarceration of people with serious mental health needs is not new. After witnessing horrific conditions experienced by “sick and insane” Americans in prisons, Dorothea Dix – a 19th Century teacher turned reformer of psychiatric care – and other advocates pushed for more humane treatment. By the late 1800s, the federal government funded 75 state psychiatric hospitals around the country.³ While inspired by good intentions, these hospitals were plagued by a lack of money and limited staff. Conditions were appalling. As a result, by the mid-1900s the deinstitutionalization movement was born.

Many observers have pointed to this movement, or, more specifically, the closing of state psychiatric hospitals, as the primary cause of the increasing incarceration of people with mental health needs. Even recently, the number of acute psychiatric beds in California has been drastically reduced, limiting the traditional option for serving people with mental health needs. Experts say communities should have between 40 to 60 psychiatric beds per 100,000 residents to meet needs.⁴ In California in 1995, there were 29.5 beds for every 100,000 people in the state.⁵ Most recent data suggest that California had 17.44 beds per 100,000 residents in 2013, representing a decrease of roughly 40 percent since 1995.⁶

Another dynamic in play in the mid- to late 1900s was the proliferation of “tough on crime” and “war on drugs” policies, which became popular both nationally and in California. These policies disproportionately affected African American communities, resulting in a dramatic increase in the incarceration of African American men, which, some have argued, has had the pervasive effect of systemic oppression.⁷ Between 1970 and 2014, the number of people incarcerated in jails nationwide quadrupled, from 157,000 to 690,000.⁸ As the number of laws criminalizing substance use and homelessness grew, so did the population of those with mental health needs in behind bars.⁹

Demographic studies offer some insight into the potential mechanism at play. People with mental health needs or experiences of trauma often have addictions to drugs or alcohol and are vulnerable to poverty and homelessness.¹⁰ “Like dolphins among tuna” in a fisherman’s net, people with mental health needs can become entangled in the justice system largely due to substance use.¹¹ California laws criminalizing homelessness are also on the rise.¹² These laws prohibit camping, sleeping, and resting in public spaces, and they disproportionately affect people with mental health needs and substance use disorders.¹³

One consequence is a criminal justice system that is overwhelmed by a population it was never designed to serve. It is estimated that one in five adults in the United States will experience a mental illness, with five percent meeting the criteria for a serious mental illness.¹⁴ Of those incarcerated in local jails, approximately 17 percent have a serious mental illness, a rate more than three times that of the general population.¹⁵

Factors that Increase Contact with the Justice System

Despite a common misperception, having a mental illness alone does not increase a person's chance of becoming involved with the criminal justice system. There are cases when people with mental health needs do commit violent acts. However, research indicates that people with mental health needs are more likely to be victims of violence than perpetrators.¹⁶ Amy Barnhorst, M.D., Assistant Clinical Professor from the Department of Psychiatry and Behavioral Sciences at the University of California, Davis, offers more details on the relationship between mental illness and violence:

"Studies show that the amount of community violence attributable to mental illness alone is approximately four percent. That means that 96% of community violence is due to other known risk factors, like substance abuse, poverty, and additional social stressors. Much of the association between mental illness and violence documented in studies is explained by the fact that substance abuse is an independent risk factor for violence, and people with mental health needs are more likely to abuse substances than people without such needs. When substance abuse is corrected for in such studies, the increased risk of violence among people with mental health needs is minimal.

Despite that reality, media coverage of mass shootings often incorrectly implies that the perpetrators of such acts are people with unmet mental health needs. In fact, the majority of such attacks are carried out by people who do not have confirmed histories of serious mental illness. This misconception sways public opinion and also influences legislators, leading to increased stigma against people with mental health needs as well as violence prevention bills targeting a group whose contribution to community violence is small."¹⁷

As Dr. Barnhorst points out, mental illness interacts with other factors that increase a person's likelihood of engaging in violence and becoming involved in the criminal justice system. Studies show that only one in 10 people with mental health needs commit crimes as a direct consequence of mental illness symptoms.¹⁸ Instead, people with mental health needs typically collide with the criminal justice system because of other risk factors for offending, such as substance use, poverty, and homelessness.¹⁹ Still, addressing mental health needs alone does not reduce the likelihood of returning to the justice system.²⁰ Some of these factors, and how people with mental health needs are more vulnerable to these factors, are discussed in greater detail below.

Substance Use and Other Personal Risk Factors

Mental illness often co-occurs with substance use disorders. According to the latest National Survey on Drug Use and Health, 8.1 million people who abused drugs or alcohol in the past year had a mental health need, but only seven percent received treatment for both.²¹ One study estimated that half of those with mental health needs who were arrested also had a substance use disorder.²² In addition, as many as nine out of ten people with mental health needs who become involved with the criminal justice system will have experienced a substance use disorder during their lifetime.²³ Prevalence rates of substance use

disorders has declined for whites but has remained stable or increased among African Americans and Latinos.²⁴

California is testing a new model of delivering a continuum of substance use services and providing integrated behavioral health and physical health care. The new model seeks to provide more intensive services to hard to reach populations, such as people involved in the justice system. This model, developed under the Drug Medi-Cal Organized Delivery System (DMC-ODS) 1115 waiver, is a five-year demonstration pilot project that includes a continuum of care, increased local control and accountability, greater administrative oversight through utilization control, evidence-based practices, and coordination with other systems of care.²⁵ Treatment services include outpatient treatment, intensive outpatient treatment, medication-assisted therapy, perinatal residential services, and detoxification. The goal is to increase recovery of those receiving services while reducing costs in other systems, such as the criminal justice system.

In addition to substance use, other personal factors may increase the likelihood a person becomes involved with the criminal justice system. Static factors include criminal history, criminal history in the family, and the number of times a person has been incarcerated. Other factors influencing one's likelihood of engaging in criminal behavior are dynamic, or subject to change.²⁶ These factors have a more direct link to offending. Of the dynamic factors listed below, the first four are most predictive of criminal behavior:²⁷

- Criminal thinking, justifying criminal behavior, or lack of remorse
- Criminal friends or associates, peer influence to engage in criminal behavior, or lack of positive involvement with the community
- Criminal or antisocial behavior, especially at an early age
- Criminal personality marked by low self-control, impulsivity, or inability to control anger
- Low levels of participation or engagement at school or work
- Dysfunction in the family, lack of family support or positive communication
- Criminal recreation or leisure activities
- Substance abuse, or inability to stop drug and alcohol use²⁸

Effective models for improving outcomes for people with mental health needs involved in the criminal justice system use assessments of the above risk factors in addition to assessing for mental health needs.²⁹ These assessments allow administrators to place needs along a continuum - low to high - to determine the best course of intervention and correctional supervision.³⁰ For example, people with higher risks to offend should be prioritized for more intensive in-custody and community supervision when released.³¹ People with lower risks to offend can be harmed by too much correctional supervision or by being placed with people at a higher risk to offend.³² Risk factors, mental health needs, and substance use needs should be assessed using validated tools, and should be assessed as early as possible in the criminal justice trajectory, and then reassessed over time to capture changes.³³

Recovery through Mental Health and Court Collaboration

Jeremy Sorensen is a Sacramento County Mental Health Court success story. With a bi-polar disorder and a history of self-medication with drugs and alcohol, he had been in and out of the criminal justice system most of his life. But one day last year Sorensen was pulled over for driving under the influence of methamphetamine. The arrest could have cost him custody of his son. Instead, it changed his life.

Thanks to his treatment provider, Sorensen was referred to the Mental Health Court, a program that offers diversion and a clean record to participants who agree to treatment. For Sorensen, it was the perfect fit, providing structure and accountability as well as a medication he says “has been phenomenal” and “changed my way of thinking.”

Judge Lawrence Brown, who supervises the program for Sacramento County Superior Court, says Sorensen is typical of those who appear before him – inconsistent with medications while battling addictions to illegal drugs. The Mental Health Court, he says, keeps participants on track with a rigorous schedule of meetings, appointments, and conferences with a judge. Brown says it blends “the treatment approach with the criminal justice system.”

“It’s an extraordinarily compassionate approach to the justice system,” Brown said. “It’s almost inhumane to have a seriously mentally ill person incarcerated if they otherwise could be in the community, have treatment, have access to their medication, and be held accountable.”

It worked for Sorensen. He “graduated” from Mental Health Court in a year, the minimum possible time, and now volunteers as a mentor and peer support counselor at a mental health service provider.

Poverty and Other Environmental Risk Factors

People living in poverty are more likely to live in environments that support risk factors for offending – and are more likely to become involved in the criminal justice system.³⁴ Approximately four in 10 Californians are living at or near the poverty level.³⁵ Communities of color are disproportionately affected, with 28.8 percent of Latinos and 20.2 percent of African Americans living at or near the poverty line, compared to 14 percent of whites.³⁶ Research has consistently demonstrated that the lower a person’s socioeconomic status, the higher that person’s risk for developing a mental illness.³⁷

In some cases, poverty leads to homelessness, and housing is consistently identified as a critical and missing link in preventing justice involvement of those with mental health conditions. Despite the expansion of evidence-based supportive housing practices in many communities, homelessness remains a major problem for those in the criminal justice system and those with unmet mental health needs. According to some estimates, as many as 50 percent of homeless people are estimated to have been incarcerated at some point.³⁸ Further, people in jail have experienced homelessness 7.5 to 11.3 times more than people in the general population.³⁹

Other statistics show that:

- An estimated one-third of the homeless population has an unaddressed mental health need.
- Roughly three out of four homeless people experience some form of serious mental illness.
- Among all homeless people, an estimated 23 percent will have co-occurring mental health and substance use conditions.⁴⁰

California is recognizing the importance of supportive housing in addressing mental health and substance use needs, and the state is making investments. For example, the state recently authorized a \$2 billion supportive housing bond program called No Place Like Home.⁴¹ This program is designed to invest in permanent supportive housing for homeless people with mental health needs. The program will use a *Housing First* strategy, guided by the theory that people need their basic needs met before tackling chronic health challenges. These bonds are repaid using Mental Health Services Act funds.

Making Progress through Law Enforcement and Clinician Partnership

The Los Angeles Police Department was one of the first law enforcement agencies in the nation to integrate mental health workers into their field operations. Efforts began more than two decades ago, and the department is constantly improving its approach to better help officers and community members alike.

Lt. Brian Bixler oversees the department's Mental Evaluation Unit and says the LAPD has "a five-pronged approach" in its management of field encounters involving people with mental illness. "Our first piece is training, our second piece is triage, then there's the crisis response piece, and then there's follow-up and community outreach engagement," Bixler said.

Training begins at the LAPD's academy, where cadets learn how to de-escalate a mental health crisis on the streets. After graduating, many officers participate in an additional four-day program that further prepares them to respond to mental health challenges in the field.

Most of the department's interventions are provided through crisis response teams, which consist of a specially-trained LAPD officer and a clinician from the Los Angeles County Department of Mental Health. The teams can be called to a scene that involves a person in a mental health crisis, and, after the situation is de-escalated, team members can transport the individual to a county hospital or one of several community-based treatment centers.

The LAPD has dedicated 17 supervisors and 75 officers to its System-wide Mental Assessment Response Team, or SMART.

Follow-up is provided by another team, the CASE Assessment Management Program, or CAMP, that includes a county mental health clinician who can link individuals with housing, treatment, and other interventions designed to keep people stable and out of the criminal justice system.

In all, the county Department of Mental Health provides five supervisors and 33 clinicians to the LAPD.

Social determinants, or "the conditions in which people are born, grow, live, work and age," play an important role in determining mental health outcomes and criminal justice involvement.⁴² Recent research has identified links between mental health and the built environment, including housing insecurity, unemployment, adverse childhood experiences, discrimination and social exclusion, and poverty.⁴³ Similarly, a large body of research connects criminal behavior with neighborhood characteristics, poverty, and economic opportunity. For example, Social Disorganization Theory suggests that the availability of institutional assets and community cohesion, degree of residential mobility, and economic status have an influence on crime rates.⁴⁴ These parallel areas of research suggest that a portion of mental health needs and criminal behavior can be explained by social and economic factors largely outside of a person's control.

Inequities in social and economic conditions contribute to the observed disparities in mental health and criminal justice outcomes. People from communities of color and other historically marginalized groups are more likely to be affected by social and economic disadvantage. These communities are more likely to experience conditions of daily living characterized by unemployment, residential and food insecurity, racism and discrimination, neighborhood violence, exposure to adverse childhood experiences, poverty, and other adverse social and economic conditions.

Diverse Communities and System Disparities

People of color are more likely to experience poverty, homelessness, job insecurity, and other adverse social and economic determinants of mental illness and criminal justice involvement. People of color, particularly from African American and Latino communities, and members of LGBTQ communities experience greater exposure to risk and trauma, less access to prevention and intervention services, and greater exposure to racism and discrimination. These challenges increase the likelihood that people of color with mental health needs will be arrested.⁴⁵ In a vicious cycle, mental health consumers from communities of color spend more time incarcerated, which erects barriers to their care, thus reducing the likelihood that they will receive treatment and support upon reentry into communities.⁴⁶

A few statistics help illustrate this problem. While they account for 6.5 percent of the general population in California, African Americans represent 28.9 percent of the state prison population.⁴⁷ Latinos, meanwhile, make up 41.1 percent of the prison population and 38.8 percent of the general population.⁴⁸ Data from the Center for American Progress suggest that individuals identifying as LGBTQ or gender non-conforming also are overrepresented in criminal justice systems.⁴⁹ Trans women, especially from communities of color, are particularly vulnerable to entering the criminal justice system through engaging in sex work.⁵⁰ Trans women sex workers experience significant trauma, including physical, sexual, and emotional abuse, and frequently engage in high-risk behaviors, such as substance use.⁵¹

Substantial disparities also exist for communities of color and LGBTQ communities within the mental health system. Members of communities of color – specifically Latino, African American, Native American, and some Asian American communities - tend to experience greater exposure to poverty, discrimination, homelessness, and violence, and many also lack access to mental health services.⁵² Mental health service usage data suggest that Latinos have among the lowest rates for access to care, and that these low rates have persisted for decades.⁵³

While service usage rates for African Americans tend to be commensurate or slightly higher than those for non-Latino Whites, many researchers suggest these numbers reflect access to care in coercive or emergency settings rather than supportive and appropriate care.⁵⁴ For example, research indicates that African Americans are more likely to receive mental health services as a result of involvement with the criminal justice system, a child welfare agency, or hospital emergency departments. This dynamic suggests that African Americans are less likely to have access to treatment that could potentially *prevent* involvement in each of these settings.⁵⁵ Native Americans,⁵⁶ refugee groups,⁵⁷ and members of groups based on sexual orientation and gender identity also are less likely to receive mental health services.⁵⁸

Additional work is needed to identify other disparity populations and to understand the needs in these communities. For example, people with intellectual disabilities are overrepresented in the criminal justice system and may present with mental health needs. Special efforts should be made to gather information on the needs and opportunities to intervene with people with intellectual disabilities. Refugee

communities may also disproportionately suffer from mental health needs, most notably Post-Traumatic Stress Disorder. These communities may face specific barriers when encountering law enforcement or navigating the criminal justice system.

A Need for Culturally Competent Services

Frankie Guzman was first arrested at age 15 and sent to the California Youth Authority with a 15-year sentence. “I was depressed, certainly most of my life, living in an environment where there’s no hope and a whole lot of danger and the only support you get from government is jail.”

For minorities with mental health needs, barriers to treatment can be significant and surface early in life. “At the general level in the Latino community and the African American community, mental health providers are viewed with a lot of skepticism and a lot of distrust,” said Guzman.

He was released early, but like many people with unmet mental health needs, he returned to prison. When he was released again at age 21, Guzman attended community college, transferred to UC Berkeley and then obtained his law degree from UCLA. Today he is an attorney for the National Center for Youth Law, advocating for children involved in the criminal justice system.

One solution may lie in community settings with culturally competent services that also incorporate alternative methods not based on pharmaceuticals. “That’s not to say that people don’t need it, but I’ve heard from a number of people that they’re totally turned off when a mental health provider offers medicine as a first resort.”

Small Group Discussion Findings

During small group discussions held for this project, participants identified trauma as a key factor contributing to their mental health needs and criminal justice involvement. Participants spoke of early childhood trauma, including experiences of sexual and physical abuse, family and neighborhood violence, and parental incarceration, that left them feeling different, alone, scared, and vulnerable to exploitation. For transgender participants, experiences of childhood molestation and sexual assault were ubiquitous.

“I think that it happened during my childhood years because I was raped. So I had all this trauma going on in my life that I couldn’t be like other people. Not other people – children ... I grew up afraid, with a lot of fear of living.”

- Native American Participant

“When I left home at age 14, I was studying in high school but I had to leave because I had my first rejection and abuse because of my gender by my family. I arrived in the street. In San Salvador at the time there was a street that was known as the ‘Traviana.’ It was a zone for trans women. It was a place for prostitution.”

- Transgender Participant

Native American participants said the experience of intergenerational trauma – trauma that is transmitted through generations related to historical race-based oppression and violence – had played a key role in the development of mental health problems and criminal justice involvement.

“Because I work in Native communities, how do you tell them there is something wrong when all that has been normalized for so many years? Because if you go in there and tell them something is wrong they will feel it is really disrespectful. Like who are you? My dad taught me this, my grandfather did this, and uncles did this. We are talking about sexual abuse, domestic violence, suicide, mass incarceration, addiction of everything. That’s all on our plate all at one time.”

- Native American Participant

African American and Transgender participants, in particular Transgender participants of color, identified racial discrimination as a factor affecting criminal justice involvement and mental illness in their communities. Participants discussed recent police shootings, some said they felt unjustly targeted by law enforcement. Based on their experiences in their neighborhoods and families, as well as with mental health, law enforcement, and other public programs, participants expressed despair, hopelessness, anger, fear, and mistrust.

Many participants said that while incarcerated, they felt their mental health and addiction needs were not addressed or were made worse by isolation and confinement. Participants also said that medication had not helped them resolve problems that had existed since early childhood. Across small group discussions, all participants spoke of the experiences of trauma while incarcerated, stemming from solitary confinement, exposure to violence and assault, and lack of access to adequate food and medical care. Participants described feeling like they were not seen or treated as human beings, and suggested that this dehumanization contributed to their mental health needs. Some said incarceration had deeply changed them, rendering them unable to relate to others normally.

“Being in prison locked up makes it worse. You don’t come out the same ... I don’t like talking a lot because the hurt is there. I used to talk a lot. Now I don’t have no words for nothing. I am very closed inside.”

- African American Participant

Participants also described many challenges they faced post-incarceration. These included an inability to obtain proper mental health services and help with reintegration into the community. Many participants discussed the lack of opportunities to pursue employment and to gain financial independence. A large portion of participants were living below the poverty line and had experienced or were currently experiencing homelessness. Participants who were connected with programs through local community-based organizations credited these programs with helping them regain independence, financial stability, and mental health.

“I think race has a lot to do with not seeking help. Because we have a lot of pride. Especially with the men. We have a lot of pride.”

- Latino Participant

“I think it is important not to treat the mental health problems of trans women with medications, instead with recreational therapies, social therapies where we can vent and we can hear each other’s stories. Because hearing everyone’s stories here, it’s like they are telling the biography of my life. The same story.”

- Transgender Participant

Stigma and Implicit Biases

People with mental health needs, particularly members of LGBTQ communities and communities of color, are often affected by the explicit and implicit biases of others. Explicit biases are deliberately formed attitudes based on stereotypes.⁵⁹ Implicit biases, on the other hand, are unconscious and automatic associations made between stereotypes and groups of people.⁶⁰ These stereotypes can be about race, gender, age, religion, sexual orientation, or health status, including mental illness.⁶¹

Stigma and Discrimination

People with mental health and substance use needs are often stigmatized by others. Stigmatizing beliefs are based on prejudices, stereotypes, and discrimination, including beliefs that people with mental health needs are violent, incompetent, or irresponsible.⁶² Stigma and discrimination often prevent people with mental health needs from seeking treatment, especially when combined with other forms of discrimination that are based on race, ethnicity, or sexual identity.⁶³

Stigma and discrimination also can be experienced as coercive or segregated treatment. Mental health stigma can be social, such as prejudicial attitudes and discriminating behavior directed at people with mental health needs, often causing feelings of despair, shame, guilt, distress, and hopelessness. Stigma can also be directed at the self, as a person with mental health needs may internalize discrimination from others, resulting in isolation or apprehension about seeking or accepting services. The U.S. Surgeon General's report on mental health further addresses stigma by stating:

“Stigmatization of people with mental disorders has persisted throughout history. It is manifested by bias, distrust, stereotyping, fear, embarrassment, anger, and/or avoidance. Stigma leads others to avoid living, socializing or working with, renting to, or employing people with mental disorders, especially severe disorders such as schizophrenia.⁶⁴ It reduces patients’ access to resources and opportunities (e.g., housing, jobs) and leads to low self-esteem, isolation, and hopelessness. It deters the public from seeking, and wanting to pay for, care. In its most overt and egregious form, stigma results in outright discrimination and abuse. More tragically, it deprives people of their dignity and interferes with their full participation in society.”⁶⁵

Stigma and discrimination can affect the ability of people with mental health needs to obtain or retain employment, especially for those with criminal history.⁶⁶ It can also prevent or hinder the development of necessary housing and treatment facilities in certain areas that may need services the most. NIMBYism (“Not in my backyard”) is one prime example. Within the context of this report, NIMBYism refers to opposition by community members to having housing or other facilities for mental health consumers or people with criminal histories in their neighborhoods, and it “has deep roots in fear, racism, classism, ableism, and growing antidevelopment reactions.”⁶⁷

Community resistance is usually based on negative stereotypes about people with mental health or substance use needs, and is made worse by the additional stigma of previous involvement with the criminal justice system. Earlier this year, NIMBYism was identified as a factor that was preventing the development of crisis residential and stabilization programs under the Mental Health Wellness Act of 2013, SB 82.⁶⁸ So much so that the grant had to be extended to give counties more time to address opposition and other obstacles.⁶⁹

Implicit Bias

Implicit bias theory has been used to explain disparities in criminal justice. Implicit biases occur outside of conscious awareness and often may not be consistent with a person's overt or conscious beliefs. Race-based bias can affect every encounter people have within the criminal justice system, including initial encounters with law enforcement, arrests, sentencing, and decisions while in custody. Studies suggest that people are more likely to perceive African Americans as a threat and to associate African Americans with criminal behavior. In computer simulations, participants are more likely to shoot an unarmed African American man than an unarmed white man.⁷⁰

While there has been less research exploring the link between implicit biases and mental illness, existing studies suggests that people tend to hold negative unconscious biases towards people with mental health needs.⁷¹ Implicit biases can be addressed through explicit efforts to reduce stereotypes. Strategies such as increasing awareness of implicit bias, increasing exposure to groups that are the target of stereotypes, and explicitly practicing changing one's overt thought processes may reduce the influence of implicit bias in decision-making. Implicit bias training was recommended by the President's Task Force on 21st Century Policing and has been implemented in many law enforcement agencies across the country.⁷²

DRAFT

Mental Health Services Act

Q What is the Mental Health Services Act?

The Mental Health Services Act, or Proposition 63, passed by voters in 2004, is funded through a 1% tax on personal income over \$1 million. In 2017, it will generate an estimated \$2 billion for mental health services in California.

The Mental Health Services Act is built around five key components:

COMMUNITY SERVICES & SUPPORT (CSS)

The CSS component provides services for people with severe mental illnesses using a client-centered and family-driven, wellness, and recovery- focused approach.

Considerations for how services similar to those delivered using the Mentally Ill Offender Crime Reduction Grant Program should be made when planning for CSS services. (Welfare and Institutions Code §5813.5(f))

When programs and services include collaboration with the criminal justice system, any law enforcement function or any function that supports a law enforcement purpose shall not be funded. (Title 9, California Code of Regulations § 3610(e))

CSS Funding Categories:

- **Full Service Partnership:** program to provide a full spectrum of direct mental health services for people with serious mental illness through an approach known as “whatever it takes” to support recovery, including housing, employment, and education services and supports.
- **General System Development:** program to improve the mental health service delivery system for all clients.
- **Outreach and Engagement:** program to reach, identify, and engage unserved people with serious mental illness so they receive appropriate services.
- **Mental Health Services Act Housing Program:** program to acquire, rehabilitate or construct permanent supportive housing for clients with serious mental illness.

PREVENTION & EARLY INTERVENTION (PEI)

The PEI component focuses on providing an early response to mental health needs before they become severe and disabling, particularly for underserved communities. PEI programs strive to prevent homelessness, incarceration, school failure, suicide, unemployment, prolonged suffering, and removal of children from their homes that can result from untreated mental health needs.

INNOVATION (INN)

The INN component is designed to discover unique ways of operating in the mental health landscape. The goal is to increase access to services, especially for underserved communities, increase quality of services, and promote interagency collaboration. The MHSOAC approves funding for projects in this component.

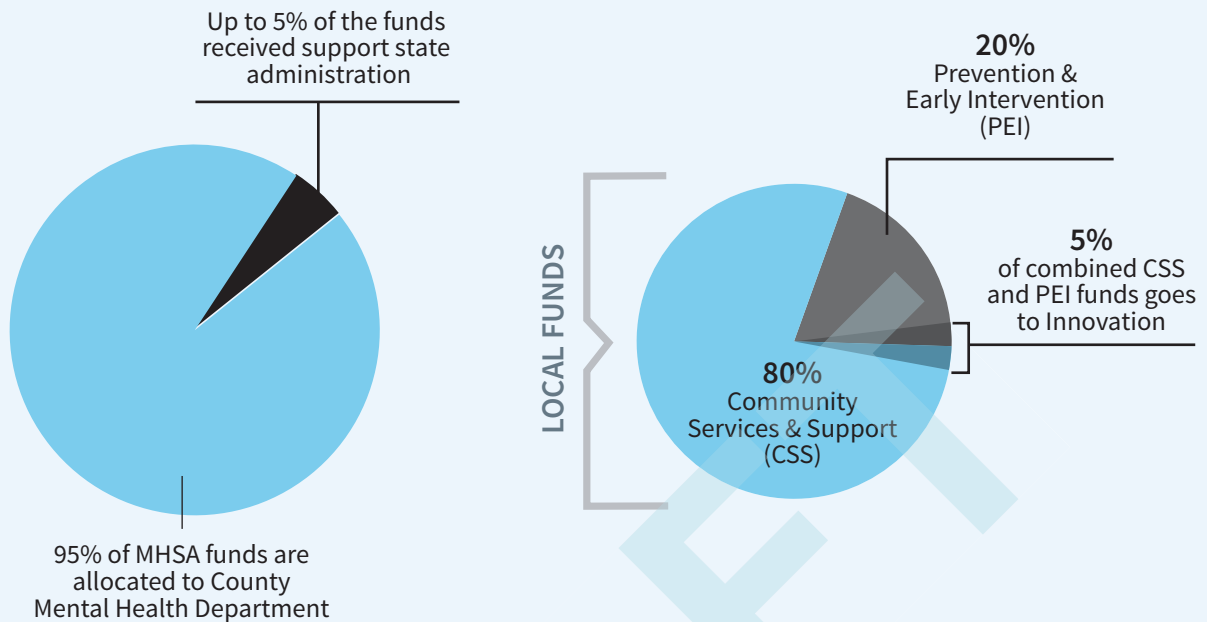
CAPITAL FACILITIES AND TECHNOLOGICAL NEEDS (CFTN)

The CFTN component provides one-time funding for infrastructure and technology to support the mental health care system.

WORKFORCE EDUCATION AND TRAINING (WET)

The WET component includes funds for employment and training to bring in more qualified people to work in the field of mental health.

Q How are Mental Health Service Act dollars allocated?



Q How are Mental Health Services Act funds prioritized?

Spending priorities are set through a Community Program Planning Process, which is driven by input from stakeholders.

Stakeholders, as defined by Welfare and Institutions Code §5848, include adults and seniors with severe mental illness, families of children, adults, and seniors with severe mental illness, providers of services, law enforcement agencies, education, social services agencies, veterans and their representatives, providers of alcohol and drug services, and health care organizations, and other community members.

Q Can Mental Health Services Act funding be used for people involved in the criminal justice system?

Mental Health Services Act – funded programs and services have the potential to divert people with mental health needs from various stages of the criminal justice system. Examples are found throughout this report.

The MHSA explicitly prohibits use of funds for services for people incarcerated in prison or parolees from state prison (Welfare and Institutions §5813.5(f)). While the Mental Health Services Act prohibits the use of funds for programming or treatment in detention

settings, such funds can be used for discharge planning and connecting people with local community-based services prior to release.

People on probation, including probationers under Public Safety Realignment (AB 109, chapter 15, Stats. 2011), are not prohibited from MHSA funding. However, MHSA should be used to expand mental health services and not to supplant existing state or county funds to provide mental health services. (Welfare and Institutions §5891(a))

Planning for Prevention and Diversion

“Fragmentation is at the heart of the ineffectiveness of our increasingly frantic efforts to nurture improvement.”

- Kurt C. Stange, M.D., Ph.D., from “The Problem of Fragmentation and the Need for Integrative Solutions”

In passing the Mental Health Services Act in 2004, voters called for the transformation of California’s mental health system from a “fail first” to a “help first” system. In short, that directive means that instead of rationing care to those with the greatest need, perhaps following a crisis or a person’s incarceration, California should emphasize prevention and early intervention. The goal of the Act is to transform California’s mental health system into an outcome-focused system of care. One specific objective is to reduce the incarceration of people with mental health needs.

It is worth stating that incarceration can be detrimental to a person’s ability to manage his or her mental health needs. Jail can be a frightening place for anyone, and particularly for a person with unmet mental health needs. Incarceration often also results in traumatization that can exacerbate symptoms. People with mental health needs require services in the community, such as appropriate and culturally responsive treatment that addresses housing deficits, substance use, trauma, risk factors for offending, and other dynamics that diminish recovery. Often, however, such treatment is distributed through multiple public programs and agencies, often referred to as “silos.” One agency might address a person’s housing needs, while another might treat a person’s risk factors for offending and a third might provide addiction counseling. As siloed services, these efforts often are not coordinated, might promote conflicting strategies, and frequently result in inadequate care.

“Significant investments by state and community partners are needed on upstream efforts such as crisis intervention and prevention to reduce law enforcement involvement. The importance of partnerships with these efforts cannot be overstated. All local partners are critical to success.”

- Donnell Ewert, Shasta County Behavioral Health Director

The variety of funding streams and eligibility requirements for disparate agencies complicate the coordination of service delivery and make it difficult to fill gaps in services and capacity. Typically, funding structures require counties to develop programs and services that fit within specific parameters, an approach that does not necessarily involve doing what it takes to meet the needs of the population. This challenge has been understood for decades and has frustrated efforts to focus on people rather than programs.

The long-sought solution often is cross-system collaboration. Better communication can identify a person at risk before they become a person in crisis. Better coordination among agencies can lead to more effective responses. Collaboration among agencies can make the best use of available funds, staffing, and facilities. Mapping available programs and services and engaging community members can help county agencies develop a shared understanding of available resources and how best to coordinate them.

Identifying Opportunities for Prevention and Diversion

In recent months, more than half of California's counties have signed resolutions under the Stepping Up Initiative to reduce the number of people with mental health needs in local jails through prevention and diversion.⁷³ That commitment reflects both the imperative and the opportunity. The imperative is driven by mounting costs, crowded facilities, and a moral awareness that jails should not be the default provider of mental health services. Fortunately, the need for change is aligned with promising conditions for change.

Practitioners and researchers are equipped with lessons learned from nearly a generation of system change efforts around the country. Governance and policy changes have provided counties with more responsibilities and resources. And new technologies are powering emerging innovations in integrated service delivery. The potential to carry out significant system change that will control costs and improve outcomes now matches an ambition long held by policy makers, program administrators, practitioners, family members, and consumers.

Pushing for local commitment, collaboration, and planning, The Stepping Up Initiative was established in 2015 to work with local leaders to safely reduce the number of people with mental health needs involved in the criminal justice system.⁷⁴ The national initiative is a partnership led by the Council of State Governments Justice Center, American Psychiatric Association Foundation, and the National Association of Counties.⁷⁵

“Yolo County is fully committed to reducing the numbers of mentally ill in our criminal justice system. Our Board of Supervisors has adopted this as a key initiative in our three-year strategic plan along with fully embracing the Stepping Up movement. We are excited to work with our other state and county partners toward achieving these outcomes statewide.”

- Karen Larsen, Yolo County Behavioral Health Director

The initiative encourages counties to adopt resolutions – a formal commitment by county leaders – to reduce the number of people with mental health needs in jail, commit to sharing lessons learned with other counties, and encourage county officials and community members to participate. Counties agree to convene decision-makers, collect data, analyze treatment and service capacity, and develop plans to measure outcomes and track progress over time. To date, over 30 California counties, representing over 70 percent of the state's jail population, have passed the resolution.⁷⁶

As part of their nationwide effort, the Stepping Up Initiative produced a framework for a collaborative, data-driven approach. The framework organizes county efforts around six key questions to help counties assess their community's existing efforts to reduce the number of people with mental health needs in local jails and better understand service needs and system gaps.⁷⁷

These six questions are:

1. **Is our leadership committed?** Counties should establish a planning team or committee to foster cross-system collaboration.
2. **Do we conduct timely screening and assessment?** Counties need a clear and accurate understanding of the prevalence of mental illnesses in their jail populations to track progress over time and guide quality improvement.
3. **Do we have baseline data?** Baseline data provides counties benchmarks to evaluate progress and determine whether key outcomes are being realized. The Council of State Governments Justice Center has identified four key outcome measures for developing a baseline and tracking progress:
 - Reduction in the number of people with mental illness booked into jail
 - Shorter jail stays for people with mental illnesses
 - Increase in the percentage of people with mental illnesses in jail who are connected to the right services and supports once released
 - Lower rates of recidivism
4. **Have we conducted a comprehensive process analysis and inventory of services?** Each county should create a comprehensive plan for prevention and diversion, based on an inventory of current services to identify gaps. The Sequential Intercept Model can help counties collaborate across departments and begin compiling an inventory of services to map the existing landscape. See below for more information about the Sequential Intercept Model.
5. **Have we prioritized policy, practice, and funding improvements?** County leaders should provide guidance to the planning team on how to make policy recommendations and budget requests that are practical, concrete, and aligned with the fiscal realities and budget process of the county.
6. **Do we track progress?** Using data to track outcomes is essential to continuous quality improvement, and can help justify future funding and expansion of effective programs.

The Sequential Intercept Model

The Sequential Intercept Model is one strategy available to help counties map available programs, and begin to develop a shared understanding of available resources and how best to coordinate them. The Sequential Intercept Model was developed in the 1990s in response to the high prevalence of mental illness in people involved in the criminal justice system.⁷⁸ The model provides a comprehensive framework for identifying points of intervention that may reduce criminal justice involvement of those with mental health needs. Fresno, Kern, Los Angeles, San Francisco, and San Luis Obispo counties, as well as the City of Long Beach and the Yurok Tribe in far Northern California, are jurisdictions that have created Sequential Intercept Models.⁷⁹

“Fresno County has invested in sequential intercept mapping (SIM) and it has proven to be a highly valuable tool for understanding and assessing our current system. In our county, buy-in by all criminal justice partners has been imperative for utilizing SIM to both increase opportunities for diversion and strategize solutions for filling gaps along the continuum.”

- Dawan Utecht, Fresno County Behavioral Health Director

Under the model, interventions occur along a continuum, beginning with crisis services and progressing to a call to law enforcement or emergency services, initial detention and court hearings, jail and prison, re-entry into communities, and, finally, community supervision.⁸⁰ The goal is to improve mental health and prevent deeper involvement in the criminal justice system.

Intercept Zero: Community

According to Sequential Intercept Model developers, the “ultimate intercept,” or “Intercept Zero,” is “an accessible, comprehensive, effective mental health treatment system focused on the needs of individuals with serious and persistent mental disorders ...” and “... is undoubtedly the most effective means of preventing the criminalization of people with mental illness.”⁸¹ The goal is to create a system that is responsive to the greatest range of possible needs, one that connects people to available services to either prevent a mental health crisis or catch a crisis early, before there is a law enforcement response. Robust crisis response models and proactive responses are essential at this intercept.⁸²

Further, consumers with repeat hospitalizations can be referred to assisted outpatient treatment programs in counties that are implementing such programs, and possibly prevent incarceration if connected to appropriate community-based treatment.⁸³ Assisted outpatient treatment refers to civil court-ordered community-based mental health services for people unable to voluntarily access needed services.⁸⁴ Assisted outpatient treatment could be utilized at any intercept to divert people from the criminal justice system who require intensive outpatient services, including intensive Full Service Partnership-type programs with higher staff to client ratios, or those “stepping down” from inpatient care.⁸⁵

“How do we work with the systems that exist and build new systems where these people – maybe they’re service-resistant – can get the help they need and they may not have to call 911? People with mental illness aren’t criminals. Mental health emergencies are medical emergencies.”

- Lt. Brian Bixler, Los Angeles Police Department

Intervening at Intercept Zero also means providing enhanced prevention services, especially for communities of color and LGBTQ communities. Exposure to adverse childhood experiences and trauma can increase vulnerability to the development of mental health needs, substance abuse, and criminal justice involvement in people from communities of color.⁸⁶ Programs that decrease exposure to adverse childhood experiences and help people cope with trauma may divert the trajectory toward criminal justice involvement.⁸⁷ One example of a community-defined practice at this intercept is the Harmonious Solutions program in San Diego County. The program provides young African American men culturally competent support for conflict resolution and positive interpersonal relationships based on African-centered values and practices.⁸⁸ In addition, recent efforts by the California Reducing Disparities Project to implement community-defined practices hold promise for reducing criminal justice involvement through more “upstream” approaches to prevention.⁸⁹

Exciting innovations for non-law enforcement crisis response are emerging nationally and in California. In Eugene, Oregon, the Crisis Assistance Helping Out on the Streets program provides mobile crisis intervention using teams consisting of a medic – either a nurse or EMT – and a mental health crisis worker

to stabilize, assess, refer to services, and, at times, transport to treatment people in crisis.⁹⁰ As part of California’s Community Paramedicine Pilot Project, specialty trained paramedics in Stanislaus County were dispatched via 911 calls believed to be behavioral health emergencies to assess and transport people in crisis to services.⁹¹ The pilot saw positive outcomes in both cost and effectiveness, but efforts were hampered by lack of treatment capacity and by services that could not address substance use needs, in addition to mental health needs.⁹²

The Investment in Mental Health Wellness Act of 2013 was enacted to increase the continuum of mental health crisis services throughout California, and it is another strategy to help communities build what might be characterized as Intercept Zero in California.⁹³ Key objectives of the act include expanding access to services, such as crisis intervention services, reducing unnecessary hospitalization, and mitigating law enforcement expenditures on mental health crises. The act funds local grants to support capital development and mobile crisis response, and to expand crisis triage personnel. The purpose of these grants is to increase the number of personnel to provide crisis intervention, crisis stabilization, mobile crisis support, and intensive case management and linkage to services.

California counties are investing in mental health services to support prevention at Intercept Zero

- ***Butte County | The Crisis Connect Program***

Butte County is using Investment in Mental Health Wellness Act (SB 82, 2013) grant funding to station crisis triage staff at specific access points to expand current crisis services and help consumers avoid higher levels of care. These access points include hospital emergency rooms and local homeless service centers. The Crisis Connect team facilitates consumer movement through the crisis continuum; this includes coordinating placements, discharge planning, monitoring, and follow-up case management.⁹⁴

- ***San Bernardino County | Triage, Engagement and Support Teams***

San Bernardino County is using Investment in Mental Health Wellness Act (SB 82, 2013) grant funding to expand the county’s crisis system of care, and link crisis services to outpatient and community resources. Triage Teams utilize intensive case management services to link consumers with needed resources for ongoing stability, providing case management services for up to 60 days or longer to ensure engagement. The Triage Teams are community based and are co-located in 18 crucial points of access, such as the Department of Probation and sheriff and police stations. The primary goal for the Triage Teams is consumer stability in the least restrictive environment, sustained over a significant period.⁹⁵

- ***Napa County | Mental Health Triage Personnel Grant***

Napa County is using Investment in Mental Health Wellness Act (SB 82, 2013) grant funding to expand the crisis continuum of care to meet the needs of people at risk of needing mental health crisis intervention. The grant strengthens three components of the crisis continuum of care by: (1) funding a crisis worker to be on-site at the local emergency department to improve the timeliness of crisis interventions and provide immediate help with de-escalating a crisis situation; (2) expanding on-call hours of the SPIRIT Crisis Center Peer Counselors, who provide support to people and their families during a crisis; 3) funding the Insight Respite Center, a four-bed, peer-run program that provides an alternative to higher levels of care within a supportive, recovery-oriented community setting. The Insight Respite Center offers an alternative to crisis services and a “step down” after inpatient hospitalization to help individuals stabilize and manage their illness in a safe, welcoming, environment.⁹⁶

Intercept One: Law Enforcement

The first intercept in this model is the initial encounter with law enforcement. Police officers are often called to respond to situations involving a person with mental health needs. Programs and strategies at Intercept One seek to improve the ability of officers to effectively address these situations by providing them with training from mental health providers. Strategies may include special protocols for dispatchers to improve early identification of mental illness and strengthen dispatchers' communication to first responders, as well as training to help law enforcement combat the effects of implicit bias in high-stress situations.

Programs and strategies typically seek to help officers recognize symptoms of mental illness, de-escalate crisis situations, identify and reduce cultural bias in policing, and connect those with mental health needs with appropriate community resources. Alternatively, some pre-arrest strategies incorporate a mental health provider at the outset, pairing mental health practitioners with law enforcement in the community or in law enforcement settings. Some crisis situations cannot be deescalated or addressed in the field. To effectively divert at this intercept, communities must have alternatives to jail available and accessible in the community, including supportive services, housing, and a full array of crisis services. In Los Angeles County, for example, officers are able to directly refer people they frequently come into contact with to Assisted Outpatient Treatment, and other programs and services, as an alternative to arrest and incarceration.⁹⁷

Crisis intervention training and co-responder approaches have gained the most traction in terms of wide scale implementation and evaluation efforts. Crisis intervention training involves law enforcement personnel who are specially trained to respond to calls involving a person with mental health needs. The Memphis Crisis Intervention Team, also referred to as the "Memphis Model," is the most well-known and widely used training program for first responders, particularly law enforcement, who encounter people experiencing a mental health crisis. The training better prepares them for these encounters.⁹⁸ Most studies at this intercept have focused on crisis intervention training programs. The use of crisis intervention trainings has been correlated with increased access to mental health services, including emergency psychiatric care.⁹⁹

More recent crisis intervention training approaches have focused on just policing and implicit bias.¹⁰⁰ A multi-site project – which includes the Stockton Police Department – conducted by the National Initiative for Building Community Trust and Justice, aims to improve law enforcement in diverse communities by providing training on procedural justice, implicit bias, and fostering reconciliation with communities.¹⁰¹ These practices hold promise for improved relationships with communities, and enhanced opportunities to respond to mental health crises in diverse communities through law enforcement.

California counties are investing in mental health services to support diversion at Intercept One

- ***Fresno County | Law Enforcement Field Clinician***

In Fresno County, the Law Enforcement Field Clinician serves as a liaison with county law enforcement to provide training, outreach, and direct field response to residents with mental health needs. The program provides outreach, education, and consultation to law enforcement agencies, including direct field response to support law enforcement and addressing mental health crisis calls.¹⁰²

- ***Kings County | Crisis Intervention Team Training***

Kings County offers training modeled after a nationally recognized, evidence-based program known as the Crisis Intervention Training - Memphis Model, which trains law enforcement and other first responders to recognize the signs of mental illness when responding to a person experiencing a mental health crisis. The course teaches trainees the signs and symptoms of a mental illness as well as coaching techniques for responding appropriately and compassionately to individuals or families in crisis.¹⁰³

- ***Sacramento County | Mobile Crisis Support Teams***

Sacramento County is providing law enforcement with assistance during encounters with people experiencing a mental health crisis. Each team is comprised of a police officer or sheriff deputy trained in crisis intervention training, a licensed mental health clinician, and a peer support provider. After initial contact with the person in crisis, the clinician and peer collaborate to provide continued support and access to appropriate services.¹⁰⁴

Intercept Two: Initial Detention or Court Hearing

The second opportunity for diversion is during initial detention and court hearings. Strategies at this stage include jail diversion programs that offer conditional release and referral to community mental health services. At this intercept, approaches are considered post-booking as they occur after arrest but prior to sentencing.

Numerous jail diversion programs are in use nationwide, and they vary widely in terms of key characteristics and eligibility criteria. For example, some jail diversion programs use a formal screening procedure to determine when a person has a mental illness, while others rely on referrals by social workers, family members, or others. In addition, legal alternatives vary widely and may include deferred prosecution, deferred sentencing, reduced charges, or dismissal of charges.

Programs may offer referrals to services and case management or treatment that is monitored or mandated by the court. Despite this wide variation, key criteria of post-booking diversion programs include, (1) a process for the identification and screening of candidates for mental health interventions, and (2) negotiation among prosecutors, defense attorneys, courts, and providers to identify a plan that addresses both public safety and mental health needs. Strategies include intensive case management and services, including connections to housing, public benefits, and day treatment programs.

Empirical research on the effectiveness of jail diversion programs has focused on reductions in re-arrests, recidivism, psychiatric symptoms, homelessness, emergency room visits, and the number of days in jail. The results are mixed. Some studies demonstrate positive outcomes and others find no significant changes for diverted participants. These mixed results may be due in part to different strategies and interventions used across programs as well as different eligibility requirements for participants. Some research suggests that people with the highest mental health needs may show the greatest benefits.

Nonetheless, research supports a handful of best practices in jail diversion programs, including, (1) structured screening for identifying people with mental health needs, (2) engagement and collaboration with criminal justice stakeholders, and, (3) effective connections with mental health services.¹⁰⁵ Consistent with evidence of effectiveness for mental health practices, jail diversion strategies should include culturally responsive assessments and plans to address mental health needs, including recognition of the role of cultural discrimination and utilization of strategies that build on cultural or ethnic pride.

California counties are investing in mental health services to support diversion at Intercept Two

- ***Marin County | Support and Treatment After Release***

Marin County is providing comprehensive assessment, individualized client-centered service planning, and access to services and supports for those released from the criminal justice system. This program was formerly funded with a Mentally Ill Offender Crime Reduction Grant, and is now funded with Mental Health Services Act funds.¹⁰⁶

- ***Los Angeles County | Mental Health Court Linkage Program***

Los Angeles County has established a recovery-based program staffed by a team of mental health clinicians who are co-located at courts countywide. This program serves adults with a mental illness or co-occurring disorder who are involved with the criminal justice system. It also offers community reintegration services to help participants maintain stability and avoid re-arrest.¹⁰⁷

- ***San Francisco | UCSF Citywide Case Management Forensics***

In San Francisco, adults with mental health needs who become involved with the criminal justice system can receive case management and consultation, as well as mental health services, screening, assessment, and other services through the Behavioral Health Court.¹⁰⁸

Intercept Three: Courts

Intercept Three describes interventions that take place after initial hearings in the jails and courts. Collaborative courts, which are common in California, offer treatment or social services in lieu of jail time. Collaborative courts focus on drug use, mental health needs, veterans, people charged with a DUI, the needs of older adults, and homelessness, among other issues and populations. Drug courts are the most common of these collaborative courts and nearly every county in California has at least one.¹⁰⁹

Mental Health Court programs typically provide a comprehensive range of psychosocial services with the goal of improving long-term mental health. There are over 30 California counties operating adult mental health courts.¹¹⁰ In 2008, the Council of State Governments proposed 10 essential elements that characterize effective Mental Health Courts, including:¹¹¹

- Planning and administration of the court by relevant stakeholders
- Eligibility criteria to identify an appropriate target population and whether services are available
- Timely participant identification and linkage to services
- Terms of participation that are clear, individualized, promote public safety, and lead to positive legal outcomes for people who successfully complete the program
- Informed choice to participate in program before agreeing to terms
- Treatment supports and services in the community based on individual needs
- Confidentiality is protected when sharing a person's health and legal information
- Court team of criminal justice and mental health staff receive specialized and ongoing training
- Monitoring adherence to court requirements, and modification of treatment as necessary
- Sustainability using data to demonstrate the impact of the court

Evaluations of collaborative courts have been hampered by design challenges, including the lack of random assignment and adequate comparison groups. Despite these limitations, initial findings suggest that the use of drug courts and mental health courts results in decreased recidivism and re-arrest rates. One study reported less recidivism and improved access to treatment for mental health court participants.¹¹² Data on access to collaborative courts for communities of color and transgender people is also limited. Given the lack of access identified in other service sectors, collaborative courts should ensure that communities most affected by disparities are receiving equal access to these diversion programs.¹¹³ Program administrators should take into account feelings of mistrust, especially of governmental programs, by diverse communities as barriers to taking advantage of diversion opportunities through collaborative courts.¹¹⁴

California counties are investing in mental health services to support diversion at Intercept Three

- **Monterey County | Adult Mental Health Court**

Monterey County delivers intensive case management, psychiatric care, probation supervision, and therapeutic mental health services to people who are 18 years and older and have a history of criminal justice involvement and mental health needs. The Adult Mental Health Court is a combined effort between the Sheriff's Office, the courts, Behavioral Health, Probation, and Law Enforcement.¹¹⁵

- **Orange County | Mental Health Court (Probation Services)**

Orange County uses a team approach that includes voluntary programs, such as Opportunity County and Recovery Court and Whatever It Takes Court. These efforts provide people with chronic mental health needs with counseling, opportunities to meet with a probation officer and health care coordinator, a chance to appear in court, and access to specialized services.¹¹⁶

- **Santa Barbara County | Justice Alliance**

Santa Barbara County provides competency restoration services to people charged with misdemeanor crimes but who are found incompetent to stand trial, as well as case management to people receiving outpatient competency restoration services in supportive housing facilities.¹¹⁷

Intercept Four: Reentry

Intercept Four encompasses interventions that take place during incarceration and upon release. Most research on Intercept Four has focused on programs for reentry into communities. For jail stays, reentry programs must be adapted to the brief periods between confinement and release and, potentially, re-arrest. This rapid turnaround creates challenges for planning and providing mental health care upon release and for ensuring the delivery of coordinated and continuous care. Loss of eligibility for some programs during incarceration, such as Medi-Cal services, may further complicate access to care.¹¹⁸

Several effective models exist to guide counties in providing services following incarceration. They include:

- **ASSESSMENT, PLANNING, IDENTIFICATION, AND COORDINATION MODEL:** Under this model, staff members assess a person's clinical and social needs and public safety risks, prepare a plan for treatment and services, identify required community and correctional programs

responsible for post-release services, and coordinate the transition plan to ensure implementation and avoid gaps in care.¹¹⁹

- **RISK-NEED-RESPONSIVITY MODEL:** Three core principles of this model are matching the level of service to the offender’s risk to re-offend, assessing needs and targeting those needs in treatment, and maximizing the person’s ability to learn from a rehabilitative intervention by providing cognitive behavioral treatment and tailoring the intervention to the learning style, motivation, abilities, and strengths of the person.¹²⁰
- **ACTION APPROACH:** This collaborative approach brings together the criminal justice, mental health, and substance abuse treatment systems to promote recovery of incarcerated people with co-occurring disorders who are re-entering into the community. The model relies on education, facilitated strategic planning, and follow-up technical assistance to reduce re-incarceration.¹²¹

One strategy that helps people navigate the transition from custody to community successfully is what practitioners call a “warm hand-off.” Ideally, a warm hand-off involves connecting people leaving county jails with a range of community resources to ensure their needs are met immediately upon release.

Transitioning People from Jail into Services

Creating warm hand-offs for jail inmates in Riverside County has been a key objective of a year-long collaboration between the Riverside County Sheriff’s Department and the Riverside University Health System’s Behavioral Health Department.

Carlee Antillon, a Riverside County Behavioral Health specialist, leads discharge planning at the county’s Robert Presley Detention Center. Antillon said the process begins about six months before inmates are scheduled for release and includes helping them acquire housing, transportation, employment, clinical appointments, and medication.

Before the collaboration produced improvements in the county’s discharge procedures, inmates were typically released at random times of day or night and with little more than a packet of information. Now, county staff provide significant support, including the scheduling of appointments, Antillon said, or even a ride “straight to the clinic to be seen” upon release.

If a person qualifies, he or she can also access care at clinics funded through AB 109, California’s public safety realignment act. Services at those clinics include group therapy and care coordination through a case manager. Also available is the Full Service Partnership Program at the Jefferson Wellness Center, which provides recovery-based services to homeless people with a mental health diagnosis.

Fred Osher and Christopher King identified multiple promising practices for people with mental health needs released from confinement.¹²² These approaches include, (1) identification of individuals in need of mental health services and assessment of mental health needs, (2) cognitive behavioral and skill-building interventions, as well as psychiatric follow-up when needed, (3) coordination of care, (4) providing care in an ethical manner that takes into account supervision needs as well as freedom of choice in treatment, and, (5) team-based case management.

The Council of State Governments has developed a “Reentry Clearinghouse” website that summarizes the research on reentry programs.¹²³ Through an extensive literature search conducted in 2010 and again in 2015, the authors identified several studies examining the effectiveness of reentry programs. Studies are

categorized in terms of methodological rigor, such as High Rigor or Basic Rigor, as well as the effectiveness of programs in reducing recidivism.

Other research has explored the effectiveness of specific programs on outcomes other than recidivism. Osher and King found mixed results during their review of Assertive Community Treatment, Intensive Case Management, and forensic transition team approaches.¹²⁴ Initial findings suggest that Assertive Community Treatment may be effective for communities of color.¹²⁵ An example of community-driven practice at Intercept Four is The Warrior Down Program in Sacramento County, which provides relapse prevention and recovery support services for Native Americans who are completing treatment, returning to the community from incarceration, or who have been on their recovery journey using traditional methods or 12 Step Medicine Wheel Teaching Methods.¹²⁶

California counties are investing in mental health services to support diversion at Intercept Four

- **Lake County | Forensic Mental Health Partnership**

Lake County assists consumers in addressing their mental health needs, navigating the legal process, and planning during transition from jail to community. The Partnership also provides consumers with support in the community after release through service coordination, clinical services, and a Full Service Partnership program that pursues a “whatever it takes” approach.¹²⁷

- **San Luis Obispo County | Forensic Re-entry Services (FRS) Team**

San Luis Obispo County provides a “reach-in” strategy in the county jail, to plan the aftercare needs for persons leaving jail. This support comes in the form of assessment and referral to all appropriate health and community services as well as short-term case management during this transition.¹²⁸

- **San Diego County | Project In-Reach**

San Diego County provides discharge planning and short-term transition services to community-based treatment for at-risk African American and Latino inmates with serious mental health needs.¹²⁹

Intercept Five: Community Supervision

Intercept Five encompasses interventions that occur in the context of community supervision. According to one estimate at the end of 2008, one in every 45 adults in the United States were under either parole or probation, also referred to as community supervision.¹³⁰ Further, approximately 70 percent of people under the supervision of the criminal justice system are under community – as opposed to in-custody – supervision.¹³¹ Statistics like these have lead researchers and advocates to explore what they see as an overreliance on community supervision, and some have argued that community supervision is quite punitive.¹³² Complying with the terms of conditions of probation can be challenging for people with mental health needs, especially if they are unsupported. Often mental health services are a required condition of probation, which raises concerns about the voluntary nature of treatment or whether people are able to have a say in which particular program and services are selected for them.¹³³ Not participating in required services could result in a “technical violation,” leading to reincarceration or other punitive responses.

To improve outcomes at this intercept, specialty probation approaches hold the most promise.¹³⁴ Under this strategy, probation officers receive specialized training in mental health and are assigned a reduced caseload of people with mental health needs. This model enables probation officers to collaborate with mental health providers and establish a problem-solving, rather than punitive, approach to managing transgressions. In addition, many jurisdictions pair specialized probation programs with Forensic Assertive Community Treatment, which focuses on reducing recidivism.

“County behavioral health systems continue to promote a paradigm shift wherein local leaders – including county supervisors, law enforcement, and courts – view treatment for individuals living with mental illness or addiction as a measure that promotes public safety.”

- Yvonnia Brown, Merced County Behavioral Health Director

Research on these interventions is still limited. Jennifer Skeem and colleagues compared outcomes for probationers receiving specialty probation services and found improvements in recidivism and access to mental health services.¹³⁵ Another review suggests that the effectiveness of specialty probation programs may be influenced by relationships with probation officers.¹³⁶ Clients who had reported positive relationships with probation officers tended to have better outcomes in terms of both mental health and recidivism.¹³⁷

Participants in small group discussions held for this project reiterated the role of trauma, especially early childhood trauma, in their involvement with the criminal justice system. Addressing trauma and improving symptoms of depression, post-traumatic stress disorder, and anxiety stemming from trauma are critical steps toward reducing reoffending rates.¹³⁸ Strong case management – involving coordinated and integrated services that address trauma and other mental health needs, substance use disorder, and other factors – is one of the most effective ways to reduce justice involvement.¹³⁹

California counties are investing in mental health services to support diversion at Intercept Five

- ***Contra Costa County | Forensic Team***

Contra Costa County has established a multi-disciplinary team that provides mental health services, alcohol and drug treatment, and housing services to people who are on probation and at risk of re-offending. Efforts include assessing referrals for serious mental illness, providing rapid access to a treatment plan, and using a team approach to provide appropriate services.¹⁴⁰

- ***Stanislaus County | Integrated Forensic Team***

Stanislaus County provides comprehensive mental health and co-occurring services for adults who are on probation and/or have frequent contact with law enforcement. Available services include case management, crisis response, family support, housing and employment assistance, medication, and peer support.¹⁴¹

- **Solano County | Forensic Assertive Community Treatment**

Solano County provides intensive case management and community-based services to improve the quality of life and reduce recidivism, homelessness, and hospitalization for people with mental health needs who are involved with the criminal justice system.¹⁴²

Community Collaboration and Blending Funds

The Sequential Intercept Model and the Stepping Up Initiative's Six Questions provide frameworks for counties to supplement existing planning processes. Those counties that have created a diversion plan have done so by using federal grants, Mental Health Services Act funds, AB 109 planning dollars, and other existing funds.

The criminal justice and mental health systems have similar planning processes. County probation departments use the Community Corrections Partnership process to engage stakeholders on the allocation of AB 109 funding, among other community corrections planning initiatives. AB 109, the 2011 public safety realignment measure, shifted responsibility for certain offenders to the counties.¹⁴³ Counties received state funds that could be used for law enforcement supervision and custody, mental health, substance use, and other social services. County mental or behavioral health departments use a required Community Program Planning Process to engage stakeholders on how to spend funds from the Mental Health Services Act. Counties can spend up to five percent of their local allocation on planning.¹⁴⁴ How counties implement these planning processes varies widely.

Local Collaboration and Private-Public Funding

When it comes to keeping people with unmet mental health needs out of jail, Bexar County, Texas, is widely recognized as a national leader. In 2003, stakeholders from throughout the county's criminal justice and mental health systems teamed up to launch the county's Jail Diversion Program, and since then, more than 20,000 people with mental health needs have been diverted from jail into treatment.

Under the program, interventions occur at multiple points through three phases. In the first phase, the focus is on diverting people in crisis before they are arrested or booked in the county jail. In the second phase, the program provides screening and recommendations for alternative dispositions, such as release to a treatment facility or "mental health bond." The third phase emphasizes providing appropriate and continuous services upon release from jail or prison.

Key to the program's success is the strong collaboration among its 34 different partners, including law enforcement, courts, mental health services, hospitals, and community stakeholders. The program employs 146 multidisciplinary staff, with annual funding of approximately \$9 million provided by a blend of federal, state, and local funds.

Between 2011 and 2016, the Jail Diversion Program saved Bexar County more than \$50 million and helped resolve the serious overcrowding problem in its jail. Savings have been realized through investments in community mental health services, hiring more professionals to provide treatment, and focusing resources on rehabilitation, housing, and employment assistance.

In developing the Jail Diversion Program, county partners acknowledged that people with mental health, substance use, and housing needs contributed to jail overcrowding and excessive law enforcement overtime, and that these people could better be served by community-based services. Partners also

recognized the need to stretch existing dollars by blending funding streams, and that required trust and the willingness to collaborate across systems.

In conjunction with the Jail Diversion Program, Bexar County is also the home of Haven for Hope, a campus-style resource for addressing homelessness. Since Haven for Hope opened in 2010, the homeless population in downtown San Antonio has dropped approximately 80 percent, and nine out of ten of those receiving a housing placement have not returned to homelessness within one year. Approximately 61 percent (\$100 million) of the construction costs to build Haven for Hope came from the private sector.

Well-intentioned grant programs and pilot projects have funded system improvements in pieces, often with short-term funding and no long-term strategy. Below is a partial list of grants and pilots in California and a table showing which grants are operating in which county. These grants and pilots fund programs and services targeting the formerly incarcerated and people at risk of incarceration, or programs that intervene with vulnerable populations, such as people experiencing homelessness or people in crisis. Currently, it is difficult – if not impossible – to determine the collective impact of these funds on the people they intend to benefit, especially in counties that are receiving multiple grants from different state administrating agencies and different local recipients.

- **Investment in Mental Health Wellness Act (SB 82, 2013) | Administered by the California Health Facilities Financing Authority (CHFFA) | Approximately \$143 million over three years | Competitive Grant**

The grants from CHFFA support capital improvement, expansion, and limited start-up costs. Funding is limited to the following specific programs: crisis stabilization, crisis residential treatment, mobile crisis support teams, and peer respite.¹⁴⁵

- **The Mental Health Wellness Act (SB 82, 2013) Grant | Administered by the Mental Health Services Oversight and Accountability Commission (MHSOAC) | Approximately \$96 million over three years | Competitive Grant**

The purpose of the triage grant is to increase the number of personnel to provide crisis intervention, crisis stabilization, mobile crisis support, and intensive case management and linkage to services. These funds provide the opportunity for counties, counties acting jointly, and city mental health departments to reduce the costs associated with long stays in emergency departments, link to services for those released from jails, and reduce the time spent by law enforcement on mental health crisis calls.¹⁴⁶

- **Law Enforcement Assisted Diversion (LEAD) Grant | Administered by the Board of State and Community Corrections (BSCC) | Approximately \$15 million for three sites over three years | Competitive Grant**

LEAD grants allow law enforcement officers to redirect people suspected of committing low-level offenses to community-based services rather than to jail, addressing underlying factors that drive criminal justice contact. The program is not exclusively focused on providing addiction treatment or mental health treatment. For some participants, housing and reliable access to food may be the most pressing needs.¹⁴⁷

- **Mentally Ill Offender Crime Reduction (MIOCR) Grant | Administered by the Board of State and Community Corrections (BSCC) | Approximately \$17 million over 3 years | Competitive Grant**

The purpose of MICOR grant is to support appropriate prevention, intervention, supervision, and incarceration-based services through promising and evidence-based strategies to reduce recidivism and improve quality of life outcomes for juvenile and adult offenders with mental health needs in California.¹⁴⁸ In 2015, 21 projects in 17 counties were awarded funding. An evaluation of the first round of funding identified 10 best practice strategies:¹⁴⁹

- Interagency collaboration
- Intensive case management
- Involvement with the court
- Mental health courts
- Assistance in securing benefits
- Assistance arranging housing
- Medication management
- Use of a center or clinic
- Assistance with transportation
- Peer support

- **Safe Neighborhoods and Schools Act (Proposition 47, 2014) and AB 1056 (2015) | Administered by the Board of State and Community Corrections (BSCC) | Approximately \$104 million over three years | Competitive Grant**

The purpose of this grant is to invest funds generated by state prison savings into local prevention programs in schools, victim services, and behavioral health services. These monies support programs and services that reduce recidivism by people convicted of less serious crimes and those who have behavioral health needs. Assembly Bill 1056 (Statutes of 2015, Chapter 438) requires public agencies to leverage other funding streams to maximize grant dollars, specifically the Mental Health Services Act, among others.¹⁵⁰

- **The Whole Person Care (WPC) Program | Administered by the California Department of Health Care Services | Approximately \$1.5 billion in federal funding over five years | Competitive Pilot**

WPC is a network designed to bring together health, behavioral health, and social services agencies to provide efficient and effective resources to Medi-Cal recipients who are frequent users of the health care system. Through this funding, Medi-Cal 2020 waiver identified populations that WPC pilot programs can target and allowed the programs to further distinguish vulnerable populations based on community needs.¹⁵¹ Almost all of the designated pilot programs have the same target population, specifically, high utilizers, residents who are homeless or at risk of homelessness, and people with mental health or substance use disorders.¹⁵² Most programs set similar goals, such as assisting the homeless, improving coordinated care, and disseminating patient data between health systems.¹⁵³

SELECTED GRANTS AND PILOTS BY COUNTY

✓ = grant recipient

	CHFFA	MHSOAC	BSCC		DHCS
	<u>SB 82</u> Grantee: County Mental Health ¹⁵⁴	<u>SB 82 Triage</u> Grantee: County Mental Health ¹⁵⁵	<u>LEAD</u> Grantee: Varies ¹⁵⁶	<u>Adult</u> <u>MIOCR</u> Grantee: Varies ¹⁵⁷	<u>Proposition</u> <u>47</u> Grantee: Varies ¹⁵⁸
Alameda	✓	✓		✓	✓
Butte	✓	✓			
Calaveras		✓			
Contra Costa	✓				✓
Fresno	✓	✓			
Imperial	✓				
Kern	✓				✓
Kings	✓				✓
Lake	✓	✓			
Los Angeles	✓	✓	✓	✓	✓
Madera		✓		✓	
Marin	✓	✓			✓
Mariposa		✓			✓
Mendocino	✓				✓
Merced	✓	✓		✓	
Monterey	✓			✓	✓
Napa	✓	✓			✓
Nevada	✓	✓			
Orange	✓	✓			✓
Placer		✓			✓
Plumas					✓
Riverside	✓	✓		✓	✓
Sacramento	✓	✓			✓
San Benito					✓
San Bernardino	✓	✓			✓
San Diego	✓				✓
San Francisco		✓	✓	✓	✓
San Joaquin	✓				✓
San Luis Obispo	✓			✓	
San Mateo	✓				✓
Santa Barbara	✓	✓			
Santa Clara	✓			✓	✓
Santa Cruz	✓			✓	✓
Shasta	✓				✓
Solano	✓			✓	✓
Sonoma	✓	✓			✓
Tehama					✓
Trinity	✓	✓			
Tuolumne		✓			
Ventura	✓	✓			✓
Yolo	✓	✓			✓

Through local stakeholder planning processes and others, some counties are blending mental health and criminal justice funding - including grant funding - to develop programs and services to meet the needs of a population that spans multiple agencies. Below are examples of current programs and services with blended criminal justice and mental health funding.

- **Alameda County | ACProp47 Program | Funded with Proposition 47, Mental Health Services Act, AB 109, and other funds**

ACProp47 supports residents who are involved in the justice system and who have a mental health issue and/or substance use disorder. Specifically, funds will be used to: 1) implement a new, county-wide, intensive, multidisciplinary reentry team model to provide service for members in the target population who are experiencing moderate to severe mental health issues and/or substance use disorders; 2) augment contracts with existing community based providers to increase the number of people in the target community who receive their services; and 3) launch a new grant program designed to increase the number and ability of organizations in the county to provide comprehensive housing supports.¹⁶⁰

- **Merced County | Adult Mental Health Court and Reentry Program | Funded with Mental Health Services Act and AB109 funds**

The Mental Health Court and Re-entry Program provides case management to qualified adult probation clients. The program uses a team of four professionals to ensure participants receive all community resources during rehabilitation and reintegration and include families as partners in the recovery process.¹⁶¹

- **Riverside County | Whole Person Care | Grant match funds provided by the Mental Health Services Act, housing and hospital funds**

The Whole Person Care Pilot aims to create a pathway for early identification of needs and provide linkages and interventions to a high risk, high need population. The goal is to decrease expensive and unneeded emergency room visits and hospital usage, and to reduce criminal behavior and jail recidivism by increasing each individual's self-sufficiency and efficacy through care coordination. The pilot screens new probationers, at their first visit following release from incarceration, for serious mental illness and other needs, and then provides warm hand offs to services that will help them successfully reintegrate back into the community. Registered nurses are placed in eight probation sites to screen probationers for: behavioral, physical, and social service needs, and then link them to services.¹⁶²

- **Santa Clara County | Faith-based Collaboration | Former Mental Health Services Act Innovation, now funded with AB 109 and Mental Health Services Act Community Services and Supports funds**

Faith-based Collaboration is a group of multi-faith religious institutions, community organizations, and volunteers established to provide transitional services and offer trust, accountability, and spiritual support to individuals reentering the community and returning to their families after incarceration.¹⁶³

- **Solano County | Mentally Ill Offender Crime Reduction Program | Funded with Mental Health Services Act and Mentally Ill Offender Crime Reduction Grant funds**

The Solano County Mentally Ill Offender Crime Reduction Program created a county-wide response for the justice-involved mentally ill by forming collaborative teams to divert low level community offenders, provide prisoners with and without a sentence post-assessment, jail-based mental health programs, and offer participants reentry planning along with case management aftercare services pre- and post-release through Critical Time Intervention, an evidence-based practice.¹⁶⁴

Findings and Recommendations

While the challenge of reducing the number of Californians with mental health needs in the criminal justice system is not new, the time to affirm our commitment to resolving this vexing problem is now. Momentum at the national and state level to address this crisis is at a tipping point. Advances in innovative approaches, technology, and shifts toward system integration have created opportunities for change that cannot be ignored.

California must focus on protecting people with unmet mental health needs from engagement with the criminal justice system. Local services should be aligned through comprehensive planning to address unmet needs before they reach the attention of law enforcement. When prevention efforts fall short, counties should have more effective in-custody options to ensure they can provide appropriate and necessary services for those who cannot be diverted. Counties should have an array of options to provide competency restoration services to people found incompetent to stand trial so that people do not wait unnecessarily in jail.

California's counties are well-positioned to develop more effective responses to the increased number of people with unmet mental health needs in jails. The state should clear the path for effective responses by providing clarity regarding state and federal law, facilitating information sharing, and identifying and addressing barriers to innovation, among other tasks.

The state should also examine barriers and develop solutions to integrating and leveraging data to build responsive systems, provide better case management, and continuously improve services. The state and counties should work together to improve training and technical assistance to ensure professionals are trained and cross-trained to provide appropriate responses and quality services to clients. Evaluation and dissemination of effective practices are essential to continuous quality improvement.

The Commission recognizes its responsibility to help establish a vision and a strategy, as well as to work with state and county agencies to pursue that vision. The following principles emerged from the Commission's review and are the foundation for the specific findings and recommendations that follow.

Findings and recommendations are organized by local reform (Findings and Recommendations 1, 2, and 3), state reform (Finding and Recommendation 4), and the tools necessary to support these reforms (Findings and Recommendations 5 and 6). County projects funded through the Mental Health Services Act Innovation Component are highlighted under each recommendation to demonstrate how counties are already developing innovative practices in their communities.

Guiding Principles

The Commission developed the following principles based on information and insight gathered through its review to guide its recommendations outlined below. Each principle builds off others, so there will be natural overlap.

PREVENTION: A relatively small number of people commit offenses as a direct consequence of mental illness alone. Most become involved in the criminal justice system due to a complex combination of unmet needs. Incarceration and involvement in the justice system can be prevented by treatment and support that address the full range of needs, including supportive housing and employment, co-occurring mental health and substance use disorder treatment, services that address trauma, early detection and treatment of mental illness, positive social supports and relationships, and structured activities to build connections to the community.

DIVERSION: People with mental health needs are inappropriately overrepresented in the criminal justice system. Following an arrest, screening and assessment should be conducted as soon as possible to identify people with mental health and substance use needs, and these assessments should be used in diversion decisions. Validated risk assessment tools should be mandatory. When appropriate, people with mental health needs should be diverted out of the justice system as soon as possible and into person-centered, culturally competent services.

TREATMENT: Improving access to mental health treatment alone does not necessarily reduce the likelihood that people with mental health needs will reoffend. When diversion is not possible, people with mental health and substance use needs should receive in-custody treatment and services that adequately address such needs. Release planning for people with mental health needs should occur as soon as possible, and should include potential community providers and peers or people with lived experience. People who have been in correctional settings must be active participants in developing treatment plans.

LEADERSHIP: Change requires executive-level leadership that empowers everyone in an organization and a community to contribute to improvement efforts. State and local leaders must model collaboration when required to improve outcomes, and must collaborate with community leaders and cultural brokers. All leaders must be willing to support a culture of ongoing assessment, and investment based on those assessments. Community members, especially people with lived experience and families, should be empowered as change agents and should work side-by-side with organizational leaders to identify systemic barriers and creative solutions.

CAPACITY: There are insufficient resources along the continuum for people with mental health and substance use needs, resulting in the over-utilization of jails and emergency departments. Local communities must leverage existing funding from public and private sources, and use funding in the most cost-effective manner based on community needs.

COLLABORATION: Mental health needs are among many needs that must be met to increase recovery and decrease involvement with the criminal justice system. Improving outcomes for people with mental health needs in the justice system cannot be the responsibility of a single public entity. Collaboration requires shared responsibility. Collaboration should include people with lived experience in the criminal justice and mental health systems, as well as family members. Local collaboration must occur among

public health and public safety leaders. State collaboration must model local collaboration to support and sustain change over time.

EQUITY: An equitable system is built on just approaches that offer people an equal opportunity to obtain services regardless of race or ethnicity, gender identification, socioeconomic status, or sexual orientation. Longstanding mental health disparities exist for people in diverse communities, and incarceration rates in those communities continue to climb. More must be done to understand these trends, the impacts of historical marginalization and oppression, and to reduce disparities using culturally-competent outreach, engagement, training, and service delivery.

INTEGRATION: An integrated approach is required to address the complex needs of people with mental health needs involved in the justice system. Mental health and other services addressing unmet needs should be integrated into the same program and with the same provider/clinician. When program integration is not possible, information and data on people receiving services from different providers must be exchanged to coordinate care and track progress over time.

DRAFT

FINDING ONE:

Too many mental health consumers, particularly those from diverse communities, end up in jail because of unmet needs and system inequities. A robust, prevention-oriented system can reduce this unnecessary harm.

People with mental health needs who become involved with the criminal justice system tend to have challenging, complex needs. They are often homeless, may have long-standing physical health needs, exposure to multiple traumas and adverse childhood experiences, and may battle chronic addictions to drugs and alcohol. Diverse communities are affected by long-standing inequities in social determinants of health, including education, physical environment, and employment and other economic opportunities. These inequities, combined with other needs, contribute to disproportionate contact with law enforcement and confinement in jail.

For some people, mental health recovery can take months, years, or decades. Some people do not believe they have mental health needs or may have had multiple unpleasant experiences with the mental health system, and thus may understandably resist treatment. Some move toward recovery for periods of time but then may struggle for various reasons, including discontinuing medication use or experiencing new challenges or trauma.

During its review, the Commission heard that a large number of Californians with mental health needs often receive treatment for the first time in the criminal justice system. As many experts see it, the criminal justice system has become a de facto outreach and engagement strategy to connect people with care. Stories the Commission heard include:

- Prosecutors and public defenders who believe that keeping a person with mental health needs in the court system is the best or only way to connect them with services
- Members of the public who call 911 when they see a person on the street arguing with him or herself as a strategy to obtain help
- Parents of an adult child who is refusing treatment and are encouraged to have their child arrested as a strategy to obtain mental health services in custody

Yet calling law enforcement as an access strategy is expensive, can complicate efforts to provide effective mental health services (resulting in poorer outcomes), and distracts law enforcement personnel from their primary focus. Once a person enters the criminal justice system, considerable costs follow. These include the cost of housing such individuals and providing treatment for mental health, substance use, and physical health needs, as well as the costs associated with court proceedings and community supervision for those released on probation. In addition to added costs, involvement in the criminal justice system can inflict new trauma on people with mental health needs, making their condition worse. Involving law enforcement in mental health care often results in a criminal record, which can create another barrier to care by preventing eligibility for mental health services.

Establishing a comprehensive, community-based system focused on preventing contact with the criminal justice system must be prioritized. Creating and sustaining such a system cannot be the responsibility of a single department. It will require collaboration among county health and safety partners, including the

sharing of data across agencies to understand gaps and leveraging all available funding to maximize capacity. Several key areas consistently emerged from the Commission's work as gaps in the current delivery system, including housing, integrated care for co-occurring needs, disparities in access and utilization of services by diverse communities, and a lack of options for people transitioning out of the highest levels of mental health care.

HOUSING CAPACITY: A shortage of available housing remains one of the biggest challenges facing those with mental health and substance use needs who become involved in the criminal justice system. Affordability and availability of housing in California are challenges statewide, especially for diverse communities, and these challenges are complicated by community opposition to housing for the formerly incarcerated, especially those with mental health needs. Stigma towards people living with mental illness who are involved with the criminal justice system increases the unwillingness to develop housing in certain neighborhoods. NIMBYism ("Not in my backyard") is a major barrier to the expansion of housing, and will continue to prevent or hinder the ability to meaningfully provide needed services and supports if not addressed.

SERVICE INTEGRATION: Integrated mental health and substance abuse treatment is essential for the successful care of people with co-occurring disorders. Unfortunately, a lack of available co-occurring disorder treatment programs, combined with a shortage of appropriately trained clinicians, limits access to integrated treatment in both outpatient and inpatient mental health settings. Therefore, the systems for treatment of mental health and substance use disorder are currently separate, which makes integrated care challenging. Most publicly funded programs are not integrated and provide only mental health or substance abuse treatment.

DISPARITIES: Disparities in access to mental health services and outcomes for diverse communities remain a challenge. The Mental Health Services Act values cultural and linguistic competence and the reduction of disparities in access to services. In order to achieve the objectives of the act, state and local officials must ensure that people are served, (1) in ways that are congruent with and respectful of differing cultural views and traditions, (2) in ways that eliminate disparities in access to treatment and quality of care, and (3) in ways that create successful outcomes for all consumers and families served.

Throughout this project, the Commission heard from stakeholders that communities of color are reluctant or afraid to seek help from those outside their culture or communities. Language access continues to be a problem. Service providers and administrators need to work in cooperation with diverse communities to identify culturally and linguistically appropriate treatment and outreach strategies and to increase workforce diversity. Steve Fields, Executive Director of the Progress Foundation, recently stated, "Our workforce must reflect the look, reality and experience of the people we are hoping to serve. We need to better understand why consumers struggle with traditional and new treatment strategies, particularly medication."¹⁶⁵ Programs and services are not addressing the environment in which people live, stigma and discrimination in the cultures people grow up in, and the traumatizing effects of neighborhood or family violence, intergenerational incarceration, and poverty and homelessness that disproportionately impact diverse communities.

LACK OF "STEP DOWN" OPTIONS: Another challenge facing people who need care is the shortage of services for acute needs and lack of "step down" options as people transition from higher levels of care, such as Full Service Partnerships, into less intensive services. California has seen a reduction in the

availability of inpatient acute psychiatric hospital beds. In response, counties have developed alternative strategies to fill the gap, such as crisis residential centers and crisis stabilization units. These are short term solutions to reduce use of hospitalization and jails. Longer term solutions are still needed for people who need more intensive services and a higher level of care, and for those who are transitioning out of care.

RECOMMENDATION ONE:

California’s mental health agencies, in partnership with law enforcement and others, should have a comprehensive prevention-focused plan that reduces the incarceration of mental health consumers in their communities.

Local mental health and public safety departments should collaborate to develop a continuum of care and strategies to deliver services to reduce involvement and improve outcomes for people with mental health and substance use needs who become involved in the criminal justice system. Developing these strategies should start with an analysis of needs and gaps in care. Counties should explore the use of public health models that incorporate social determinants of health to identify prevention opportunities for communities disproportionately confined in local jails, including members of African American, Latino, Native American, and transgender communities. Strategies identified through the California Reducing Disparities Project may offer culturally and linguistically responsive options for engaging and serving communities of color and LGBTQ communities.¹⁶⁶

Counties should build programs, services, and facilities that have demonstrated effectiveness, and should measure performance over time to ensure quality improvement. Counties should make better use of data and information to guide their investments in programs and services that reduce the number of people with mental health needs in the justice system. They should also use such data to connect people needing services with appropriate community-based care.

To support local commitments to diverting those with mental health needs from the justice system, counties should have culturally and linguistically competent programs and services available that address the issues that put people at risk, such as housing instability, trauma, and inequities in education, employment, and health care. Planning should include programs that are “one-stop-shops,” with co-located mental health, substance use, and physical health services and coordinated case management to make meaningful referrals for available services in the community. These strategies should be trauma-informed and should take into account consumer experiences of cultural discrimination.

Counties should leverage the expertise of those with lived experience, including family members, when designing prevention and diversion strategies that are trauma-informed and take into account racial and cultural discrimination. Counties should continue expanding the array of crisis services, such as 23-hour crisis stabilization/observation beds, short-term crisis residential services and crisis stabilization, mobile crisis services, 24/7 crisis hotlines, warm lines, and peer crisis services.

The ubiquitous experience of trauma for people with criminal justice involvement and mental health needs cannot be ignored. Increasing access to programs that address trauma, particularly for communities of color and LGBTQ communities, is critical. Specific and concerted efforts must be made to identify the

mental health and substance use needs of ethnic and cultural minorities. These efforts should include improving access to care and quality of mental health services. Engaging new and diverse partners and building relationships with community leaders and professionals will be a critical step in addressing inequities in the mental health and criminal justice systems.

One way to identify system gaps and disconnects is by conducting formal needs assessments as part of each county's required Community Program Planning process.¹⁶⁷ Counties should make use of data and information to guide investments in programs and services that reduce the number of people with mental health needs in the justice system. Data also can support the community consultation process regarding public investments and can help to leverage funding streams that come from different sources and are allocated to different agencies. Needs assessments could help fill system gaps, but models for a continuum of care that addresses a full range of mental health and substance use needs is still needed.

The lack of standards for a mental health continuum of care is receiving national attention. Recently, the Substance Abuse and Mental Health Services Administration's Center for Mental Health Services convened some two dozen experts to advise the agency on the development of a model mental health continuum of care. Consensus was reached that guidelines were needed, as the nature and quality of mental health care varied so greatly by community. In the convening, experts noted that services were fragmented, and often incomplete. The Commission can support these efforts by working with county mental health leaders, peers, providers, and others to develop standards as part of its review of local plans.¹⁶⁸

MHSA Innovation Highlight – Advancing Mental Health Urgent Care Models in California

Sacramento County | Mental Health Crisis/Urgent Care Clinic

The Sacramento County Division of Behavioral Health Services is implementing an innovative project to adapt urgent care models used in other counties to meet the needs of the community. This adaptation will include integration of wellness and recovery principles in service delivery. Innovative adaptations include an after-hours outpatient treatment program operation to allow for more flexible staffing patterns, direct linkage to behavioral health services, and a screening tool that allows staff to screen for physical health issues, expediting care coordination.

<https://www.dhhs.saccounty.net/BHS/Documents/Reports--Workplans/MHSA-Reports-and-Workplans/RT-2016-17-MHSA-Annual-Update--Sacramento-County.pdf>

FINDING TWO:

California’s jails are not equipped to serve mental health consumers. Diversion should be prioritized, but counties need more effective in-custody options to ensure they can provide appropriate and necessary services to those who cannot be diverted.

Each county must prioritize diversion to ensure that no one ends up incarcerated because of unmet mental health needs. Despite those efforts, some people with mental health needs will inevitably become incarcerated in local jails. Unlike state prisons, jails were not designed or intended to house people for long periods of time. Prior to criminal justice realignment, jails mostly held people awaiting trial and those serving sentences for up to one year. Jails today house and treat people serving lengthy sentences, including people with complex, long-term unmet mental health, substance use, and physical health needs.

The challenges of effectively serving people with mental health needs in jail are well documented. Jails lack appropriate treatment space due to their physical design, and inadequate staffing and training are common. People with mental health needs tend to stay in jail longer, return to jail more often, and cost local jurisdictions more money while incarcerated.¹⁶⁹ More frequently than not, people with mental health needs are jailed for minor offenses, such as trespassing, disorderly conduct, disturbing the peace, or illicit drug use.¹⁷⁰ Jail staff are challenged with how to manage people with mental health needs in custodial settings, which are often crowded, brightly lit, and loud. People with mental illness may be hypersensitive to this environment, and may exhibit behaviors that jail staff struggle to control.

Mental Health Services in Local Jails

California Code of Regulations, Title 15, outlines the standards for local detention facilities, including standards for mental health screening and treatment. Below is an overview of several regulations related to jail mental health.

- Screening for mental health needs by licensed health personnel or trained facility staff should occur at the time of intake, and a written plan developed for those who appear at screening to need mental health services.¹⁷¹ Health care providers develop written individualized treatment plans for people receiving mental health services in jail, including referrals to treatment after release if recommended by treatment staff.¹⁷²
- Local facility administrators have the responsibility of ensuring emergency and basic mental health care.¹⁷³ Each facility establishes policies and procedures to provide mental health services, including:
 - Identification and referral of inmates with mental health needs
 - Mental health treatment programs provided by qualified staff
 - Crisis intervention services
 - Basic mental health services provided to inmates as clinically indicated
 - Medication support services
 - The provision of health services sufficiently coordinated such that care is appropriately integrated, medical and mental health needs are met, and the impact of any of these conditions on each other is adequately addressed.¹⁷⁴

- Written policies and procedures are developed to govern the use of psychotropic medications.¹⁷⁵ Medication may only be administered involuntarily on an emergency basis if a person is found by a physician to be a danger to him/herself or others by reason of a mental illness.¹⁷⁶
- Written plans for informed consent of inmates in a language understood by the inmate are developed, and all examinations, treatments, and procedures affected by informed consent standards in the community are likewise observed for inmate care.¹⁷⁷ Absent informed consent in non-emergency situations, a court order is required before involuntary medical treatment can be administered to an inmate.¹⁷⁸
- Each facility develops a comprehensive suicide prevention program to identify, monitor, and provide treatment to those at risk of suicide.¹⁷⁹

While some inmates serve lengthy sentences, for others, the time from intake to release can be as short as a few hours. Treatment initiated in custody is frequently terminated when a person is released, and care typically does not resume once that person enters the community. This “churning” of people with complex mental health and substance use needs often makes it difficult, and in some cases impossible, to complete thorough assessments of a person’s mental health history or current needs, provide effective treatment, and develop appropriate discharge plans before release.

Uncertainty about a person’s release date is another challenge, one that makes coordination of services difficult. The criminal justice system lacks a consistent, adequate method for connecting inmates to appropriate services upon release, a gap that aggravates behavioral health conditions and contributes to subsequent encounters with law enforcement. On the front end in California, mental health screenings are required at initial booking in local jails. But jails face an array of challenges that delay those screenings. Challenges include people too agitated for screening or under the influence of drugs or alcohol, unavailability of trained staff, and a large number of bookings at the same time.¹⁸⁰

Mental Health Training for Jail Staff

The Board of State and Community Corrections is reviewing and updating core training requirements for Adult Corrections Officers, Juvenile Corrections Officers, and Probation Officers.¹⁸¹ Each classification has specific courses and hours for mental health training.¹⁸² The last major content revision to the Adult Corrections Officer curriculum was effective in 1998.¹⁸³ The curriculum includes 6.5 hours dedicated to mental health – 2.5 hours on mental health issues and four hours on suicide issues. Another 26 hours of related courses, such as principles of use of force, booking inmates, and interpersonal communications, include mental health as a learning objective.¹⁸⁴

Local departments are offering crisis intervention training to custody staff in addition to law enforcement in the community. For example, Santa Clara County developed a custody-specific, 16-hour Behavioral Health Concepts and De-Escalation Techniques curriculum in partnership with the local behavioral health department, which is now mandatory for all correctional deputies.¹⁸⁵

Mental health advocates have expressed additional concerns, including lack of access to appropriate levels of care, medication-only approaches to treatment, overuse/misuse of solitary confinement, inadequate staff to deliver care, inaccurate and incomplete medical records, problematic medication practices, and failure to screen for and prevent suicide.¹⁸⁶

The National Institute of Corrections assessed jails and the challenges sheriffs face in housing and treating those with mental health needs. They found:

CHALLENGES FOR INMATES		
Many of the inmates with mental health needs have a dual diagnosis (co-occurring mental illness and substance abuse).	Lack of medication may have led to the behavior(s) which led to the arrest.	Inmates with mental health needs often returned to the community with no treatment plans or housing.
Inmates with mental health needs are overrepresented in segregated housing.	Incarceration exacerbates mental illness symptoms — segregation accelerates deterioration.	Inmates with mental health needs are better housed in units with access to open space (e.g. dayrooms and outside recreation), and with staff who are informed about their conditions and needs.
Upon booking and intake, people with mental health needs are often unable to comprehend or follow the correctional staff directions.	Inmates with mental health needs are often not able to recall their history (medication names or dosage, address, next of kin).	People with mental health needs are booked in after periods of not taking their medication.

CHALLENGES FOR JAIL STAFF		
Correctional staff are not normally trained to intervene effectively with those with mental health needs, so they isolate them.	A use of force is traditionally used to get inmates with mental health needs to comply with movement or general directions (changes in housing, orders to shower, or clean their cells).	Some jails do not refer to prior classification records to put the inmate's "story" together.
Staff repeatedly asks the same questions each time the inmate is processed as a new intake.	Staff must determine if there was a lack of medication or noncompliance.	

BOTTOM LINE		
Diversion to community-based care is a better option.	People with mental health needs are not suited for jail unless their behaviors are criminal in nature and demand incarceration.	They are better suited in the community with proper housing, case management, and medication.

Awareness of these concerns is increasing, and counties are developing strategies to address those with high levels of need who cannot be diverted from jail. In 2015, 15 California counties were awarded \$500 million in funds from the state to improve local jail facilities.¹⁸⁷ Most, if not all, of these counties requested funds to build or renovate existing jail space to create an environment that would allow for better treatment and housing of those with behavioral health needs.¹⁸⁸ Sonoma County, for example, is investing \$49 million in a 72-bed jail unit to provide improved behavioral health treatment services as well as an environment designed to promote social and therapeutic interactions.¹⁸⁹

Mirroring models found in the community, county sheriffs are developing multi-tiered approaches to providing services that address a full continuum of mental health and substance use disorders. This approach ranges from providing intensive treatment in high-need, acute, inpatient “hospital-like” units to dispensing medication through appointments with licensed mental health clinicians. In March 2017, the Sacramento County Main Jail launched a 20-bed Intensive Outpatient Program. The program provides care to those with serious mental health needs who would benefit from the structure of a therapeutic environment and who require more frequent observation than inmates receiving mental health services in a jail’s general population. The program serves as both a step-down from the jail’s Acute Inpatient Unit and a step-up for inmates requiring more intensive mental health services than what is available in the general custody setting. Services are provided by a multidisciplinary team and include group and individual therapy, case management, medication evaluation and follow-up, and discharge planning.

Before counties can effectively design solutions, they should begin with an assessment of their jail population to understand the types of offenders under their custody. In 2016, Minnesota’s Hennepin County conducted a one-day “snapshot” of people in its jail by performing full medical assessments on 640 of its 680 inmates. Officials found that over half of the people they assessed met the criteria for having a mental illness. In an interview following the assessments, Hennepin County Sheriff Rick Stanek said, “Now that we have better information about the extent of mental illness among jail inmates, we can begin working on better ways to provide the services they need and deserve.”¹⁹⁰

Using Data to Understand the Jail Population and Opportunities for Diversion

To help counties reduce costs and improve outcomes, California Forward developed the Justice System Change Initiative.¹⁹¹ Through this initiative counties – including Riverside, San Bernardino, Santa Cruz, and El Dorado – take a system-change approach, beginning with data assessments of different aspects of the criminal justice system, including a jail utilization study. The studies reveal opportunities for reducing incarceration and developing more effective community-based alternatives. The analysis explores the reasons for booking, length of stay, and the typical daily population. It allows counties to assess high-utilizers, disparities, and bottlenecks in the judicial process that increase jail time and costs.

Riverside and San Bernardino counties accessed jail data about inmates with serious mental health needs. El Dorado accessed data via the referrals to mental health services and Santa Cruz retrieved data from a tallied process of jail entries and exits that were merged with data from the county’s Behavioral Health Division. All counties found three major findings: inmates with mental health needs have double the number of bookings of the general jail population and twice the length of jail times for lesser crimes. The population with people with mental illness also has an increased likelihood to be in detention for causes other than a new offense, such as probation violations or court holds.

RECOMMENDATION TWO:

The Board of State and Community Corrections should facilitate a collaborative effort with counties to identify, develop, and deploy services and strategies that improve outcomes for mental health consumers in jail, including universal screening for mental health needs at booking and enhanced training for custody staff.

The California Board of State and Community Corrections was established in 2012 to provide leadership to the criminal justice system, administer public safety grant funding, deliver technical assistance on community corrections, and provide regulatory authority over local detention facilities.¹⁹² The board is charged with ensuring that local detention facilities are meeting legislative mandates for enough space to deliver rehabilitation programs. The board should lead on promoting practices that will ensure people in jail with mental health and substance use needs are receiving services necessary for rehabilitation. To do this effectively, counties must use assessments of mental health, substance use, and risk factors for offending to determine appropriate levels of supervision and intervention.¹⁹³ All three must be assessed and addressed to reduce recidivism and increase mental health and substance use recovery.¹⁹⁴ In some cases, addressing serious mental health needs prior to addressing other risks related to offending could reduce future involvement with the criminal justice system.¹⁹⁵ Appropriately addressing mental health and substance use needs should be viewed as a matter of public safety, and must be included with programming to address risks for offending.

Delivering interventions that will improve outcomes for mental health consumers begins with an initial screening at booking of every person entering local jails. Universal screening for mental health and substance use disorders at booking, along with timely follow-up assessments, must be mandatory. Efforts should identify barriers to conducting universal screening and assessment for mental health and substance use needs, and ways to overcome those barriers. Several promising screening tools have been identified, including the Brief Jail Mental Health Screen, the Correctional Mental Health Screen for Men, the Correctional Mental Health Screen for Women, the England Mental Health Screen, and the Jail Screening Assessment Tool.¹⁹⁶

Efforts should review the use of isolation or solitary confinement, and explore promising developments in trauma-informed correctional care, as such practices have been proven effective in reducing criminal risk factors and supporting the effectiveness of mental health and substance use services in jail.¹⁹⁷ Efforts should also explore ways to deploy culturally and linguistically appropriate services in custody settings, inspired by community-defined practices for people from communities of color and LGBTQ communities.

Revisions to the mental health curriculum for correctional staff training should continue as well. Trainings should reflect crisis intervention training and mental health awareness training that many law enforcement jurisdictions are currently implementing in the community. All trainings should address issues of stigma, discrimination, and implicit biases, and should include training on cultural and religious diversity and ensuring language access – or how to assist people who communicate in languages other than English.

MHSA Innovation Highlight – Advancing Collaborative Strategies in California

Sutter-Yuba County | Improving Mental Health Outcomes via Interagency Collaboration and Service Delivery Learning for Supervised Offenders who are At Risk of or Have Serious Mental Illness

Sutter and Yuba Counties have a joint mental health system. The counties have developed an innovative project that embeds a mental health clinician within an existing multi-disciplinary probation team to provide mental health assessments, post-release recovery plans, and connections to ancillary services that contribute to positive mental health prior to release.

<https://www.co.sutter.ca.us/contents/pdf/hs/mh/mhsa/pdf/Public%20Review%20Draft-2016-17%20MHSA%20Annual%20Update.pdf>

DRAFT

FINDING THREE:

A large and growing number of people found incompetent to stand trial because of unmet mental health needs are forced to spend months in jail awaiting services necessary for their cases to proceed.

Many counties are reporting an increase in the number of people found incompetent to stand trial. Under state and federal law, all individuals who face criminal charges must be mentally competent to help in their defense. By definition, a person who is incompetent to stand trial lacks the mental competency required to participate in legal proceedings. Competency restoration to a large extent involves delivering mental health treatment, with additional education on the legal process. Responsibility for restoration of competency is bifurcated, with the State responsible for felony competency restoration and the counties charged with handling misdemeanor competency restoration.¹⁹⁸

In California, there is a monthly statewide waitlist with an ongoing average of approximately 500 people who face felony charges and have been deemed by the courts to be mentally incompetent to stand trial. These individuals are waiting in jail for a bed to become available in a state hospital in order to undergo evaluation and receive treatment to restore them to competency. Once these people are housed at a state hospital, the state spends significant resources to provide treatment – approximately \$170 million annually.¹⁹⁹

In 2017, the California State Department of Hospitals conducted a national survey to determine whether other states were experiencing an increase in people found incompetent to stand trial, and what they were doing to meet increased demand.²⁰⁰ They found that 38 of 47 responding states reported an increase in the number of referrals for competency evaluations.²⁰¹ The highest ranking potential cause of the increase was the inadequate number of inpatient psychiatric beds in the community.²⁰² Other potential causes included inadequate general mental health services, inadequate crisis services, and inadequate Assertive Community Treatment services in the community.²⁰³ The majority of respondents cited jail diversion as the solution (55 percent), followed by increasing the number of state hospital beds (43 percent).²⁰⁴

For California, one expert suggests the trend may be related to changing attitudes in the legal community. “When I was a young lawyer, it was unheard of to declare a misdemeanor incompetent to stand trial because it resulted in so much of a longer time locked down in the county jail,” said Judge Peter Espinoza, director of the Los Angeles County Office of Diversion and Reentry. “Now,” he added, “the public defender’s office seems to have reached the conclusion that they’re doing their clients a better service by going through the mental health process, declaring their misdemeanor clients incompetent to stand trial so they can be properly diagnosed and receive services in an attempt to stop the recycling or churning of this population in the county jail.”²⁰⁵

According to the Department of Hospitals survey, potential solutions included developing jail-based competency restoration and outpatient or community-based competency restoration. In Fiscal Year 2007-2008, the former state Department of Mental Health received a \$4.3 million budget allocation to begin pilot programs examining jail-based approaches to addressing the backlog in state hospitals. After several

years of delays, the department, working with a private vendor, established a pilot program in San Bernardino County to treat people accused of a felony and found incompetent in the county jail instead of a state hospital. Jail-based competency restoration is expanding, and is now found in Mendocino, Riverside, Sacramento, San Diego, and Sonoma counties, and elsewhere in California.

For various reasons cited in this report, jails are challenging places for people with mental health needs, including those waiting or receiving competency restoration services. Like other states, California has explored strategies to improve competency restoration outside of state hospital settings. While California has focused on strategies for jail-based approaches, other states have explored expanded community-based approaches. Some 39 states allow outpatient restoration of competency, 16 of which operate formal outpatient competency restoration programs.²⁰⁶ In their review of such programs, Disability Rights of California found the following features and benefits:²⁰⁷

- Intensive case management, including housing, psychosocial rehabilitation, and voluntary medication
- Individualized treatment
- Longer lengths of stay in outpatient settings because of less pressure to transition out of inpatient care prematurely
- “Freed up” inpatient bed space
- Less costly compared to inpatient programs, at times 20 percent savings
- Less restrictive and more recovery-oriented

Recognizing the ongoing need for improved access to competency restoration services, California should expand similar options.

RECOMMENDATION THREE:

To reduce the backlog of people found incompetent to stand trial, California must maximize diversion from the criminal justice system. For people who cannot be diverted and are found incompetent to stand trial, the state and counties should expand options for restoring competency.

Effective prevention and early diversion strategies have the potential to reduce the number of people found to be incompetent to stand trial because there will be fewer people brought to trial. Among other alternatives, counties should explore community-based competency restoration programs with supportive housing for misdemeanants and low-risk felons. Using jail cells to hold defendants who are incompetent to stand trial is costly and often ineffective. Just as counties are expanding pre-trial community-based services, counties can expand community-based restoration programs. Both strategies can reduce jail overcrowding and potentially reduce future criminal involvement. Risk assessment tools can help identify people who can be safely managed in the community and can determine the appropriate level of community supervision and services.

One way the state can reduce the number of people waiting for services from a state hospital is to fund a community-based pilot program to connect people needing competency restoration services with

intensive services in the community, such as Forensic Assertive Community Treatment. Data from the California Department of State Hospitals demonstrates that many people coming into their care for competency restoration are compiling crimes at a faster rate and almost half (47 percent) are homeless.²⁰⁸ Community-based supportive services have the potential to address factors, such as housing, that are likely contributing to the increasing number of people with unmet mental health needs being found incompetent to stand trial.

The state should encourage counties to utilize Mental Health Services Act Innovation funds to address this need.

MHSA Innovation Highlight – Expanding Community-based Competency Restoration

El Dorado County | Community-based Competency Restoration

El Dorado County launched this innovative project to determine if providing competency restoration services in an outpatient setting to misdemeanants will reduce the cost of restoration and strengthen misdemeanants' ties to the mental health treatment system. This project provides participants with supportive mental health services, including wellness center activities, and encourages family and friends to participate in the restoration to competency process.

<https://edcgov.us/government/mentalhealth/mhsa%20plans/documents/FY%202016-17%20MHSA%20Plan%20Update%20ADOPTED%206-13-16.pdf>

FINDING FOUR:

California has not put in place a statewide, systemic approach for prevention and diversion to reduce criminal justice involvement for mental health consumers and improve outcomes.

Under criminal justice and mental health realignment policies, counties have responsibility for delivering a large proportion of California's mental health services and criminal justice strategies. California's counties are well-positioned to develop more effective responses to the increased number of people with unmet mental health needs in jails. The state should clear the path for such effective responses, by providing clarity regarding state and federal law, facilitating information sharing, and identifying and addressing barriers to innovation, among other tasks.

County by county, progress is happening. But each individual innovation also has the potential to accelerate statewide improvements – if the lessons learned are communicated beyond county borders. Counties are being asked to collaborate and integrate services, and the state should follow suit. California needs clear and consistent champions to sustain change and momentum over time.

Significantly improving results will require more than new programs. Lasting, transformative change will require developing the ability within public agencies to methodically improve day-to-day operations. System-level change requires collaboration among local agencies serving and interacting with community members. It requires state agencies to coordinate the guidance and regulation they provide county agencies. And just as leadership is essential to changing organizations, partnerships are essential to changing systems. State agencies have three primary responsibilities in effecting system-level change:

- State agencies must provide clear, consistent, and reliable information regarding obligations and requirements in federal and state law. State agencies must clear the ambiguity that can paralyze local managers and frustrate innovations.
- State agencies must facilitate the sharing of information to encourage innovations and the replication of best practices. They must align their discretionary authority and resources to support proactive local managers and help build capacity in all counties.
- State agencies must identify barriers to innovation – in law, regulations, or bureaucratic procedures – and align formal policies and organizational culture to support continuous improvement.

State entities will need to work together to support transformational change within counties. While there is more than one way to structure a collaborative effort, three attributes will be required for it to be successful:

- The charge for the collaborative effort must be clearly articulated in desired outcomes with explicit metrics for measuring progress.
- The agencies must be accountable for their collective and individual efforts to the Governor and the Legislature.
- The collaborative must have dedicated leadership and organize its activities to include relevant agencies, and it must build trust over time as a result of meaningful progress toward shared goals.

California's Council on Criminal Justice and Behavioral Health - formerly the Council on Mentally Ill Offenders²⁰⁹ - has a clear leadership role in promoting coordination among criminal justice and behavioral health systems. That coordination should focus on strategies to improve outcomes. The council has largely been underfunded, understaffed, and underutilized. The statute that created the council was written prior to the current mental health and criminal justice realignment structure, and does not reflect the current, largely locally-driven service and correctional systems.

Currently, the council is housed within the Office of the Secretary of the California Department of Corrections and Rehabilitation.²¹⁰ The council has 12 members:

- The Secretary of the Department of Corrections and Rehabilitation
- The Director of State Hospitals
- The Director of Health Care Services
- Nine other appointees:
 - The Governor appoints three members, at least one representing behavioral health.
 - The Senate appoints two members, one representing law enforcement and one representing behavioral health.
 - The Assembly appoints two members, one representing law enforcement and one representing behavioral health.
 - The Attorney General appoints one member.
 - The Chief Justice of the California Supreme Court appoints a superior court judge.

The statutory goal of the council is to investigate and promote cost-effective approaches to meeting the long-term needs of behavioral health consumers who are at risk of becoming involved with or who have a history of involvement with the criminal justice system. The council has the following areas of focus:

- Identifies strategies for preventing people with behavioral health needs from becoming offenders
- Identifies strategies for improving the cost-effectiveness of services for people with behavioral health needs who have a history of offending
- Identifies incentives to encourage state and local systems to adopt cost-effective approaches for serving people with behavioral health needs who are likely to offend or who have a history of offending

The council considers strategies that:

- Improve service coordination among state and local behavioral health, criminal justice, and juvenile justice programs
- Improve the ability of offenders with behavioral health needs to transition successfully between corrections-based and community-based treatment programs

Every year the council submits a report to the Legislature detailing its activities, including recommendations for improving the cost-effectiveness of behavioral health and criminal justice programs.

RECOMMENDATION FOUR:

The Council on Criminal Justice and Behavioral Health should fortify its efforts to champion collaboration among state agencies to support local prevention and diversion of mental health consumers in the criminal justice system.

In addition to the council, several state agencies play an important role in financing, regulating, and supporting county agencies responsible for community-level mental health services and criminal justice functions. The Board of State and Community Corrections was re-chartered to set standards for and distribute funds to local agencies.²¹¹ The California Department of Corrections and Rehabilitation manages and operates the state's prison system, and delivers mental health and rehabilitative services, such as job training, to prison inmates and people on parole in local communities.²¹² The Mental Health Services Oversight and Accountability Commission was established to promote transformational change in California's mental health system to improve outcomes, including reducing incarceration.²¹³ Originally established to manage Medi-Cal health benefit programs in California, the Department of Health Care Services now also oversees community substance use and mental health programs.²¹⁴ The Department of State Hospitals oversees California's state hospital system, which provides mental health services and competency restoration services for people charged with felonies and found incompetent to stand trial.²¹⁵

As part of its responsibilities, the council should identify how other state and local agencies – including the Commission – should collaborate. Under this recommendation, the Council on Criminal Justice and Behavioral Health would need additional funding to perform its expanded role.

The Council on Criminal Justice and Behavioral Health should be charged with:

- Housing a Behavioral Health and Justice Center of Excellence, including a clearinghouse on best practices. These would include evidence-based and community-defined practices for diverse communities.
- Leading a collaborative effort to develop a statewide diversion plan, and an annual update, driven by data, to promote continuous quality improvement
- Promoting information sharing and developing clear outcomes and data to support measurement
- Identifying and removing barriers to funding, clarifying what can be done with funding, and sharing what others are doing with funding to ensure dollars are used most effectively
- Identifying and addressing barriers to best practice implementation
- Continuing to build state and local capacity for ongoing improvement, including expanding approaches with a track record of effectiveness

Interagency collaborations fail more often than they succeed. To ensure its success, state collaboration will need:

- Clear goals articulated as desired outcomes with explicit metrics for measuring progress
- Accountability to the Governor and the Legislature for collective and individual efforts
- Dedicated leadership committed to solving problems and working toward system change

FINDING FIVE:

Data is a critical tool in decision-making and service delivery, but state and local agencies are not effectively harnessing its power to improve outcomes for those in need.

In California today, it is impossible to accurately describe the number of people with mental health needs housed in county jails. A lack of accurate, up-to-date information on consumers, coupled with inconsistent data collection practices and definitions, is a significant barrier to efforts to keep people with mental health needs out of the criminal justice system. Without data, it is difficult to understand not only the scope of the problem, but its multiple dimensions and potential solutions.

Community-based treatment providers do not consistently share information with correctional health care providers, and vice versa. Program costs and outcomes often are not tracked. Community consultation processes often do not include data to monitor outcomes and the quality of services. Data regarding race, ethnicity, sexual orientation, and gender identity is lacking, making the task of identifying, tracking, and monitoring disparities within the system challenging.

Data can be a powerful tool to identify gaps and disconnects, guide management decisions, and drive continuous improvement efforts. Information technology also is providing better methods for integrating services, coordinating the efforts of public agencies, and informing real-time decisions by professionals.

At the local level, data can support the coordination of services in the community and in custody. Data can help administrators allocate resources across systems. Even small scale efforts can benefit by using data to measure shared outcomes. By understanding needs and whether programs are meeting those needs, data could support funding decisions and program improvements. Improving data collection and utilization also could help shape a strategic plan for future investments. When data is not collected or available, people within a system become invisible and problems are minimized. Data can help an individual be “seen” and consequently reached and served.

Some collaborative efforts have relied on team approaches, with behavioral health and criminal justice staff meeting frequently to discuss shared clients. This approach can work well for individual clients. But a system approach must be predicated on using data to develop a better understanding of challenges and opportunities.

Local governments nationally spend at least \$22 billion to incarcerate approximately 11 million people each year.²¹⁶ By using data, communities can fully understand the cost of a relatively small number of people cycling in and out of their publicly funded systems. San Diego County’s Project 25, for example, identified 28 people who alone consumed \$3.5 million in public resources in 2010.²¹⁷ In Miami-Dade County, Florida, 97 people with serious mental health needs accounted for \$13.7 million in services over four years, spending more than 39,000 days in county jails, emergency rooms, state hospitals, or psychiatric facilities.²¹⁸

Over the last year or so, state and national efforts have pushed local communities to use data to better understand “high utilizers” of public systems. Such efforts seek to demonstrate that if agencies can

identify a small number of people using the majority of public resources, potential cost savings can be realized through targeted outreach, engagement, and service delivery.

The small Fresno County city of Selma is a case in point. Police Chief Greg Garner said that for years, police officers and other emergency service workers were frustrated by repeatedly encountering the same community members struggling with the same problems. “The genesis of their problems is mental illness, but traditionally, they’ve just been hidden away in an ER or jail cell,” Garner said. “That not only costs a lot of money, their problems never get addressed.”

Now, under a Fresno County triage program that dispatches mental health workers to help police in the field, disruptive individuals with mental health needs are receiving referrals and treatment, Garner said. “Having trained mental health clinicians respond in the field with our officers has been a godsend. And for the people we encounter, the program means they get plugged into support services rather than deposited in the criminal justice system.”²¹⁹

At the national level in 2016, the White House launched the Data-Driven Justice Initiative to promote state and local practices to identify people with physical and behavioral health needs served through the criminal justice and health care systems. With such data, agencies can target scarce resources toward the greatest needs and identify those falling through the cracks. Los Angeles, San Diego, San Francisco, and Santa Clara counties joined the Initiative. Participating counties agreed to facilitate data sharing, implement pre-arrest diversion, and use data-driven risk assessment tools.

Along with the potential to use data comes the barriers to sharing data. There are technological barriers, such as antiquated systems in incompatible formats or data kept in paper files. There are cultural barriers, such as mistrust of how data will be used, interpreted, or modified by others outside programs or agencies. Then there are legal barriers, which can be real – such as restrictions defined by law – and perceived, perhaps a misunderstanding of complicated privacy rules and restrictions. The number one barrier identified by stakeholders to sharing data was confusion or fear around violating client confidentiality, or, more directly, violating the Health Insurance Portability and Accountability Act (HIPAA), which protects confidential medical information.

While the need for privacy is generally understood and accepted in the field, professionals also express frustration over the lack of clarity around what type of information can be shared, who may receive the information, and how it may be distributed. The California Office of Health Information Integrity, within the California Health and Human Services Agency, is responsible for ensuring compliance with HIPAA and other privacy laws. In July 2017, the agency, in collaboration with an advisory group, released a document to clarify laws and regulations using common scenarios, including three specific to the justice-involved population with behavioral health needs.²²⁰

RECOMMENDATION FIVE:

The California Health and Human Services Agency should reduce or eliminate barriers so that data and information technology are used to drive decision-making, identify service gaps, and guide investments in programs to reduce the number of people with mental health needs in the criminal justice system.

The California Health and Human Services Agency is engaged in several efforts related to promoting data integration and improving care coordination. In addition to housing the Office of Health Information Integrity, the agency oversees departments and offices that provide a wide range of services in the areas of health care, mental health, public health, alcohol and drug treatment, income assistance, social services and assistance to people with disabilities, and the state-level data that is collected on each. Additionally, the Department of Health Care Services is charged with administering the Whole Person Care Pilot, which has the overarching goal of service coordination, and data sharing and integration to support that coordination.²²¹ The department is also collaborating with the Council on Criminal Justice and Behavioral Health to study patterns of health care service utilization among former offenders released from state prison. To achieve the study's goals, the department's health care information will be linked with the California Department of Corrections and Rehabilitation's prison data.²²²

Data is a valuable tool for providing person-centered, culturally competent, and community-based care, especially through the integration of services provided by multiple local agencies and providers. Further, collecting data on race, ethnicity, sexual orientation, and gender identity will enable researchers and policy makers to better understand and address the nature and extent of disparities within the mental health and criminal justice systems. The agency could lead in advancing the statewide use of emerging technology to integrate data while ensuring protection of confidential health information. The agency should support efforts to ensure that screening and assessment and care coordination become standard operating procedure in California.

Key outcome measures previously mentioned in this report – reduction in the number of people with mental illness booked into jail, shorter jail stays for people with mental illnesses, increase in the percentage of people with mental illnesses in jail connected to the right services and supports once released, and lower rates of recidivism – also seek to track and improve progress on diversion efforts, but more must be done to understand missed prevention opportunities. Related to these key outcomes are two questions counties must ask to identify ways to improve prevention opportunities: (1) How many people in jail have a mental health need?, and (2) How many of those people were actively receiving mental health services at the time of booking?

Asking these questions can help community-based service providers and administrators identify gaps in efforts to reach and engage unserved and underserved consumers and enhance efforts to prevent incarceration. Answering these questions may require integrating community-based mental health data and jail data. The agency should support data integration efforts. The Commission could support the agency's efforts by demonstrating the value of integrated data through the linking and analyzing of mental health and criminal justice data.

MHSA Innovation Highlight – Using Technology to Improve Outcomes during Emergencies

Kern County |Special Needs Registry – Smart 911

Kern County is making use of technology to give consumers the ability to decide what information they would like first responders to know in case of a crisis. Rave Mobile Safety, Inc. founded Smart 911, a web program registry available on personal technology devices and in kiosks located at each Kern Behavioral Health Recovery Services treatment facility. The registry allows residents and Kern Behavioral Health clients to create a free, secure special needs profile providing dispatchers and first responders access to critical information. The effort creates improved interagency partnerships among fire, police, and other public safety entities during emergencies.

http://docs.wixstatic.com/ugd/2d0775_0a4c6a2c60804548a740e75367760114.pdf

DRAFT

FINDING SIX:

To build effective prevention and diversion systems, criminal justice and mental health professionals will need new knowledge, skills, and abilities to better serve mental health consumers and their communities.

Throughout the criminal justice system, public safety professionals are increasingly interacting with people with unmet mental health and substance use needs, often in roles they may not have been trained to fulfill. Law enforcement officers are often called to respond to behavior resulting from unaddressed or under-addressed mental health needs, and many lack training to manage such situations. In dangerous or high stress situations, the effects of implicit bias are particularly pronounced.²²³ New approaches for training law enforcement to recognize and ameliorate the effects of implicit bias hold promise for improving policing in communities of color.²²⁴ These strategies also may serve to improve law enforcement responses to people with mental health needs.

Behavioral health professionals also often feel ill-equipped to address risks and needs associated with a client's likelihood of committing crime, such as criminal thinking. Public safety realignment has increased the number and variety of situations requiring mental health professionals to work with individuals with significant criminal justice involvement. As people are being assessed for mental health needs, mental health professionals are often in a position to identify risk factors known to increase the likelihood a person will become involved with the criminal justice system. While mental health curricula teach students to evaluate clients and help strengthen their support systems, such curricula do not routinely provide guidance on identification of risk factors for justice involvement or best practices for intervention.

Public safety professionals need sufficient training to feel confident in decisions to divert people to available resources in the community. Law enforcement officers, judges, district attorneys, public defenders, and probation officers must have confidence in determining appropriate responses. Public safety and behavioral health partners and providers must be made aware of available programs and services, as well as county protocols for diverting people out of the justice system.

Some counties working to reduce the number of people with mental health needs in jails are struggling with how or where to start. Counties recognize the importance of having a local leader or champion for their efforts, but it is not always clear who that champion is or should be. In some counties, the district attorney fulfills the role. In others, the local champion is a judge. Whoever is designated, a local leader is essential to sustaining the commitment to diversion.

California has made strides in recent years in the delivery of more crisis intervention training to law enforcement, better equipping officers for mental health crisis encounters. For example, in 2015, the Santa Barbara County Sheriff's Office recognized the need for a specialized unit to address community needs involving law enforcement's response to calls for service involving mentally ill persons, including those in crisis. The Sheriff's Behavioral Sciences Unit (B.S.U.) was formed to oversee cases involving mental illness, to develop a Crisis Intervention Team, and to build community partnerships that adopted restorative justice principles and diverted people from the criminal justice system into appropriate services.

Since its establishment, the B.S.U. has collaborated with Santa Barbara County's mental health agency, local hospitals, the local chapter of the National Alliance on Mental Illness, other private non-profit support groups, and other local law enforcement agencies. The B.S.U. has assisted these agencies by developing and facilitating training on how to better handle these challenging calls for service. The result has been improved communication and collaboration with the community and other allied agencies.

The B.S.U. is staffed with a part-time coordinator, volunteer psychologists, and collaterally-assigned sheriff's personnel, including deputies, detectives, custody deputies and dispatchers. The B.S.U. developed 8-hour and 40-hour Commission on Peace Officer Standards and Training-approved Crisis Intervention Team courses, and to date has trained over 650 law enforcement officers, custody deputies and dispatchers, including all sworn sheriff's personnel. The unit has also trained members of all but one of county's police departments, and other staff from enforcement agencies within and outside Santa Barbara County.

Consistent with Santa Barbara's model, an increasing number of local law enforcement agencies are incorporating Crisis Intervention Team training, resulting in improved inter-agency relationships, de-escalation of critical incidents, and a greater understanding of how to effectively help people in crisis.

Despite this successful example, other training and technical assistance efforts that span the boundaries of criminal justice and mental health professionals are often delivered in siloes and, in some cases, are underfunded given the demand. Below are examples of assistance being delivered in California.

SUPPORT FOR CRIMINAL JUSTICE PARTNERS: The Judicial Council receives Mental Health Services Act funding to provide technical assistance for new or expanding mental health courts and to provide support for council advisory committees charged with implementing the Mental Health Issues Implementation Task Force recommendations.²²⁵ The task force was created to advise the council on how recommendations to improve the responses of the criminal justice system for people with mental health needs should be implemented. Recommendations focus on improving criminal court cases outcomes and administration of justice, and improving access to treatment for those moving through the criminal justice system.

SUPPORT FOR LOCAL DIVERSION EFFORTS: Over the last year, the Council of State Governments, as part of the Stepping Up Initiative in California, has provided targeted technical assistance to California counties. In partnership with county associations, the council surveyed all California counties and asked what would have the greatest impact on improving county capacity for diversion.²²⁶ The majority (49 counties) identified resources to collect and track data, followed by research-based interventions for people involved with the justice system who have behavioral health needs (46 counties), and information about strategies and solutions that work (43 counties).²²⁷

Technical assistance efforts since have included participation in local Stepping Up meetings, including in Calaveras, Imperial, Los Angeles, Orange, San Diego, Santa Barbara, Santa Clara, and Yolo counties, facilitation of peer-to-peer learning among California Stepping Up project coordinators, and ongoing assistance focused on screening and assessment and data collection in Calaveras, Imperial, and Orange counties. Technical assistance has been made possible by funding from public and private funding, such as from the American Psychiatric Association Foundation, Bureau of Justice Assistance, United States Department of Justice, and The California Endowment.

SUPPORT FOR LEADERS IN DIVERSION: Words to Deeds, a project of the Forensic Mental Health Association of California, has been leading efforts to bring together key decision-makers to develop strategies to reduce the incarceration of people with mental health needs. Through conferences utilizing a peer-to-peer model, leaders from state and local government, the courts, criminal justice, corrections, and mental health organizations come together to identify challenges and explore strategies that reduce the number of, and improve outcomes for, people with mental health needs in the criminal justice system.

RECOMMENDATION SIX:

The State, in partnership with the counties, should expand technical assistance resources to improve cross-professional training, increase the use of data and evaluation, and advance the dissemination of best practices, including community-driven and evidence-based practices.

The state and counties should improve training and technical assistance to ensure appropriate responses to mental health consumers are delivered and that continuous improvements are made over time. Training and technical assistance must include efforts to address disparities and cultural biases, including disseminating information on system inequities. The state should evaluate barriers to data sharing and promote way to share data while ensuring confidentiality of health information, including how counties are developing universal consent forms.²²⁸ The state should review all available funding – including private sources – that could be directed to delivering strategic and cost-effective technical assistance to counties seeking to prevent the incarceration of mental health consumers and divert those in the criminal justice system into community-based services. Training and technical assistance efforts should focus on three primary areas: strategic cross-professional training, evaluation, and dissemination.

STRATEGIC CROSS-PROFESSIONAL TRAINING: Training and technical assistance must be made available to ensure professionals are cross-trained to meet diversion program objectives and goals. Law enforcement officers, judges, district attorneys, public defenders, and probation officers should receive training on mental illness specific to their respective roles. Mental health professionals should receive training on risk factors for offending so they can recognize these signs early in the course of providing care. Training should be targeted based on the role of each professional within the system, and the programs and services that are being provided.

DATA COLLECTION AND EVALUATION: Training and technical assistance must include a research and evaluation component. Support should be available to counties so that data collection and analysis become common practice, where it is not already. Programs and services must be evaluated regularly to track progress over time, to communicate what works and what does not work, and to ensure continuous quality improvement. Training on sound evaluation methods should be flexible to fit county and program size. Technical assistance should be available to address barriers to data collection, integration, and analysis as they arise. While the field of evidence-based practices continues to grow, there is a greater need for culturally congruent research, and expansion of community-defined practices that reduce mental health disparities *and* reduce or prevent criminal justice involvement, specifically for members of African

American, Latino, Native American, and transgender communities. Ongoing qualitative, participatory action research, or community-based participatory research will help to address gaps in current research.

DISSEMINATION: Training and technical assistance must include dissemination of best practices, including community-driven and evidence-based practices. Resources should be consolidated into one, easily accessible web-based location. Counties should have an online forum for sharing lessons learned and promising approaches. Counties should be able to share program outcomes for the benefit of administrators and providers, but, more importantly, for the public.

MHSA Innovation Highlight – Leveraging Cross-Professional Collaboration

Glenn County | System-Wide Mental Assessment Response Team (SMART)

The Glenn County System-Wide Mental Assessment Response Team (SMART) was among the first communities to foster police/mental health co-responder teams that assist in monitoring safety at school as well as the community during crisis situations, provide and link individuals to ongoing clinical services, co-occurring treatment, or probation services, offer suicide evaluation along with prevention through evidence-based practices, and educate school staff on victimization prevention.

[http://www.countyofglenn.net/sites/default/files/Behavioral Health/Glenn%20MHSA%20FY%2017-20%20Three%20Year%20Plan%2006-19-17%20FINAL%20AS%20POSTED.pdf](http://www.countyofglenn.net/sites/default/files/Behavioral%20Health/Glenn%20MHSA%20FY%2017-20%20Three%20Year%20Plan%2006-19-17%20FINAL%20AS%20POSTED.pdf)

Summary of Findings and Recommendations

FINDING 1	Too many mental health consumers, particularly those from diverse communities, end up in jail because of unmet needs and system inequities. A robust, prevention-oriented system can reduce this unnecessary harm.	
California’s mental health agencies, in partnership with law enforcement and others, should have a comprehensive prevention-focused plan that reduces the incarceration of mental health consumers in their communities.		RECOMMENDATION 1
FINDING 2	California’s jails are not equipped to serve mental health consumers. Diversion should be prioritized but counties need more effective in-custody options to ensure they can provide appropriate and necessary services for those who cannot be diverted.	
The Board of State and Community Corrections should facilitate a collaborative effort with counties to identify, develop, and deploy services and strategies that improve outcomes for mental health consumers in jail, including universal screening for mental health needs at booking and enhanced training for custody staff.		RECOMMENDATION 2
FINDING 3	A large and growing number of people found incompetent to stand trial because of unmet mental health needs are forced to spend months in jail awaiting services necessary for their cases to proceed.	
To reduce the backlog of people found incompetent to stand trial, California must maximize diversion from the criminal justice system. For people who cannot be diverted and are found incompetent to stand trial, the state and counties should expand options for restoring competency.		RECOMMENDATION 3
FINDING 4	California has not put in place a statewide, systemic approach for prevention and diversion to reduce criminal justice involvement for mental health consumers and improve outcomes	
The Council on Criminal Justice and Behavioral Health should fortify its efforts to champion collaboration among state agencies to support local prevention and diversion of mental health consumers from the criminal justice system.		RECOMMENDATION 4
FINDING 5	Data is a critical tool in decision-making and service delivery, but state and local agencies are not effectively harnessing its power to improve outcomes for those in need.	
The California Health and Human Services Agency should reduce or eliminate barriers so that data and information technology are used to drive decision-making, identify service gaps, and guide investments in programs to reduce the number of people with mental health needs in the criminal justice system.		RECOMMENDATION 5
FINDING 6	To build effective prevention and diversion systems, criminal justice and mental health professionals will need new knowledge, skills, and abilities to better serve mental health consumers and their communities.	
The State, in partnership with the counties, should expand technical assistance resources to improve cross-professional training, increase the use of data and evaluation, and the dissemination of best practices, including community-driven and evidence-based practices.		RECOMMENDATION 6

Conclusion

Experts suggest more and more people with mental health needs are booked into jails across California each year. The influx is overwhelming our jails and the people who run them, because jails were not designed to house or serve those with mental illness. Despite the best efforts of administrators, jails are often crowded, chaotic, and understaffed – a dangerous mix – and it is not surprising that people with mental health needs often do not receive the services they need. Upon release, many find care in the community elusive as well. Thus, a large percentage collide with law enforcement again and cycle back into custody.

While this problem is daunting and complex, it is not intractable. Throughout this project, the Commission was heartened and inspired by the good work and promising initiatives already underway across California and the nation. Now we must build upon that foundation through a unified, integrated approach, with all community members taking responsibility for their share of the solution. As we move forward, we must examine all available funding sources, including those in the private sector, and be willing to share fiscal and human resources. We must help communities modernize their playbooks and translate research into effective practice. We must collaborate and share experience to perpetuate success. And we must harness data and technology to improve decision-making and track results.

Holistic change will certainly take time, and without a firm commitment to prevention and diversion – and swift action to support that commitment by the state and counties – success is not guaranteed. But California has the tools and knowledge needed to undertake meaningful reform now, along with local and national momentum to help see it through. Lasting change will not be realized by the valiant efforts of one person or a single agency, but by a unified dedication to produce real results. Alone we simply cannot ensure that fewer Californians with mental illness tumble tragically into the criminal justice system.

But together we can.

Endnotes

- ¹ The Council on Mentally Ill Offenders was changed to the Council on Criminal Justice and Behavioral Health (Chartered by Secretary of State. Chapter 269, Statutes of 2017).
- ² California Corrections Standards Authority, Mentally Ill in Jails Workgroup. *Jails and the Mentally Ill: Issues and Analysis*. Available online: <http://www.sfsuperiorcourt.org/sites/default/files/pdfs/2338%20Jails%20and%20the%20Mentally%20Ill.pdf>.
- ³ Torrey, E. F. (1997). *Out of the Shadows: Confronting America's Mental Illness Crisis*. Chapter 3. New York: John Wiley & Sons.
- ⁴ La, E. M., Lich, K. H., Wells, R., Ellis, A. R., Swartz, M. S., Zhu, R., & Morrissey, J. P. (2016). Increasing access to state psychiatric hospital beds: Exploring supply-side solutions. *Psychiatric Services*, 67, 523–528.
- ⁵ California Hospital Association. (2016). *California's Acute Psychiatric Bed Loss*. Available online: http://www.calhospital.org/sites/main/files/file-attachments/6_-_psychbeddata.pdf.
- ⁶ Ibid.
- ⁷ Weatherspoon, F. D. (2007). The Mass Incarceration of African-American Males: A Return to Institutionalized Slavery, Oppression, and Disenfranchisement of Constitutional Rights. *Texas Wesleyan Law Review*, 13(2), 599-618.
- ⁸ Subramanian, R., Henrichson, C., & Kang-Brown, J. (2015). *In our Own Backyard: Confronting growth and disparities in American jails*. New York: Vera Institute of Justice. Available online: https://storage.googleapis.com/vera-web-assets/downloads/Publications/in-our-own-backyard-confronting-growth-and-disparities-in-american-jails/legacy_downloads/incarceration-trends-in-our-own-backyard-fullreport.pdf.
- ⁹ Mueser, K. T., & Drake, R. E. (2007). *Comorbidity: What have we learned and where are we going?* Washington, DC: American Psychological Association.
- ¹⁰ Lurigio, A. J. (2009). *Comorbidity*. In N. A. Piotrowski (Ed.), *Encyclopedia of psychology and mental health* (pp. 439-442). Pasadena, CA: Salem Press.
- ¹¹ Lurigio, A. J., & Swartz, J. A. (2000). *Changing the contours of the criminal justice system to meet the needs of persons with serious mental illness*. In J. Horney (Ed.), *NIJ 2000 Series: Policies, processes, and decisions of the criminal justice system* (Vol. 3, pp. 45-108). Washington, DC: National Institute of Justice.
- ¹² Selbin, J., Campos-Bui, S., Feldstein, S., Fisher, M., & Miller, N. (2016). *California's New Vagrancy Laws: The growing enactment and enforcement of anti-homeless laws in the golden state* (2016 Update). UC Berkeley Public Law Research Paper No. 2794386. Available at SSRN: <https://ssrn.com/abstract=2794386> or <http://dx.doi.org/10.2139/ssrn.2794386>.
- ¹³ Ibid.
- ¹⁴ National Institute of Mental Health. *The Numbers Count – Mental Disorders in America*. Available online: www.nimh.nih.gov/publicat/numbers.cfm.
- ¹⁵ Steadman, H. J., Osher, F. C., Clark Robbins, P., Case, B., & Samuels, S. (2009). Prevalence of serious mental illness among jail inmates. *Psychiatric Services*, 60(6), 761-765.
- ¹⁶ Teplin, L. A., McClelland, G. M., Abram, K. M., & Weiner, D. A. (2005). Crime Victimization in Adults with Severe Mental Illness: Comparison with the National Crime Victimization Survey. *Archives of General Psychiatry*, 62(8), 911–921.
- ¹⁷ Barnhorst, A. (personal communication, September 13, 2017).
- ¹⁸ Skeem, J., Manchak, S., Peterson, J.K. (2011). Correctional policy for offenders with mental illness: creating a new paradigm for recidivism reduction. *Law & Human Behavior*, 35, 110-126.
- ¹⁹ Andrews, D., & Bonta, J. (Eds.). (2010). *The Psychology of Criminal Conduct* (5th Edition ed.). New Providence, NJ: Matthew Bender & Company, Inc., Lexis Nexis Group.
- ²⁰ Draine, J., Wilson, A., & Pogorzelski, W. (2007). Limitations and potential in current research on services for people with mental illness in the criminal justice system. *Journal of Offender Rehabilitation*, 45, 159-177.
- ²¹ Center for Behavioral Health Statistics and Quality. (2016). *Key substance use and mental health indicators in the United States: Results from the 2015 National Survey on Drug Use and Health* (HHS Publication No. SMA 16-4984, NSDUH Series H-51). Retrieved from <http://www.samhsa.gov/data/>.
- ²² Soderstrom, I. A. (2007). Mental Illness in offender populations: Prevalence, duty and implications. *Journal of Offender Rehabilitation*, 45, 1-17.
- ²³ Ibid.
- ²⁴ Schmidt, L., Greenfield, T., & Mulia, N. (2006). *Unequal Treatment: Racial and Ethnic Disparities in Alcoholism Treatment Services*. National Institute on Alcohol Abuse and Alcoholism.
- ²⁵ For more information, please see: <http://www.dhcs.ca.gov/provgovpart/Pages/Drug-Medi-Cal-Organized-Delivery-System.aspx>.
- ²⁶ Andrews, D.A., Zinger, I., Hoge, R.D., Bonta, J., Gendreau, P., & Cullen, F.T. (1990). Does Correctional treatment work? A psychologically informed meta-analysis. *Criminology*, 28, 369-404.
- ²⁷ Andrews, D.A., & Bonta, J. (2006). *The Psychology of Criminal Conduct* (4th ed.). Newark, NJ: LexisNexis
- ²⁸ Andrews, D., & Bonta, J. (Eds.). (2010). *The Psychology of Criminal Conduct* (5th Edition ed.). New Providence, NJ: Matthew Bender & Company, Inc., Lexis Nexis Group.
- ²⁹ Osher, F., D'Amora, D., Poltkin, M., Jarrett, N., & Eggleston, A. (2012). *Adults with behavioral health needs under correctional supervision: A shared framework for reducing recidivism and promoting recovery*. Council of State Governments Justice Center. Criminal Justice/Mental Health Consensus Project. Available online: https://www.bja.gov/Publications/CSG_Behavioral_Framework.pdf.
- ³⁰ Ibid.
- ³¹ Ibid.
- ³² Ibid.
- ³³ Ibid.

- ³⁴ Graif, C., Gladfelter, A. S., & Matthews, S. A. (2014). Urban Poverty and Neighborhood Effects on Crime: Incorporating Spatial and Network Perspectives. *Sociology Compass*, 8(9), 1140–1155.
- ³⁵ Bohn, S., & Danielson, C. (2017). *Just the Facts: Poverty in California*. Retrieved from http://www.ppic.org/content/pubs/itf/JTF_PovertyJTF.pdf.
- ³⁶ Ibid.
- ³⁷ Hudson, C. G. (2005). Socioeconomic status and mental illness: Tests of the social causation and selection hypotheses. *American Journal of Orthopsychiatry*, 75(1), 3-18.
- ³⁸ Metraux, S., & Culhane, D. (2006). Recent incarceration history among a sheltered homeless population. *Crime and Delinquency*, 52(3):504-517.
- ³⁹ Greenberg, G., & Rosenheck, R. (2008). Jail incarceration, homelessness, and mental health: a national study. *Psychiatry Services*, 59(2):170-177.
- ⁴⁰ Center for Behavioral Health Statistics and Quality. (2016). *Key substance use and mental health indicators in the United States: Results from the 2015 National Survey on Drug Use and Health* (HHS Publication No. SMA 16-4984, NSDUH Series H-51). Retrieved from <http://www.samhsa.gov/data/>.
- ⁴¹ For more information, please see: <http://www.hcd.ca.gov/grants-funding/active-funding/nplh.shtml>.
- ⁴² For more information, please see: http://www.who.int/topics/social_determinants/en/.
- ⁴³ Compton, M. T., & Shim, R. S. (2015). The social determinants of mental health. *Focus*, 13(4), 419-425.
- ⁴⁴ Sampson, R. J., and Byron Groves, W. (1989). Community structure and crime: Testing social-disorganization theory. *American journal of sociology*, 94(4), 774-802.
- ⁴⁵ Smith, R. J., & Levinson, J. D. (2011). Impact of Implicit Racial Bias on the Exercise of Prosecutorial Discretion. *The Seattle University Law Review*, 35, 795.
- ⁴⁶ Woods, L. N., Lanza, A. S., Dyson, W., & Gordon, D. M. (2013). The role of prevention in promoting continuity of health care in prisoner reentry initiatives. *American Journal of Public Health*, 103 (5), 830-838.
- ⁴⁷ California Department of Corrections (2013). *Prison Census Data as of December 31, 2012*. http://www.cdcr.ca.gov/Reports_Research/Offender_Information_Services_Branch/Annual/Census/CENSUSd1312.pdf.
- ⁴⁸ Ibid.
- ⁴⁹ Center for American Progress & Movement Advancement Project (2016). *Unjust: How the broken criminal justice system fails LGBT people*. Denver, CO: Movement Advancement Project. Available online: <http://www.lgbtmap.org/file/lgbt-criminal-justice-unjust.pdf>.
- ⁵⁰ Center for American Progress & Movement Advancement Project (2016). *Unjust: How the broken criminal justice system fails transgender people*. Available online: <http://www.lgbtmap.org/file/lgbt-criminal-justice-trans.pdf>.
- ⁵¹ Nadal, K. L., Vargas, V., Meterko, V., Hamit, S., & McLean, K. (2012). Transgender female sex workers: Personal perspectives, gender identity development, and psychological processes. In M. A. Paludi (Ed.), *Managing diversity in today's workplace: Strategies for employees and employers: Vol. 1. Gender, race, sexual orientation, ethnicity, and power* (pp. 123–153). Santa Barbara, CA: Praeger.
- ⁵² Holden, K., McGregor, B., Thandi, P., Fresh, E., Sheats, K., Belton, A., Mattox, G., & Satcher, D. (2014). Toward Culturally Centered Integrative Care for Addressing Mental Health Disparities among Ethnic Minorities. *Psychological Services*, 11 (4), 357–368. <http://doi.org/10.1037/a0038122>.
- ⁵³ Behavioral Health Concepts (2017). *Medical Specialty Mental Health: External Quality Review FY 2016-2017*. Available online: http://calegro.com/data/reports_and_presentations/Fiscal%20Year%202015-2016%20Reports/CalEQRO_Statewide-Annual-Report_FY15-16.pdf.
- ⁵⁴ Chow, J. C. C., Jaffee, K., & Snowden, L. (2003). Racial/ethnic disparities in the use of mental health services in poverty areas. *American Journal of Public Health*, 93 (5), 792-797.
- ⁵⁵ Woods, D. V., King, N., Hanna, S. M., & Murray, C. (2012). *We Ain't Crazy! Just Coping With a Crazy System Pathways into the Black Population for Eliminating Mental Health Disparities*. African American Strategic Population Workgroup Report. Available online: https://archive.cdph.ca.gov/programs/Documents/African_Am_CRDP_Pop_Rept_FINAL2012.pdf.
- ⁵⁶ Native American Strategic Population Workgroup Report (2012). *Native Vision: A Focus on Improving Behavioral Health Wellness for California Native Americans*. Available online: http://www.nativehealth.org/sites/dev.nh.edeloa.net/files/native_vision_report_compressed.pdf.
- ⁵⁷ California Mental Health Services Act Multicultural Coalition (2014). *State of the State 4; 2013-2014: Reducing Disparities in Mental Health, Refugee/Asylees and Individuals with Intellectual Disabilities*. Available online: <http://remhdco.org/wp-content/uploads/2013/05/State-of-the-State-IV-RefugeeAsylees-Individuals-with-Intellectual-Developmental-Disabilities-FINAL.pdf>.
- ⁵⁸ Lesbian Gay, Transgender, Queer and Questioning Strategic Population Report (2012). *First Do No Harm: Reducing Disparities for Lesbian Gay, Transgender, Queer and Questioning*. Available online: https://archive.cdph.ca.gov/programs/Documents/LGBTQ_Population_Report.pdf.
- ⁵⁹ For more information, please see: <https://perception.org/research/explicit-bias/>.
- ⁶⁰ For more information, please see: <https://perception.org/research/implicit-bias/>.
- ⁶¹ Stier, A., & Hinshaw, S. P. (2007). Explicit and implicit stigma against individuals with mental illness. *Australian Psychologist*, 42, 106–117.
- ⁶² Corrigan, P.W. & Watson, A.C. (2002). Understanding the impact of stigma on people with mental illness, *World Psychiatry*, 1(1):16-20.
- ⁶³ Ibid.
- ⁶⁴ Penn, D. L., & Martin, J. (1998). The stigma of severe mental illness: Some potential solutions for a recalcitrant problem. *Psychiatric Quarterly*, 69, 235-247.
- ⁶⁵ U.S. Department of Health and Human Services. (1999). *Mental Health: A report of the Surgeon General*. Rockville, MD: Author.
- ⁶⁶ Brohan, E., & Thornicroft, G. (2010). Stigma and discrimination of mental health problems: workplace implications. *Occupational Medicine*, 60(6), 414–415. <https://doi.org/10.1093/occmed/kq048>.
- ⁶⁷ Iglesias, T. (2002). Managing local opposition to affordable housing: A new approach to NIMBY. *Journal of Affordable Housing and Community Development*, 12(1), 78-121.

- ⁶⁸ Memo from the California Behavioral Health Directors Association to the legislature. Dated March 23, 2017. Available online: http://www.cbhda.org/wp-content/uploads/2014/12/CBHDA-Memo-CHFFA-SB-82-extension_Final-32317.pdf.
- ⁶⁹ California Budget Fiscal Year 2017-18 included an extension of the Investment in Mental Health Wellness Grant Program until December 31, 2021. For more information, see AB 97 (2017): https://leginfo.ca.gov/faces/billTextClient.xhtml?bill_id=20170180AB97.
- ⁷⁰ Spencer, K. B., Charbonneau, A. K., & Glaser, J. (2016). Implicit Bias and Policing. *Social and Personality Psychology Compass*, 10(1), 50-63.
- ⁷¹ Robb, J., & Stone, J. (2016). Implicit bias toward people with mental illness: A systematic literature review. *Journal of Rehabilitation*, 82(4), 3-13.
- ⁷² President's Task Force on 21st Century Policing (2015). *Final Report of the President's Task Force on 21st Century Policing*. Washington, DC: Office of Community Oriented Policing Services. Available online at http://www.cops.usdoj.gov/pdf/taskforce/TaskForce_FinalReport.pdf.
- ⁷³ For more information, please see: <https://stepuptogether.org/>.
- ⁷⁴ Ibid.
- ⁷⁵ Ibid.
- ⁷⁶ Adams, D., & Siggins, E. (2017). *Understanding and Improving Key Measures to Reduce the Number of People with Mental Illnesses in Jail: Stepping Up California Efforts*. Council of State Governments, Justice Center. Presentation publicly available here: <http://www.cdcr.ca.gov/COMIO/Meetings.html>.
- ⁷⁷ Haneberg, R., Fabelo, T., Osher, F., & Thompson, M. (2017). *Reducing the Number of People with Mental Illness in Jail: Six Questions county Leaders Need to Ask*. Available online: https://stepuptogether.org/wp-content/uploads/2017/01/Reducing-the-Number-of-People-with-Mental-Illnesses-in-Jail_Six-Questions.pdf.
- ⁷⁸ Munetz, M. R., & Griffin, P. A. (2006). Use of the sequential intercept model as an approach to decriminalization of people with serious mental illness. *Psychiatric Services*, 57(4), 544-549.
- ⁷⁹ Case, B., Policy Research Associates (personal communication, April 5, 2017).
- ⁸⁰ Munetz, M. R., & Griffin, P. A. (2006). Use of the sequential intercept model as an approach to decriminalization of people with serious mental illness. *Psychiatric Services*, 57(4), 544-549.
- ⁸¹ Ibid.
- ⁸² For more information, please see: <https://www.prainc.com/wp-content/uploads/2016/11/Intercept-0-Infographic-2.pdf>.
- ⁸³ Lamb H. R., Weinberger L. E. (2013). Some perspectives on criminalization. *The Journal of the American Academy of Psychiatry and the Law*, 41, 287-293.
- ⁸⁴ Welfare and Institutions Code (WIC) Sections 5345-5349.5
- ⁸⁵ K. Bunch. Psychologist with the Los Angeles County Mental Health Department and MHSOAC Commissioner (personal communication, October 11, 2017).
- ⁸⁶ Levenson, J., & Grady, M. (2016). Childhood adversity, substance abuse, and violence: implications for trauma-informed social work practice. *Journal of Social Work Practice in the Addictions*, 16(1-2), 24-45.
- ⁸⁷ Woods, D. V., King, N., Hanna, S. M., & Murray, C. (2012). *We Ain't Crazy! Just Coping With a Crazy System Pathways into the Black Population for Eliminating Mental Health Disparities*. African American Strategic Population Workgroup Report. Available online: https://archive.cdph.ca.gov/programs/Documents/African_Am_CRDP_Pop_Rept_FINAL2012.pdf.
- ⁸⁸ For more information, please see: <http://www.harmoniouslivesolutions.org/>.
- ⁸⁹ For more information, please see: <https://www.cdph.ca.gov/Programs/OHE/Pages/CRDP.aspx>.
- ⁹⁰ White Bird Clinic, CAHOOTS, <http://whitebirdclinic.org/cahoots/>.
- ⁹¹ Coffman, J. M., Wides, C., Niedzwiecki, M., & Geyn, I. (2017). Evaluation of California's Community Paramedicine Pilot Project. Healthforce Center at UCSF. Available online here: https://healthforce.ucsf.edu/sites/healthforce.ucsf.edu/files/publication-pdf/Evaluation%20of%20California%20CP%20Pilot%20Program_final%5B1%5D.pdf.
- ⁹² Ibid.
- ⁹³ For more information, please see: <http://mhsaac.ca.gov/triage-homepage>.
- ⁹⁴ For more information, please see: [https://www.buttecounty.net/Portals/5/Administration/MHSA/ButteCountyMentalHealthServicesAct\(MHSA\)2017-2020ProgramandExpenditurePlan.pdf](https://www.buttecounty.net/Portals/5/Administration/MHSA/ButteCountyMentalHealthServicesAct(MHSA)2017-2020ProgramandExpenditurePlan.pdf).
- ⁹⁵ For more information, please see: http://www.sbcounty.gov/uploads/DBH/content/MHSA_Three_Year_Plan%202017_18-2019_20.pdf.
- ⁹⁶ Citation forthcoming.
- ⁹⁷ For more information, please see: http://dmh.lacounty.gov/wps/portal/dmh/our_services/countywide?1dmy&page=dept.lac.dmh.home.services.countywide.detail.hidden&urilc=wcm%3Apath%3A/dmh+content/dmh+site/home/our+services/countywide+services/countywide+services+detail/aotla.
- ⁹⁸ For more information, please see: <http://cit.memphis.edu/aboutCIT.php>.
- ⁹⁹ Reuland, M., & Yasuhara, K. (2015). Law Enforcement and Emergency Services. In Griffin, P. A., Heilbrun, K., Mulvey, E. P., DeMatteo, D., & Schubert, C. A. (Eds.), *The sequential intercept model and criminal justice: Promoting community alternatives for individuals with serious mental illness* (p.40). New York, NY: Oxford University Press, USA.
- ¹⁰⁰ Implicit bias refers to an unconscious and automatic association made between stereotypes and groups of people. These stereotypes can be about race, gender, age, religion, sexual orientation, or health status, including mental illness.
- ¹⁰¹ See National Initiative for Building Community Trust and Justice: <https://trustandjustice.org/about/mission>.
- ¹⁰² For more information, please see: http://www.co.fresno.ca.us/uploadedFiles/Departments/Behavioral_Health/MHSA/Approved%20Three-Year%20Plan%20-%20Book.pdf.
- ¹⁰³ For more information, please see: http://www.kcbh.org/uploads/2/6/2/9/26293851/kingsmhsa_-3yearplan-final_20141219-stc_1_.pdf.
- ¹⁰⁴ For more information, please see: <https://www.dhhs.saccounty.net/BHS/Documents/Reports--Workplans/MHSA-Reports-and-Workplans/RT-2016-17-MHSA-Annual-Update--Sacramento-County.pdf>.
- ¹⁰⁵ Griffin, P. A., Heilbrun, K., Mulvey, E. P., DeMatteo, D., & Schubert, C. A. (Eds.). (2015). *The Sequential Intercept Model and Criminal Justice: Promoting Community Alternatives for Individuals with Serious Mental Illness*. Oxford University Press, USA.

- ¹⁰⁶ For more information, please see: https://www.marinhhs.org/sites/default/files/libraries/2016_12/12.6.16_bos_approved_mhsa_annual_update_for_fy16-17_fy14-15_services_and_outcomes_final.pdf.
- ¹⁰⁷ For more information, please see: http://file.lacounty.gov/SDSInter/dmh/1017240_MHSA3YearPlanFY17-181-23-17.pdf.
- ¹⁰⁸ For more information, please see: https://www.sfdph.org/dph/files/CBHSdocs/MHSAdocs/FY2016-2017_AnnualUpdate.pdf.
- ¹⁰⁹ Judicial Council. *Fact Sheet: Collaborative Justice Courts, July 2017*. Available online: http://www.courts.ca.gov/documents/CollaborativeCourts_factsheet.pdf.
- ¹¹⁰ Ibid.
- ¹¹¹ Thompson, M., Osher, F., & Tomasini-Joshi, D. (2008). *Improving responses to people with mental illnesses: The essential elements of a mental health court*. New York: Council of State Governments Justice Center. For more information, including an up-to-date Mental Health Court Curriculum, please see: <https://learning.csgjusticecenter.org/>.
- ¹¹² Redlich, A. D., & Cusack, K. J. (2010). Mental health treatment in criminal justice settings. *Mental Health Services: A Public Health Perspective*, 3, 421-440.
- ¹¹³ Agency for Healthcare Research and Quality (2015). *National Healthcare Quality and Disparities Report and 5th Anniversary Update on the National Quality Strategy*. <http://www.ahrq.gov/research/findings/nhqrdr/nhqrdr15/index.html>
- ¹¹⁴ George, S., Duran, N., & Norris, K. (2014). A systematic review of barriers and facilitators to minority research participation among African Americans, Latinos, Asian Americans, and Pacific Islanders. *American Journal of Public Health*, 104(2), e16-e31.
- ¹¹⁵ For more information, please see: <https://www.co.monterey.ca.us/home/showdocument?id=15387>.
- ¹¹⁶ For more information, please see: http://cams.ocgov.com/Web_Publisher/Agenda05_24_2016_files/images/O00316-000634A.PDF.
- ¹¹⁷ For more information, please see: <https://www.countyofsb.org/behavioral-wellness/asset.c/3173>.
- ¹¹⁸ Regenstein, M., & Christie-Maples, J. (2012). *Medicaid coverage for individuals in jail pending disposition: opportunities for improved health and health care at lower costs*. Washington, DC: Department of Health Policy, School of Public Health and Health Services, George Washington University. Available online: <http://www.cochs.org/files/GWU/MedicaidCoverage.pdf>.
- ¹¹⁹ Osher, F. C., Steadman, H. J., & Barr, H. (2002). *A Best Practice Approach to Community Re-Entry from Jails for Inmates with Co-occurring Disorders: The APIC Model*. Delmar, NY: The National GAINS Center.
- ¹²⁰ Bonta, J., & Andrews, D. A. (2007). Risk-need-responsivity model for offender assessment and rehabilitation. *Rehabilitation*, 6(1), 1-22.
- ¹²¹ Vogel, W. M., Noether, C. D., & Steadman, H. J. (2007). Preparing communities for re-entry of offenders with mental illness: The ACTION approach. *Journal of Offender Rehabilitation*, 45(1), 167-188.
- ¹²² Osher, F., & King, C. (2015). Intercept 4: Reentry from jails and prisons. In Griffin, P. A., Heilbrun, K., Mulvey, E. P., DeMatteo, D., & Schubert, C. A. (Eds.), *The sequential intercept model and criminal justice: Promoting community alternatives for individuals with serious mental illness* (p.95). New York, NY: Oxford University Press, USA.
- ¹²³ Council of State Governments (2016). What Works in Reentry Clearinghouse. <https://whatworks.csgjusticecenter.org/evaluation/sacks-et-al-2012-2>.
- ¹²⁴ Osher, F., & King, C. (2015). Intercept 4: Reentry from jails and prisons. In Griffin, P. A., Heilbrun, K., Mulvey, E. P., DeMatteo, D., & Schubert, C. A. (Eds.), *The sequential intercept model and criminal justice: Promoting community alternatives for individuals with serious mental illness* (p.95). New York, NY: Oxford University Press, USA.
- ¹²⁵ Cusack, K. J., Morrissey, J. P., Cuddeback, G. S., Prins, A., & Williams, D. M. (2010). Criminal Justice Involvement, Behavioral Health Service Use, and Costs of Forensic Assertive Community Treatment: A Randomized Trial. *Community Mental Health Journal*, 46(4), 356-363.
- ¹²⁶ For more information, please see: https://www.cibhs.org/sites/main/files/file_attachments/cimh_fsp_adult_cr_final.pdf.
- ¹²⁷ For more information, please see: http://www.co.lake.ca.us/Assets/Mental+Health_AODS/docs/MH/Updates/2016-2017+Annual+Update.pdf.
- ¹²⁸ For more information, please see: <http://agenda.slocounty.ca.gov/agenda/sanluisobispo/4911/TUHQSAyMDE1LTE2IEFubnVhbCBVcGRhdGVfRmluYWwucGRm/12/n/47105.doc>.
- ¹²⁹ For more information, please see: <http://www.sandiegocounty.gov/content/dam/sdc/hhsa/programs/bhs/homepage/MHSA/MHSA%20FY2016-17%20Annual%20Update%20FULL%20REPORT%20.pdf>.
- ¹³⁰ Glaze, L. E., & Bonczar, T. P. (2009). Probation and parole in the United States, 2008 (Bureau of Justice Statistics Bulletin No. NCJ 228230). Washington, DC: US Department of Justice.
- ¹³¹ Ibid.
- ¹³² Phelps, M., & Curry, C. (2017-04-26). Supervision in the Community: Probation and Parole. *Oxford Research Encyclopedia of Criminology*. Retrieved 2 Oct. 2017, from <http://criminology.oxfordre.com/view/10.1093/acrefore/9780190264079.001.0001/acrefore-9780190264079-e-239>.
- ¹³³ Ditton, P. (1999). *Mental health and treatment: Inmates and probationers*. Washington, DC: Bureau of Justice Statistics.
- ¹³⁴ Skeem, J. L., Manchak, S., & Montoya, L. (2017). Comparing public safety outcomes for traditional probation vs specialty mental health probation. *JAMA Psychiatry*, 74(9), 942-948. doi:10.1001/jamapsychiatry.2017.1384.
- ¹³⁵ Loudon, J. E., Manchak, S., O'Connor, M., & Skeem, J. L. (2015). Applying the sequential intercept model to reduce recidivism among probationers and parolees with mental illness. In Griffin, P. A., Heilbrun, K., Mulvey, E. P., DeMatteo, D., & Schubert, C. A. (Eds.), *The sequential intercept model and criminal justice: Promoting community alternatives for individuals with serious mental illness* (118-131). New York, NY: Oxford University Press, USA.
- ¹³⁶ Ibid.
- ¹³⁷ Ibid.
- ¹³⁸ Wallace, B. C., Conner, L. C., & Dass-Brailsford, P. (2011). Integrated trauma treatment in correctional health care and community-based treatment upon reentry. *Journal of Correctional Health Care*, 17(4), 329-343.
- ¹³⁹ Lurigio A. J. (2011). People with serious mental illness in the criminal justice system causes, consequences, and correctives. *The Prison Journal*, 91(3 suppl): 66S-86S.

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- ¹⁴⁰ For more information, please see: <https://cchealth.org/mentalhealth/mhsa/pdf/2017-0316-three-year-plan.pdf>.
- ¹⁴¹ For more information, please see: <http://www.stanislausmhsa.com/pdf/public/annualupdates/annualupdatefy16-17.pdf>.
- ¹⁴² For more information, please see: <http://www.solanocounty.com/civicax/filebank/blobdload.aspx?blobid=25478>.
- ¹⁴³ Public Safety Realignment (AB 109, chapter 15, Stats. 2011) is the 2011 Governor-initiated legislation that keeps non-violent, non-serious, non-sexual offenders in local jails and on probation or in treatment programs instead of sending them to state prisons.
- ¹⁴⁴ California Code of Regulations, Title 9, Section 3300, subdivision (d).
- ¹⁴⁵ For more information, please see: <http://www.treasurer.ca.gov/chffa/imhwa/>.
- ¹⁴⁶ For more information, please see: <http://mhsoac.ca.gov/triage-homepage>.
- ¹⁴⁷ For more information, please see: http://www.bscc.ca.gov/s_cppladgrant.php.
- ¹⁴⁸ For more information, please see: http://www.bscc.ca.gov/s_cppmiocr.php.
- ¹⁴⁹ California Board of Corrections. (2005). *Mentally Ill Offender Crime Reduction Grant Program: Overview of Statewide Evaluation Findings*. Not paginated. Available online: <http://sd15.senate.ca.gov/sites/sd15.senate.ca.gov/files/7b.pdf>.
- ¹⁵⁰ For more information, please see: http://www.bscc.ca.gov/s_bsccprop47.php.
- ¹⁵¹ For more information, please see: <http://www.dhcs.ca.gov/services/Pages/WholePersonCarePilots.aspx>.
- ¹⁵² Pagel, L., Schwartz, T., & Ryan, J. (2017). *The California Whole Person Care Pilot Program: County partnerships to improve the health of Medical beneficiaries*. Harbage Consulting. Available online: http://harbageconsulting.com/wp-content/uploads/2017/02/WPC-Summary_Final_02282017.pdf.
- ¹⁵³ Ibid.
- ¹⁵⁴ For more information, please see: <http://treasurer.ca.gov/chffa/meeting/staff/2016/20160922/8.pdf>
- ¹⁵⁵ For more information, please see: <http://mhsoac.ca.gov/triage-homepage>
- ¹⁵⁶ For more information, please see: http://www.bscc.ca.gov/s_cppladgrant.php
- ¹⁵⁷ For more information, please see: <http://www.bscc.ca.gov/news.php?id=65>
- ¹⁵⁸ For more information, please see: http://www.bscc.ca.gov/s_bsccprop47.php
- ¹⁵⁹ For more information, please see: <http://www.dhcs.ca.gov/provgovpart/Documents/WPCApplicationStats.pdf>. The Small County Whole Person Care Collaborative consists of Plumas, Mariposa, and San Benito Counties.
- ¹⁶⁰ For more information, please see: <http://www.bscc.ca.gov/downloads/2017-8-29%20Prop%2047%20Project%20Summaries.pdf>.
- ¹⁶¹ For more information, please see: http://web2.co.merced.ca.us/pdfs/mentalhealth/mhsa/mhsa_annual_update_2015_2016.pdf.
- ¹⁶² For more information, please see: http://rivcocob.org/agenda/2016/09_27_16_files/03-24.pdf.
- ¹⁶³ For more information, please see: <https://www.sccgov.org/sites/bhd/AboutUs/MHSA/Documents/2017/mhsa-fy17-ann-update-plan-new-inn-proj-07-14-17.pdf>.
- ¹⁶⁴ For more information, please see: <http://www.solanocounty.com/civicax/filebank/blobdload.aspx?blobid=25478>.
- ¹⁶⁵ Statements made during a One Mind Initiative at Work event on September 14, 2017 in Saint Helena, CA.
- ¹⁶⁶ For more information, please see: <https://www.cdph.ca.gov/Programs/OHE/Pages/CRDP.aspx>.
- ¹⁶⁷ Welfare and Institutions Code Section 5847.
- ¹⁶⁸ Welfare and Institutions Code Sections 5845(d)(6), 5846(c), and 5847(a).
- ¹⁶⁹ Kim, K., Becker-Cohen, M., & Serakos, M. (2015). *The Processing and Treatment of Mentally Ill Persons in the Criminal Justice System: A Scan of Practice and Background Analysis*. Washington, D.C.: Urban Institute.
- ¹⁷⁰ Ibid.
- ¹⁷¹ California Code of Regulations, Title 15, Section 1207.
- ¹⁷² California Code of Regulations, Title 15, Section 1210.
- ¹⁷³ California Code of Regulations, Title 15, Section 1200.
- ¹⁷⁴ California Code of Regulations, Title 15, Section 1209.
- ¹⁷⁵ California Code of Regulations, Title 15, Section 1217.
- ¹⁷⁶ Ibid.
- ¹⁷⁷ California Code of Regulations, Title 15, Section 1214.
- ¹⁷⁸ Ibid.
- ¹⁷⁹ California Code of Regulations, Title 15, Section 1030.
- ¹⁸⁰ California Corrections Standards Authority, Mentally Ill in Jails Workgroup. *Jails and the Mentally Ill: Issues and Analysis*. Available online: <http://www.sfsuperiorcourt.org/sites/default/files/pdfs/2338%20Jails%20and%20the%20Mentally%20Ill.pdf>.
- ¹⁸¹ For more information, please see: <http://www.cdcr.ca.gov/COMIO/Uploadfile/pdfs/2016/Aug17/BSSC%20Training%20and%20Mental%20Health%20.pdf>.
- ¹⁸² Ibid.
- ¹⁸³ Ibid.
- ¹⁸⁴ Ibid.
- ¹⁸⁵ For more information, please see: <file:///C:/Users/bacashlevmills/Downloads/Timetable%20for%20the%20Provision%20of%20Crisis%20Intervention%20Training%20to%20all%20Custody%20Staff.pdf>.
- ¹⁸⁶ Correspondence from Disability Rights California to the Commission dated July 25, 2017.
- ¹⁸⁷ For more information, please see: <http://www.bscc.ca.gov/downloads/SB%20863%20PR%2011.12.15.pdf>.
- ¹⁸⁸ Ibid.
- ¹⁸⁹ Ibid.
- ¹⁹⁰ Minnesota Public Radio. <http://blogs.mprnews.org/newscut/2016/09/hennepin-survey-shows-link-between-jail-inmates-and-mental-illness/>.
- ¹⁹¹ California Forward is a bipartisan governance improvement organization that advances innovative ideas and sound analysis to develop, enact and implement pragmatic solutions that are needed to grow jobs, promote cost-effective public services and create accountability for results.
- ¹⁹² Penal Code Sections 6024-6025.

- ¹⁹³ Osher, F., D'Amora, D., Poltkin, M., Jarrett, N., Eggleston, A. (2012). *Adults with behavioral health needs under correctional supervision: A shared framework for reducing recidivism and promoting recovery*. Council of State Governments Justice Center. Criminal Justice/Mental Health Consensus Project.
- ¹⁹⁴ Ibid.
- ¹⁹⁵ Bonta, J., Law, M., & Hanson, C. (1998). The prediction of criminal and violent recidivism among mentally disordered offenders: A meta-analysis. *Psychological Bulletin*, 123, 123-142.
- ¹⁹⁶ Martin, M. S., Colman, I., Simpson, A. I., & McKenzie, K. (2013). Mental health screening tools in correctional institutions: a systematic review. *BMC Psychiatry*, 13, 275. <http://doi.org/10.1186/1471-244X-13-275>.
- ¹⁹⁷ Miller, N. A., & Najavits, L. M. (2012). Creating trauma-informed correctional care: a balance of goals and environment. *European Journal of Psychotraumatology*, 3, 10.3402/ejpt.v3i0.17246. <http://doi.org/10.3402/ejpt.v3i0.17246>.
- ¹⁹⁸ Pursuant to California Penal Code Section 1970.
- ¹⁹⁹ Legislative Analyst's Office. (2013). *An Alternative Approach: Treating the Incompetent to Stand Trial*. Available online: <http://www.lao.ca.gov/reports/2012/hlth/ist/incompetent-stand-trial-010312.aspx>.
- ²⁰⁰ Warburton, K. "National IST Trends." June 2017. Microsoft PowerPoint file.
- ²⁰¹ Ibid.
- ²⁰² Ibid.
- ²⁰³ Ibid.
- ²⁰⁴ Ibid.
- ²⁰⁵ Statements made during an interview conducted for this report.
- ²⁰⁶ Sixteen states operate formal outpatient competency restoration programs: Arkansas, Colorado, Connecticut, Florida, Georgia, Hawaii, Louisiana, Michigan, Nevada, Ohio, Rhode Island, Tennessee, Texas, Virginia, Washington, D.C., and Wisconsin.
- ²⁰⁷ Disability Rights California. *Placement of Individuals Found Incompetent to Stand Trial: A review of competency programs and recommendations*. Available online: <http://www.disabilityrightscalifornia.org/pubs/CM5201.pdf>.
- ²⁰⁸ Warburton, K. "National IST Trends." June 2017. Microsoft PowerPoint file.
- ²⁰⁹ Chaptered by Secretary of State. Chapter 269, Statutes of 2017.
- ²¹⁰ Penal Code Section 6044, which originally set forth a sunset date of December 31, 2006. In 2006, SB 1422 (Chapter 901, Statutes of 2006) eliminated the sunset date.
- ²¹¹ For more information, please see: <http://www.bscc.ca.gov/>.
- ²¹² For more information, please see: <http://www.cdcr.ca.gov/>.
- ²¹³ For more information, please see: <http://www.mhsoac.ca.gov/>.
- ²¹⁴ For more information, please see: <http://www.dhcs.ca.gov/services/Pages/default.aspx>.
- ²¹⁵ For more information, please see: <http://www.dsh.ca.gov/>.
- ²¹⁶ The White House, Office of the Press Secretary. (2016). Launching the Data-Driven Justice Initiative: Disrupting the Cycle of Incarceration. Available online: <https://obamawhitehouse.archives.gov/the-press-office/2016/06/30/fact-sheet-launching-data-driven-justice-initiative-disrupting-cycle>.
- ²¹⁷ Fermanian Business and Economic Institute at Point Loma Nazarene University. (2015). Project 25: Housing the Most Frequent Users of Public Services among the Homeless. Available online: https://uwsd.org/files/galleries/Project_25_Report.pdf.
- ²¹⁸ The White House, Office of the Press Secretary. (2016). Launching the Data-Driven Justice Initiative: Disrupting the Cycle of Incarceration. Available online: <https://obamawhitehouse.archives.gov/the-press-office/2016/06/30/fact-sheet-launching-data-driven-justice-initiative-disrupting-cycle>.
- ²¹⁹ Statements made during an interview conducted for this report.
- ²²⁰ The document can be accessed here: <http://www.chhs.ca.gov/OHII/Pages/shig.aspx>.
- ²²¹ For more information, please see: <http://www.dhcs.ca.gov/services/Pages/WholePersonCarePilots.aspx>
- ²²² For more information, please see: http://www.cdcr.ca.gov/COMIO/docs/02022017meeting/Project_Update_020217.pdf
- ²²³ Bertrand, M., Chugh, D., & Mullainathan, S. (2005). Implicit Discrimination. *The American Economic Review*, 95(2), 94-98.
- ²²⁴ For more information, please see: <https://trustandjustice.org/>.
- ²²⁵ California Department of Health Care Services (2017). *Mental Health Services Act Expenditure Report – Governor's Budget Fiscal Year 2017-18*. Available online: http://www.dhcs.ca.gov/formsandpubs/Documents/Legislative%20Reports/Mental%20Health/MHSAExpenditureReport_Jan2017.pdf.
- ²²⁶ Partnering county associations include the California State Sheriffs' Association, County Behavioral Health Directors Association of California, and Chief Probation Officers of California.
- ²²⁷ Thompson, M. and Fader-Towe, H. (2016). *Best Practices: Mentally Ill Offender Crime Reduction Grants Adult Programs 2015*. Council of State Governments, Justice Center. Microsoft PowerPoint file available online: <http://www.fmhac.net/Assets/Documents/W2D/W2DX/W2D10.Day1-MikeThomsonSlides.pdf>.
- ²²⁸ For more information, please see: <http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/PDF%20F/PDF%20FinePrintExchangingBehavioral.pdf>.