

# THE TURNING POINT:

GETTING ON THE ROAD TO  
ENDING THE OVER-INCARCERATION  
OF PEOPLE WITH MENTAL HEALTH  
AND SUBSTANCE USE NEEDS

**ACLU**  
California

# ACKNOWLEDGEMENTS

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## **THE ACLU OF CALIFORNIA CRIMINAL JUSTICE AND DRUG POLICY PROJECT**

The ACLU of California's Criminal Justice and Drug Policy Project envisions a truly safe and just society achieved through respect for the dignity and fundamental rights inherent to every human being. Our mission is to reform California's approach to community safety to achieve effective community-based solutions and opportunities, sensible and proportionate interventions, and rehabilitation and transformative justice over punishment. We strive to end overcriminalization and ensure fair treatment of all people, inclusive of all races, genders, gender identities or expressions, sexual orientations, economic statuses, religions, national origins, immigration statuses, abilities, health statuses, or other identity characteristics.

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**We've reached the turning point.**

**It's time to turn towards a society that prioritizes community-based health services, fiscal responsibility, and human dignity rather than incarceration. Courageous advocates, particularly those with lived experience, will surely be the driving force toward this worthy goal.**

# EXECUTIVE SUMMARY

**F**ar too many people living with mental health and substance use (MH/SU) needs are arrested and incarcerated in California. The criminal justice system makes matters worse by exacerbating MH/SU needs and inflicting new trauma while draining government resources. A variety of factors contribute to this grim reality, including reliance on law enforcement as our primary response to MH/SU-related crises and a lack of investment in community-based services. Most agree we can no longer continue down this road. We have reached the turning point.

This report provides more than 40 recommendations for state and local advocacy to put us on the road to ending the over-incarceration of people living with MH/SU needs. The recommendations are presented according to the Sequential Intercept Mapping Model, a tool used to identify opportunities to reduce incarceration for people living with MH/SU needs at each stage of the criminal justice system. While we include recommendations for every stage of the process, we stress that interventions at the front-end, including before law enforcement contact, at the point of crisis, and during initial detention, should be prioritized as these will have the greatest impact on both the number of people who become involved and how far they go into the system.

Below are our primary recommendations for each stage in the criminal justice process.

## **ENSURE ACCESS TO QUALITY COMMUNITY-BASED MENTAL HEALTH AND SUBSTANCE USE SERVICES**

Comprehensive systems of care to promote health and prevent crises are essential to avert any level of justice-involvement. To build up these systems, our primary recommendations are to:

- Establish a peer support specialist certification program to incentivize engagement of people with lived experience;
- Expand Assertive Community Treatment Teams/ Full Service Partnerships to provide intensive services to people most in need; and
- Establish non-law enforcement mobile outreach teams to prevent crises.

## **ESTABLISH COMPREHENSIVE HEALTH-BASED RESPONSES TO CRISES TO REDUCE LAW ENFORCEMENT CONTACT**

When MH/SU-related crises occur, we must minimize contact with law enforcement through health-based crisis responses. Our primary recommendations to achieve this goal are:

- Require emergency dispatchers to receive training to recognize calls involving MH/SU-related crises and dispatch accordingly;



- Authorize paramedics to transport individuals experiencing MH/SU-related crises to community-based facilities; and
- Incentivize non-law enforcement crisis response teams to reduce the need for law enforcement involvement.

### **QUICKLY DIVERT PEOPLE LIVING WITH MH/SU NEEDS OUT OF DETENTION**

Once people are booked into jail, we must reduce the length of detention and connect people with community services as quickly as possible. Our primary recommendations to achieve this are:

- Establish uniform standards for MH/SU needs screening and require screening at jail intake to improve ability to make informed decisions; and
- Reform money bail and pretrial decision-making to dramatically reduce pretrial detention of people living with MH/SU needs.

### **IMPROVE COURT PROCESSING AND PREVENT OVERUSE OF SANCTIONS TO REDUCE TIME IN JAILS AND PRISONS AND RECIDIVISM RISK**

In this section, we separate recommendations into two subsections. The first subsection concerns the serious problem of people deemed incompetent to stand trial remaining in jail due to lack of restoration services. The second subsection includes recommendations for improving outcomes for people living with MH/SU needs in collaborative courts (e.g., drug courts) and in jail. Our primary recommendations to address this are:

- Expand access to community-based competency restoration to reduce the need to send people to state hospitals; and
- Shorten the time frame for competency restoration to reduce the backlog of state hospital beds.

### **IMPROVE SUCCESSFUL TRANSITION FROM INCARCERATION TO THE COMMUNITY**

For people living with MH/SU needs, a successful transition to the community is essential to prevent a return to the criminal justice system. Our primary recommendations to improve the likelihood of successful transition are:

- Increase the ability of individuals with past criminal justice-involvement to provide peer support and in-reach services to improve connection to the community; and
- Connect people with health navigators prior to release to link them to community health services.

### **REDUCE REINCARCERATIONS FOR VIOLATIONS OF SUPERVISION REQUIREMENTS**

Strict supervision requirements often result in findings of noncompliance and returns to jail or prison for people living with MH/SU needs. Our primary recommendations to prevent this are:

- Tailor conditions to the needs and capabilities of the individual to reduce supervision violations; and
- Expand Forensic Assertive Community Treatment teams to support successful reentry.

The report also includes recommendations to improve functioning across the criminal justice system.

We encourage advocates to utilize these recommendations to move forward on the road to ending the over-incarceration of people living with MH/SU needs across the state.





# ABOUT THIS RESOURCE

In California and across the nation, people living with mental health and substance use (MH/SU) needs<sup>1</sup> are dramatically over-represented at every stage of the criminal justice system.<sup>2</sup> The current state of affairs shirks more effective and less expensive ways of responding to people living with MH/SU needs for a system that routinely worsens health outcomes and increases the likelihood of further justice-involvement. People living with MH/SU needs routinely have their rights violated as they unnecessarily cycle through the criminal justice system and are subjected to increased harm and trauma caused by incarceration settings that cannot address their needs. It is a colossal failure with enormous human and economic costs.

The current system benefits no one. As people living with MH/SU needs suffer, law enforcement bemoans the role thrust upon them as the front line (and in many circumstances, the only) response to individuals experiencing MH/SU-related crises.

Taxpayers pick up the expensive tab for the unnecessary and ineffective incarceration of people living with MH/SU needs. Stakeholders on all sides agree: we must end the over-incarceration of people with mental health and substance use needs. We have reached the turning point.

The ACLU of California's Criminal Justice and Drug Policy Project created this resource to highlight concrete steps to reduce justice-involvement among people living with MH/SU needs in California. The ultimate goal is to establish a robust community-based array of services that can respond to the needs of this population without relying on criminal justice system intervention. Achieving this will require significant investments of time and money, as well as staunch advocacy and courageous leadership. The ACLU of California hopes to achieve this transformation in partnership with the many esteemed organizations that have led, and continue to lead, the fight for dignity for

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<sup>1</sup> Although the term “behavioral health” is commonly used to refer to both mental health and substance use needs, we use the term MH/SU needs because many find the term behavioral health offensive and stigmatizing. See e.g., Elizabeth Bowen, *Why I’ve Stopped Using the Term “Behavioral Health,”* Univ. Buffalo Sch. Soc. Work: SocialWorkSynergy, (Oct. 8, 2014), <https://socialworksynergy.org/2014/10/08/why-ive-stopped-using-the-term-behavioral-health/> (giving a social work professor’s explanation of why she will no longer use the term “behavioral health”).

<sup>2</sup> See JENNIFER BRONSON & MARCUS BERZOFKY, BUREAU OF JUSTICE STATISTICS, U.S. DEP’T OF JUSTICE, INDICATORS OF MENTAL HEALTH PROBLEMS REPORTED BY PRISONERS AND JAIL INMATES, 2011-12 1 (2017).



people living with MH/SU needs (many of whom were essential in the development of this resource and are cited in the Acknowledgments).


This resource serves to guide us onto the road to ending the over-incarceration of people living with MH/SU needs. It is not an exhaustive list of necessary work, but it provides tangible actions to begin to move forward at both the state and local levels. Implementing these recommendations will move us closer to a system where law enforcement is not the default response to MH/SU-related crises, where people living with MH/SU needs are treated with respect and dignity, and where quality MH/SU care is open and accessible to all in their communities.

Our recommended actions are presented pursuant to the Sequential Intercept Mapping Model, a tool used to identify interventions to reduce the number of individuals living with mental health needs in the criminal justice system.<sup>3</sup> Accordingly, they are categorized by the intercept in which they most aptly fit.

## THESE INTERCEPTS ARE:

- Intercept 0: Community Services/Supports;
- Intercept 1: Law Enforcement/Emergency Services;
- Intercept 2: Initial Detention/Initial Court Hearings;
- Intercept 3: Courts/Jails/Prisons;
- Intercept 4: Reentry; and
- Intercept 5: Community Corrections.<sup>4</sup>

We also include a category for actions that improve functioning across the criminal justice system. Because the overarching goal is to prevent criminal justice-involvement among people with MH/SU needs, extra attention should be paid to the goals in Intercepts 0, 1 and 2, as they attempt to limit how deep an individual goes into the criminal justice process.<sup>5</sup>



**The ultimate goal is to establish a robust community-based array of services that can respond to the needs of this population without relying on criminal justice system intervention. Achieving this will require significant investments of time and money, as well as staunch advocacy and courageous leadership.**

<sup>3</sup> See Mark R. Munetz & Patricia A. Griffin, *Use of the Sequential Intercept Model as an Approach to Decriminalization of People with Serious Mental Illness*, 57 PSYCH. SERVS., no. 4, 2006, at 544.

<sup>4</sup> Traditionally, Sequential Intercept Mapping begins at Intercept 1: Law Enforcement/Emergency Services. More recently, this has been expanded to include Intercept 0: Community Services/Supports. See Nicole Vincent-Roller, *Introducing "Intercept 0,"* POL'Y RESEARCH ASSOCS. (Nov. 23, 2016), <https://www.prainc.com/introducing-intercept-0/>.

<sup>5</sup> MEGAN FRENCH-MARCELIN, ACLU, *DIVERTING PEOPLE WITH PSYCHIATRIC DISABILITIES AWAY FROM THE CRIMINAL JUSTICE SYSTEM* 10 (2016).

# BACKGROUND

More than two-thirds of people in jail have substance use needs. The presence of both mental health and substance use needs, known as co-occurring disorders, is common; more than 70 percent of people living with serious mental illness in jails also have substance use needs. Those with co-occurring disorders account for about one-third of the nation's entire jail population.

**Currently, California does not reliably collect this data.**

People living with MH/SU needs are dramatically over-represented in the criminal justice system. Nearly one-fifth of adults in California experience mental health needs.<sup>6</sup> However, two-thirds of people in jail nationwide have mental health needs (63 percent of men and 75 percent of women).<sup>7</sup> Nationally, about 17 percent of people entering jails meet the criteria for serious mental illness<sup>8</sup> (14.5 percent of men and 31 percent of women), totaling approximately two million admissions every year.<sup>9</sup> More than two-thirds of people in jail have substance use needs.<sup>10</sup> The presence of both mental health and substance

use needs, known as co-occurring disorders, is common; more than 70 percent of people living with serious mental illness in jails also have substance use needs.<sup>11</sup> Those with co-occurring disorders account for about one-third of the nation's entire jail population.<sup>12</sup> Currently, California does not reliably collect this data.

The burden of this injustice falls heavily on black, Latino, and Native American people, people who identify as LGBTQ, and people with disabilities. These communities are disproportionately represented in our criminal justice system and are less likely to have access to appropriate MH/SU

6 Rachel N. Lipari, Struther L. Van Horn, Arthur Hughes & Matthew Williams, *State and Substate Estimates of Any Mental Illness from the 2012-2014 National Surveys on Drug Use and Health*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN. (July 20, 2017), [https://www.samhsa.gov/data/sites/default/files/report\\_3189/ShortReport-3189.html](https://www.samhsa.gov/data/sites/default/files/report_3189/ShortReport-3189.html).

7 BRONSON & BERZOFSKY, *supra* note 2, at 1; DORIS J. JAMES & LAUREN E. GLAZE, BUREAU OF JUSTICE STATISTICS, U.S. DEP'T OF JUSTICE, SPECIAL REPORT: MENTAL HEALTH PROBLEMS OF PRISON AND JAIL INMATES 1, 4 (2006).

8 "Serious mental illness" is a clinical and legal term of art which may vary depending on context and jurisdiction. The federal definition of serious mental illness is "a condition that affects 'persons aged 18 or older who currently or at any time in the past year have had a diagnosable mental, behavioral, or emotional disorder (excluding developmental and substance use disorders) of sufficient duration to meet diagnostic criteria specified within [Diagnostic and Statistical Manual-IV] that has resulted in serious functional impairment, which substantially interferes with or limits one or more major life activities.'" Dev. Servs. Grp., *Behind the Term: Serious Mental Illness*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN. 1-2 (2016), [https://www.nrepp.samhsa.gov/Docs/Literatures/Behind\\_the\\_Term\\_Serious%20%20Mental%20Illness.pdf](https://www.nrepp.samhsa.gov/Docs/Literatures/Behind_the_Term_Serious%20%20Mental%20Illness.pdf).

9 Henry J. Steadman, Fred C. Osher, Pamela Clark Robbins, Brian Case & Steven Samuels, *Prevalence of Serious Mental Illness among Jail Inmates*, 60 PSYCH SERVS., no. 6, 2009, at 761, 764.

10 Health, Mental Health, and Substance Use Disorder FAQs, COUNCIL OF STATE GOV'TS. JUSTICE CTR., <https://csgjusticecenter.org/substance-abuse/faqs/> (last visited Nov. 21, 2017).

11 *Id.*

12 Hung-En Sung, Jeff Mellow & Annette M. Mahoney, *Jail Inmates with Co-Occurring Mental Health and Substance Use Problems: Correlates and Service Needs*, 49 J. OFFENDER REHAB. 126, 136 (2010).



services in the community.<sup>13</sup> Incarcerated women have much higher rates of mental health needs than incarcerated men, in both jails and prisons.<sup>14</sup> Incarcerated people are also poorer than the general population, especially black and Latino incarcerated people.<sup>15</sup>

Racial biases also result in differences in access to treatment in incarceration. Older, white males are more likely to be referred to and receive treatment services as compared to younger, black and Latino males, while younger, black and Latino males are more likely to be put into solitary confinement.<sup>16</sup> Similar disparities exist in the community, where white people are more likely to access treatment than black and Latino people, due partially to differences in access to care and provider biases.<sup>17</sup> On the other side of the coin, law enforcement is more likely to stop, search, and arrest black and Latino people, despite lower rates of contraband recovered.<sup>18</sup>

Many factors converge to generate this grim reality. Failure to adequately invest in culturally humble and linguistically competent community-based MH/SU services and supports leaves many to cope without access to basic necessities.<sup>19</sup> When a crisis occurs or a community member reports someone who appears to have MH/SU needs, the response falls to law enforcement, with seven to ten percent of all police contacts involving people with mental health needs.<sup>20</sup> These encounters often end negatively. Police are nearly twice as likely to arrest someone if s/he appears to have MH/SU needs, even for similar alleged offenses.<sup>21</sup> One-quarter to half of all victims of police shootings are people living with MH/SU needs.<sup>22</sup> About one-quarter of people living with MH/SU needs in jails are incarcerated for a public order offense, demonstrating both insufficient community services to prevent these social issues and an increased law enforcement response, particularly in communities of color (including

13 See, e.g., ASHLEY NELLIS, SENTENCING PROJECT, *THE COLOR OF JUSTICE: RACIAL AND ETHNIC DISPARITY IN STATE PRISONS* 5 (2016) (showing that black people are incarcerated in California prisons at nearly nine times the rate and Latinos at nearly twice the rate as white people); CTR. AM. PROGRESS & MOVEMENT ADVANCEMENT PROJECT, *UNJUST: HOW THE BROKEN JUVENILE AND CRIMINAL JUSTICE SYSTEMS FAIL LGBTQ YOUTH* 1 (2016) (demonstrating over-representation of LGBTQ youth in the criminal justice system); REBECCA VALLAS, CTR. AM. PROGRESS, *DISABLED BEHIND BARS: THE MASS INCARCERATION OF PEOPLE WITH DISABILITIES IN AMERICA'S JAILS AND PRISONS* 1-2 (2016) (noting that people in prison and jail are three and four times more likely, respectively, to report a disability); CAL. PAN-ETHNIC HEALTH NETWORK, *CALIFORNIA REDUCING DISPARITIES PROJECT STRATEGIC PLAN TO REDUCE MENTAL HEALTH DISPARITIES* 5, 38-39 (2014), <http://cpehn.org/sites/default/files/crdpstrategicplan2014final2.pdf> (highlighting disparities in mental health treatment and access among people of color and LGBTQ communities).

14 JAMES & GLAZE, *supra* note 8, at 4.

15 BERNADETTE RABUY & DANIEL KOPF, *PRISON POL'Y INST., DETAINING THE POOR: HOW MONEY BAIL PERPETUATES AN ENDLESS CYCLE OF POVERTY AND JAIL TIME* 2 (2016).

16 Fatos Kaba et al., *Disparities in Mental Health Referral and Diagnosis in the New York City Jail Mental Health Service*, 105 AM. J. PUB. HEALTH, no. 9, 2015, at 1911, 1914.

17 *Id.* at 1915.

18 See e.g., CITY & CTY. OF S.F., *REPORT OF THE BLUE RIBBON PANEL ON TRANSPARENCY, ACCOUNTABILITY, AND FAIRNESS IN LAW ENFORCEMENT* 28-31 (2016) (finding racial disparities in rates of stops, searches, and arrests in San Francisco); IAN AYRES & JONATHAN BOROWSKY, *A STUDY OF RACIALLY DISPARATE OUTCOMES IN THE LOS ANGELES POLICE DEPARTMENT* 27 (2008) (finding black and Latino people were more likely to be stopped, searched, and arrested than whites, despite lower rates of contraband found).

19 Shannon Lange & Jurgen Rehm, *The Effectiveness of Criminal Justice Diversion Initiatives in North America: A Systematic Literature Review*, 10 INT'L J. FORENSIC MENTAL HEALTH 200, 200 (2011). "Cultural humility is a lifelong process of self-reflection and self-critique whereby the individual not only learns about another's culture, but one starts with an examination of her/his own beliefs and cultural identities." Katherine A. Yeager & Susan Bauer-Wu, *Cultural Humility: Essential Foundation for Clinical Researchers*, 26 Applied Nursing Research, no. 4, 2013, at 251, 252.

20 Stephanie Franz & Randy Borum, *Crisis Intervention Teams May Prevent Arrest of People with Mental Illness*, 12 POLICE PRACTICE & RESEARCH, no. 3, 2010, at 265.

21 Robert Bernstein & Tammy Seltzer, *Criminalization of People with Mental Illness: The Role of Mental Health Courts in System Reform*, 7 UNIV. D.C. L. REV. 143, 145 (2003).

22 E. FULLER TORREY ET AL., *TREATMENT ADVOCACY CTR. & NAT'L SHERIFFS' ASS'N, JUSTIFIABLE HOMICIDES BY LAW ENFORCEMENT: WHAT IS THE ROLE OF MENTAL ILLNESS* 7 (2013); Wesley Lowery et al., *Distraught People, Deadly Results*, WASH. POST (June 30, 2015), 25 [http://www.washingtonpost.com/sf/investigative/2015/06/30/distraught-people-deadly-results/?utm\\_term=.0c9e4baf5053](http://www.washingtonpost.com/sf/investigative/2015/06/30/distraught-people-deadly-results/?utm_term=.0c9e4baf5053).



increased enforcement for offenses such as loitering, urinating in public, disturbing the peace, and of course, the war on drugs).<sup>23</sup>

Once in jail, people living with MH/SU needs are incarcerated longer. For example, in Riverside County, people receiving MH/SU care in the jail have been booked into jail twice as many times as the rest of the population, and their average length of stay is more than 2.5 times as long as those not receiving MH/SU care.<sup>24</sup> In Los Angeles County, people receiving mental health services in the jail were incarcerated more than twice as long, on average, as people who did not receive those services. (On average, people charged with misdemeanors who received mental health services stayed in jail more than three times as long as people who did not receive those services).<sup>25</sup> One factor contributing to longer stays is that people with MH/SU needs may have difficulty complying with the strict rules of the jail or prison, and are therefore more likely to be sanctioned for rule violations.<sup>26</sup>

Nationwide, nearly 90 percent of people living with MH/SU needs receive little to no treatment while

incarcerated, and any treatment they do receive is likely to be substandard.<sup>27</sup> They are also at increased risk of physical and sexual violence, both by correctional staff and by other incarcerated people.<sup>28</sup> In general, the research has shown that incarceration has a negative impact on both physical health and MH/SU, in the short- and long-term, for incarcerated people and their families.<sup>29</sup>

People living with MH/SU needs are more likely to return to the criminal justice system, thus reinfllicting trauma and costs.<sup>30</sup> They are also at increased risk of death after custody. A study from New York City found that people leaving jails were eight times as likely to experience a fatal overdose and more than five times as likely to be the victim of homicide in the first two weeks of release as compared to the general population.<sup>31</sup> The risk increased with length of time in jail.<sup>32</sup> This corroborates previous research finding a more than 12-fold increase in the risk of death from all causes after release from prison.<sup>33</sup>

Unsurprisingly, incarcerating people living with MH/SU needs is incredibly expensive. For example, in Los Angeles County, keeping a person with mental

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23 COUNCIL OF STATE GOV'TS, CRIMINAL JUSTICE/MENTAL HEALTH CONSENSUS PROJECT 8 (2002); PAULA M. DITTON, U.S. DEP'T OF JUSTICE, BUREAU OF JUSTICE STATISTICS SPECIAL REPORT: MENTAL HEALTH TREATMENT OF INMATES AND PROBATIONERS 4 (1999).

24 SCOTT MACDONALD & KEVIN O'CONNELL, CAL. FORWARD, JUSTICE SYSTEM CHANGE INITIATIVE-RIVERSIDE COUNTY JAIL UTILIZATION REPORT 27 (2015).

25 SARAH LIEBOWITZ, PETER J. ELIASBERG, IRA A. BURNIM & EMILY B. READ, ACLU S. CAL. & BAZELON CTR. MENTAL HEALTH LAW, A WAY FORWARD: DIVERTING PEOPLE WITH MENTAL ILLNESS FROM INHUMANE AND EXPENSIVE JAILS INTO COMMUNITY-BASED TREATMENT THAT WORKS 8 (2014).

26 COUNCIL OF STATE GOV'TS, *supra* note 24, at 8-9; see HUMAN RIGHTS WATCH, ILL EQUIPPED: U.S. PRISONS AND OFFENDERS WITH MENTAL ILLNESS 59-60 (2003) (listing studies that found people with mental health needs in prisons have higher than average disciplinary rates); see JAMES & GLAZE, *supra* note 8, at 10 (noting people with mental health needs were twice as likely to receive sanctions for rule violations).

27 DAVID CLOUD & CHELSEA DAVIS, VERA INST., TREATMENT ALTERNATIVES TO INCARCERATION FOR PEOPLE WITH MENTAL HEALTH NEEDS IN THE CRIMINAL JUSTICE SYSTEM: THE COST-SAVINGS IMPLICATIONS 1 (2013).

28 Tonie L. Nicholls, Zina Lee, Raymond R. Corrado & James R. P. Ogloff, Women Inmates' Mental Health Needs: Evidence of the Validity of the Jail Screening Assessment Tool (JSAT), 3 INT'L J. FORENSIC MENTAL HEALTH 168 (2004).

29 NAT'L ACADEMIES OF SCI., IMPROVING COLLECTION OF INDICATORS OF CRIMINAL JUSTICE SYSTEM INVOLVEMENT IN POPULATION HEALTH DATA PROGRAMS 25 (2017).

30 Jacques Baillargeon et al., Psychiatric Disorders and the Repeat Incarcerations: The Revolving Prison Door, 166 AM. J. PSYCH. 166, no. 1, 2009, at 105.

31 Sungwoo Lim et al., Risks of Drug-Related Death, Suicide, and Homicide During the Immediate Post-Release Period Among People Released From New York City Jails, 2001-2005, 175 AM. J. EPIDEMIOLOGY 519, 524 (2012).

32 *Id.*

33 Ingrid A. Binswanger et al., Release from Prison – A High Risk of Death for Former Inmates, 356 N. ENG. J. MED., no. 2, 2007, at 157, 160.



health needs in jail can cost up to four times as much as providing intensive community-based services.<sup>34</sup> If people living with MH/SU needs were instead directed to health services in the community, we

would achieve better health and fiscal outcomes. While there are many facets to this crisis, there are many avenues of opportunity. We present several advocacy options in the following sections.

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34 LIEBOWITZ, ELIASBERG, BURNIM & READ, *supra* note 26, at 8-9.



**One-quarter to one-half of all victims of police shootings are people living with MH/SU needs.**

Fridoon Rawshan Nehad and his family came to the United States in 2003 after years of separation. He had battled mental illness and PTSD since being drafted into the Afghan military as a teenager in the 1980s. On April 30, 2015, an anonymous 911 caller incorrectly reported that Nehad was carrying a knife. A San Diego Police Department (SDPD) officer responded to the 911 call, shooting and killing Nehad within seconds of encountering him. Initially, SDPD claimed Nehad was holding a knife and charged at the officer. However, because the shooting was captured on video, it was clear Nehad held only a pen and never charged or threatened the officer. Nehad's death graphically illustrates the tragic outcomes that occur too frequently when police are relied upon as the primary responders to people experiencing MH/SU-related crises. Investing in non-law enforcement mobile crisis response teams should help to avoid negative interactions between police and people living with MH/SU needs.



# GETTING ON THE ROAD TO ENDING OVER-INCARCERATION OF PEOPLE LIVING WITH MH/SU NEEDS

The actions presented in this section are organized into stages of the “Sequential Intercept Mapping” Model, a tool used to identify interventions that reduce the number of individuals living with mental health needs in the criminal justice system.<sup>35</sup>

These stages are:

- **INTERCEPT 0:** Community Services/Supports;
- **INTERCEPT 1:** Law Enforcement/Emergency Services;
- **INTERCEPT 2:** Initial Detention/Initial Court Hearings;
- **INTERCEPT 3:** Courts/Jails/Prisons;
- **INTERCEPT 4:** Reentry; and
- **INTERCEPT 5:** Community Corrections.

This report also includes a section entitled “Improve Functioning across the Criminal Justice System” for action items that can fall into multiple intercepts.

Interventions at the front-end of the process (i.e., Intercepts 0-2) are more likely to reduce trauma and save costs by minimizing entanglement with

the justice system and connecting people to community-based services earlier.<sup>36</sup> We therefore urge prioritization of actions in those categories.

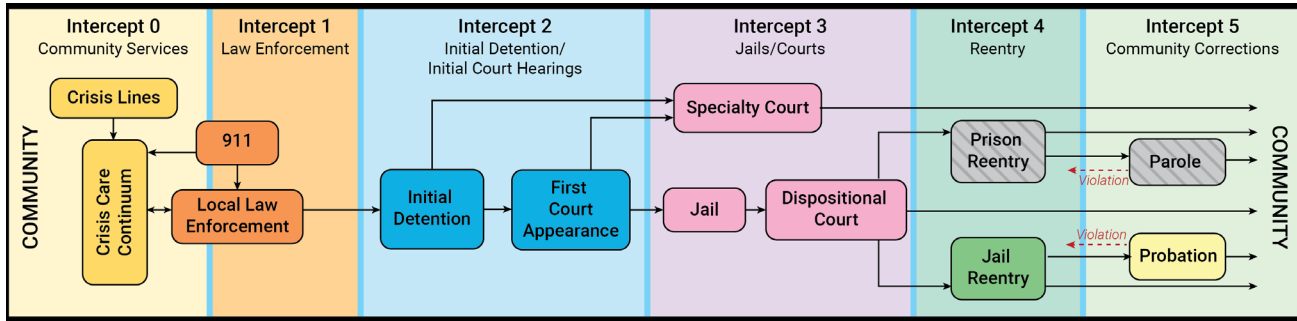
Because people living with MH/SU needs are over-represented in the criminal justice system, any systemic reforms are likely to have a disproportionate impact on this population. We support such reforms, including ending overuse of solitary confinement and facilitating access to IDs and other societal necessities at reentry. To maintain a specific focus on people living with MH/SU needs, we do not include these recommendations in this report. One exception is bail and pretrial reform, which we include because of its potentially enormous impact on this population and because many mental health advocates are heavily involved in this reform effort.

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<sup>35</sup> See Munetz & Griffin, *supra* note 4.

<sup>36</sup> See, e.g., DARRELL STEINBERG, DAVID MILLS & MICHAEL ROMANO, STANFORD L. SCH. THREE STRIKES PROJ., WHEN DID PRISONS BECOME ACCEPTABLE MENTAL HEALTHCARE FACILITIES? 10 (2015) (noting the annual cost of keeping someone in prison is \$51,000 compared to \$20,412 for community housing and outpatient treatment). CATHERINE CAMILLETI, BUREAU OF JUSTICE ASSIST., U.S. DEP'T OF JUSTICE, PRETRIAL DIVERSION PROGRAMS: RESEARCH SUMMARY 3 (2010) (describing benefits of pretrial diversion programs).

## SEQUENTIAL INTERCEPT MAPPING MODEL



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We also acknowledge there are other impactful recommendations not included in this report because they reflect more complex initiatives to be addressed down the road. An example of this is the decriminalization of personal drug use and possession.<sup>37</sup> In implementing any of the recommended actions, the following principles must be at the forefront:

- The voices of those directly impacted (i.e., those living with MH/SU needs who have a criminal record and their families) should guide both policy and programming. Inclusion of people with lived experience in provision of services, training of health and law enforcement professionals, and education of policymakers is essential to building a system that will respond to the needs of the people it is trying to serve.
- Policymaking on this issue should primarily aim to reduce disparities between black, Latino, Native American, and LGBTQ communities and the white community. These disparities include over-representation in the criminal justice system and inadequate access to quality community-based MH/SU treatment. Interventions must be race conscious and address generational trauma of racism and inequalities in economic and social opportunity.<sup>38</sup>
- These efforts should pay attention to the needs of Native American tribes and people living in rural areas. These populations are often left out of policymaking. They also lack the resources that more urban counties have for provision of services and for capacity to seek and obtain additional funding.
- Services should be culturally humble, linguistically competent, and consider differences in the treatment of MH/SU needs depending on individuals' ethnicity and background (e.g., veteran, immigration status).
- Advocacy should support efforts to reduce stigma around MH/SU issues and treatment, which will lead to increases in access of services.<sup>39</sup>

<sup>37</sup> The ACLU supports decriminalization of drug possession. See HUMAN RIGHTS WATCH & ACLU, EVERY 25 SECONDS: THE HUMAN TOLL OF CRIMINALIZING DRUG USE IN THE UNITED STATES 187 (2016).

<sup>38</sup> The Racial and Ethnic Mental Health Disparities Coalition advocates for this approach, directed by conversations with the populations that are most impacted. See JIM GILMER, WHY A VULNERABLE POPULATION'S INITIATIVE? (2017) (on file with author).

<sup>39</sup> J. SCOTT ASHWOOD ET AL., RAND CORP., INVESTMENT IN SOCIAL MARKETING CAMPAIGN TO REDUCE STIGMA AND DISCRIMINATION ASSOCIATED WITH MENTAL ILLNESS YIELDS POSITIVE ECONOMIC BENEFITS TO CALIFORNIA 1 (2016) (finding that exposure to marketing to reduce stigma increased treatment seeking and resulted in an over tenfold return on investment).

# ENSURE ACCESS TO QUALITY COMMUNITY-BASED MENTAL HEALTH AND SUBSTANCE USE SERVICES

## INTERCEPT 0: COMMUNITY SERVICES/SUPPORTS

Intercept 0 encompasses all the services and supports that should be available in the community to prevent MH/SU-related crises. Recommendations in this section are intended to build a comprehensive system of care to prevent crises and mitigate the need for emergency response.

### O-A. ESTABLISH A PEER SUPPORT SPECIALIST CERTIFICATION PROGRAM TO INCENTIVIZE ENGAGEMENT OF PEOPLE WITH LIVED EXPERIENCE

People who live or have lived with MH/SU needs and/or have been in the criminal justice system can play an important role in helping others to navigate the complex healthcare and criminal justice systems. They can also supplement the MH/SU service provider workforce where there is a critical shortage. While some localities have established peer specialist certificate programs, California has no standard certification or funding source to sustain these essential positions.<sup>40</sup> California is in the minority among states in this regard; as of July 2016, 41 states and the District of Columbia had an

established peer specialist certification program.<sup>41</sup> Certification of peer specialists will allow Medi-Cal to reimburse for services provided by appropriately trained individuals who have lived with MH/SU needs and provide a sustained source of funding. The Department of Corrections and Rehabilitation's Council on Criminal Justice and Behavioral Health (formerly the Council on Mentally Ill Offenders) supports peer support specialist certification.<sup>42</sup>

**Action:** Support efforts to establish a statewide peer support specialist certification program that allows peer-provided services to be reimbursed through Medi-Cal. While local jurisdictions could use Mental Health Services Act (MHSA), Public Safety Realignment, or other funds to pay for peer support specialists, a statewide certification program will establish an ongoing funding source.

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<sup>40</sup> See *Peer Specialist Mental Health Certificate, RICHMOND AREA MULTI-SERVS.*, <http://www.ramsinc.org/peer.php> (last visited Dec. 8, 2017).

<sup>41</sup> LAURA KAUFMAN, WENDY B. KUHN & STACEY S. MANSER, UNIV. TEX. AUSTIN TEX. INST. EXCELLENCE IN MENTAL HEALTH, *PEER SPECIALIST TRAINING & CERTIFICATION PROGRAMS: NATIONAL OVERVIEW 2016* 1, 4 (2016).

<sup>42</sup> CAL. DEP'T CORR. & REHAB., COUNCIL ON MENTALLY ILL OFFENDERS, *16TH ANNUAL LEGISLATIVE REPORT 52* (2017).

## O-B. EXPAND ASSERTIVE COMMUNITY TREATMENT TEAMS/FULL SERVICE PARTNERSHIPS TO PROVIDE INTENSIVE SERVICES TO PEOPLE MOST IN NEED

Assertive Community Treatment (ACT) Teams provide high-intensity case management and support services for people with serious MH/SU needs. One form of ACT in California, known as Full Service Partnerships (FSPs), led to significant reductions in homelessness (47 percent), emergency care (79 percent), psychiatric hospitalizations (42 percent), arrests (82 percent), and incarcerations (27 percent) among participants in FY 2011-12.<sup>43</sup> The San Diego In-Home Outreach Team (IHOT) uses ACT to reach people with serious mental health needs. The IHOT program realized an increase in the utilization of community mental health services and a reduction in use of crisis response teams and emergency psychiatric hospitalizations.<sup>44</sup> Despite these impressive results, FSPs are not at a capacity to meet the need in California.<sup>45</sup> The state can support expansion of these teams through increased funding. Establishing a peer support specialist certification program will also help with expansion and sustainability of FSPs (see Recommendation O-A.).

**Action:** Support funding for Assertive Community Treatment Teams/Full Service Partnerships and support incentives (such as tax breaks or other financial inducements to insurance companies and/or hospital systems) to invest in ACT and FSP programs. MHSA, Public Safety Realignment, and Medi-Cal funds can support these programs locally. Advocates can also push

their local hospitals to invest in these programs as part of their community benefit plans (initiatives undertaken by nonprofit hospitals to improve community health that are required for the hospital to receive a tax exemption).<sup>46</sup>

## O-C. ESTABLISH NON-LAW ENFORCEMENT MOBILE OUTREACH TEAMS TO PREVENT CRISES

Proactive mobile outreach to individuals living with MH/SU needs and/or experiencing homelessness is a critical way to prevent crises and connect people to resources prior to their contact with emergency services or law enforcement. It is important to establish mobile outreach teams that are not a part of the criminal justice system, where many people may have had past traumatic experiences. Healthcare professionals, social workers, and/or peers can utilize their unique skills and training to engage people without the involvement of law enforcement. Various examples exist across the state, including the Outreach Program of the Women's Community Clinic, which provides outreach, health education, and referrals to homeless women in San Francisco.<sup>47</sup> The Whole Person Care Pilot program, overseen by the Department of Health Care Services, envisions the use of local mobile outreach teams to engage individuals who have significant health needs and/or are homeless.<sup>48</sup> Mental Health Services Act funds may be used to pay for these outreach teams.<sup>49</sup>

**Action:** Support the establishment and funding of non-law enforcement mobile outreach teams. The Whole Person Care Pilot may provide fiscal

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43 STEINBERG INST. & CTY. BEHAVIORAL HEALTH DIRS. ASS'N CAL., PROP 63 REVIEW: MENTAL HEALTH SERVICES ACT DELIVERING ON PROMISE TO CALIFORNIANS 1-3 (2015).

44 SAN DIEGO CTY., QUARTERLY STATUS REPORT ON SERVICES FOR INDIVIDUALS WITH SERIOUS MENTAL ILLNESS WHO ARE RESISTANT TO TREATMENT 7 (2015).

45 See e.g., Dana Littlefield, *From Jail to Treatment: Helping Get the Mentally Ill on Track*, SAN DIEGO UNION TRIBUNE (Nov. 12, 2017), <http://www.sandiegouniontribune.com/news/courts/sd-me-mentalhealth-justice-20171112-story.html> (explaining a shortage of ACT capacity and long waiting lists).

46 HILLTOP INST., UNIV. MD., WHAT ARE HOSPITAL COMMUNITY BENEFITS? 1 (2013). Current California hospital community benefit plans are available online. See Hospital Community Benefit Plans, CAL. OFF. STATEWIDE HEALTH PLANNING & DEV., <https://www.oshpd.ca.gov/HID/CommunityBenefit/Plans.html> (last visited Dec. 12, 2017).

47 Outreach Program, WOMEN'S CMY. CLINIC, <http://womenscommunityclinic.org/outreach-program/> (last visited Dec. 12, 2017).

48 See CAL. DEP'T HEALTH CARE SERVS., WHOLE PERSON CARE PROGRAM: MEDI-CAL 2020 WAIVER INITIATIVE 14 (2016), available at, <http://www.dhcs.ca.gov/provgovpart/Documents/WPCProgramOverview.pdf>.

49 CAL. CODE REGS., title. 9, § 3640; see also § 3610(e) (prohibiting MHSA funds from being used to pay for law enforcement).

incentives for establishing these teams. Counties may allocate MHSA funds and/or Public Safety Realignment and general funds to establish or expand these programs. Advocates can also push local hospitals to invest in mobile outreach teams as part of their community benefit plans.<sup>50</sup>

## **O-D. EXPAND HOUSING OPTIONS TO REDUCE LAW ENFORCEMENT CONTACT AND IMPROVE HEALTH**

It is nearly impossible to address the health concerns of people with MH/SU needs who do not have a stable and safe living environment. Permanent housing accompanied by voluntary intensive services for people with MH/SU needs reduces emergency department and jail admissions, use of alcohol and drugs, and severity of mental health needs.<sup>51</sup> Recent developments present advocates with opportunities to increase local housing options for people living with MH/SU needs. One opportunity is a statewide \$2 billion bond to finance construction of permanent supportive housing for people living with serious mental health needs. Counties will be able to apply for these funds beginning in the summer of 2018.<sup>52</sup> In addition, California established flexible housing pools as an option under the Whole Person Care Pilot program.<sup>53</sup> Seventeen counties are implementing these housing pools, which allow the state and counties to allocate funding to support long-term housing, including rental subsidies and increasing housing stock.<sup>54</sup> For counties that have not opted into the Whole Person Care Pilot program, there may be opportunities to join the program and establish a housing pool in

the future. Counties can use Medi-Cal, MHSA, and Public Safety Realignment funds to pay for services provided to people living with MH/SU needs in subsidized housing.

**Action:** Advocate to increase housing availability for people living with MH/SU needs. Mobilize local stakeholders to apply for the \$2 billion bond expected to become available summer of 2018. If your county has established a housing pool as part of the Whole Person Care Pilot program, ask county officials how to monitor the housing pool and decision-making regarding its use. Prepare community members to support local efforts to approve new housing and counter negative attitudes. Advocacy is crucial to pressure counties to take advantage of opportunities and to combat “not in my backyard” resistance to plans to construct or designate housing for people living with MH/SU needs.

## **O-E. PROTECT IMPORTANT HEALTH GAINS ACHIEVED UNDER THE AFFORDABLE CARE ACT**

Ensuring all Californians have access to affordable health coverage and services is essential to building a complete and effective MH/SU continuum of care. Implementation of the Affordable Care Act, including Medi-Cal expansion to cover low-income adults without dependent children, has increased California residents’ coverage for MH/SU treatment. It did this by making health insurance more accessible (the number of uninsured is at a record low) and requiring health insurance to cover MH/SU

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<sup>50</sup> See *supra* note 47.

<sup>51</sup> See, e.g., LYNN REASER, DIETER MAURMAN & CATHY L. GALLAGHER, POINT LOMA NAZARENE UNIV. FERMANIAN BUS. & ECON. INST., *PROJECT 25: HOUSING THE MOST FREQUENT USERS OF PUBLIC SERVICES AMONG THE HOMELESS* 5 (2015) (finding that San Diego-based housing first program cut expenses by more than 60 to 80 percent in all major categories, including ambulance, arrests, emergency department visits, hospitalizations, and jail time); Mary E. Larimer et al., *Health Care and Public Service Use and Costs Before and After Provision of Housing for Chronically Homeless Persons with Severe Alcohol Problems*, 301 J. AM. MED. ASS’N, no. 13, 2009, at 1349, 1355 (estimating cost offsets of \$2,449 per person in the first six months); THOMAS L. MOORE, CENT. CITY CONCERN, *ESTIMATED COST SAVINGS FOLLOWING ENROLLMENT IN THE COMMUNITY ENGAGEMENT PROGRAM: FINDINGS FROM A PILOT STUDY OF HOMELESS DUALY DIAGNOSED ADULTS* 9 (2006) (estimating a \$15,006 per person annual cost saving for the first year following enrollment).

<sup>52</sup> No Place Like Home Program, CAL. DEP’T OF HOUSING & CMTY. DEV., <http://hcd.ca.gov/grants-funding/active-funding/nplh.shtml#preliminary> (last visited Dec. 19, 2017).

<sup>53</sup> CTRS. MEDICARE & MEDICAID SERVS., *SPECIAL TERMS AND CONDITIONS: CALIFORNIA MEDI-CAL 2020 DEMONSTRATION 82* (2017), available at, <http://www.dhcs.ca.gov/provgovpart/Documents/MediCal2020STCs06-01-17.pdf>.

<sup>54</sup> CAL. DEP’T HEALTH CARE SERVS., *supra* note 49, at 23.



treatment as an Essential Health Benefit.<sup>55</sup> The expansion provides significant benefits for justice-involved populations who have long had less access to health coverage but higher rates of MH/SU needs.<sup>56</sup> With the current Congress' efforts to repeal or weaken the Affordable Care Act, it is crucial to protect against damage to efforts California has made to make health insurance available to residents. Advocates should guard against any attacks to Medi-Cal expansion or weakening of the Essential Health Benefit protections to continue the progress we've made to ensure all Californians are covered and able to access health services, including MH/SU care. The Department of Corrections and Rehabilitation's Council on Criminal Justice and Behavioral Health (formerly the Council on Mentally Ill Offenders) supports this recommendation.<sup>57</sup>

**Action:** Advocates should defend against attempts to repeal provisions of the Affordable Care Act. Provide education on the importance of maintaining progress in California even if the federal government repeals all, or part, of the act.

## **O-F. EXPAND PEER-RUN COMMUNITY CENTERS TO PROVIDE INVITING PLACES TO CONNECT WITH SERVICES**

Peer-run centers, also known as clubhouses, are community-based centers operated by and open to individuals living with MH/SU needs. Clubhouses provide a communal space to connect with peers, gain skills, get employment and housing assistance, and pursue educational opportunities. Members of the clubhouse work with the staff to manage

operations.<sup>58</sup> Clubhouses are included in the Substance Abuse and Mental Health Service Administration's National Registry of Evidence Based Practices and Programs.<sup>59</sup> They can reduce hospital stays, increase employment, and improve physical and mental health.<sup>60</sup> While clubhouses exist across California, state and local governments can take a direct role by providing additional funding to expand existing peer-run centers and establish new ones, as well.

**Action:** Identify local individuals with experience living with MH/SU needs who are interested in establishing peer-run community centers; and support planning and funding efforts toward that end. Support state, county, and/or city funding for the creation and expansion of clubhouses. Local MHSA and Public Safety Realignment funds can be used for this purpose. Implementation of a peer support specialist certification program can help to sustain peer-run centers (see Recommendation O-A.).

## **O-G. ALLOW SAME-DAY BILLING TO INTEGRATE PHYSICAL AND MH/SU-RELATED HEALTH VISITS**

People living with MH/SU needs often have physical health conditions, such as diabetes or cardiovascular problems.<sup>61</sup> A barrier to accessing services for individuals with both physical health needs and MH/SU needs is that providers can only be reimbursed for one visit per day. When people visiting providers for physical health care show an interest in MH/SU services, they are required to make another appointment for those services. The prohibition against same-day billing prevents integration of health care services and delays

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55 Univ. Cal. L.A. Ctr. Health Pol'y Research, *Health Policy Fact Sheet: Number of Uninsured in California Remained at Record Low in 2016* 1 (2017); Michelle Andrews, *Health Law's 10 Essential Benefits: A Look at What's at Risk in GOP Overhaul*, Kaiser Health News (Feb. 21, 2017), <https://khn.org/news/health-laws-10-essential-benefits-a-look-at-whats-at-risk-in-gop-overhaul/>.

56 ALEXANDRA GATES, SAMANTHA ARTIGA & ROBIN RUDOWITZ, KAISER FAM. FOUND., *HEALTH COVERAGE AND CARE FOR THE ADULT CRIMINAL JUSTICE-INVOLVED POPULATION* 4-7 (2014).

57 CAL. DEP'T CORR. & REHAB., *supra* note 43, at 13.

58 Psychosocial Treatments, Nat'l Alliance Mental Illness, <https://www.nami.org/supportedemployment> (last visited Nov. 21, 2017).

59 SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., *ICCD CLUBHOUSE MODEL* (2010), available at, <http://legacy.nreppadmin.net/ViewIntervention.aspx?id=189>.

60 CLUBHOUSE INT'L, *CLUBHOUSES AND CLUBHOUSE RESEARCH OUTCOMES* 1-4 (2014), available at, [https://clubhouseandalucia.files.wordpress.com/2014/10/research-outcomes\\_2014-4.pdf](https://clubhouseandalucia.files.wordpress.com/2014/10/research-outcomes_2014-4.pdf).

61 Javed Latoo, Minal Mistry & Francis J. Dunne, *Physical Morbidity and Mortality in People with Mental Illness*, 6 BRIT. J. MED. PRACTITIONERS., no. 3, 2013, at a621, a621.

access to MH/SU services. Providers should be allowed to bill for physical health and MH/SU services in the same day to facilitate access and to provide a more person-centered approach. California is in the minority among states by not allowing same-day billing; in 2010, thirty states and the District of Columbia allowed for same-day billing.<sup>62</sup> In 2016, the federal government clarified that federal Medicaid reimbursement is available for same-day billing, giving California even more incentive to allow the practice.<sup>63</sup> If California is serious about moving to a person-centered, integrated health approach, this barrier must be removed.

**Action:** Support efforts to allow providers to bill for physical health care services and MH/SU-related services delivered on the same day.

### **O-H. REVISE STATE REGULATIONS TO ALLOW ACCESS TO OPIOID MEDICATIONS ON DEMAND TO QUICKLY CONNECT PEOPLE WITH OPIOID USE NEEDS TO CARE**

When combined with counseling, medications for people living with opioid use needs, including methadone and buprenorphine, are considered the “gold standard” of care.<sup>64</sup> However, California regulations unnecessarily prohibit people from accessing these medications until they have experienced two documented failed attempts at withdrawal treatment.<sup>65</sup> This requirement goes beyond what is prescribed by federal regulations.<sup>66</sup> California’s regulations result in delay of access to the best treatment available and may also endanger

individuals by increasing their risk of overdose after withdrawal treatment fails. Even as California expands the number of providers able to prescribe these medications, the “two unsuccessful attempts” requirement will remain a barrier for people seeking care.<sup>67</sup>

**Action:** Support prompt and increased access to medications for people with opioid use needs by removing the requirement to first fail other forms of treatment.

### **O-I. ESTABLISH SITES WHERE PEOPLE CAN USE OPIOIDS UNDER THE SUPERVISION OF HEALTH PROFESSIONALS TO REDUCE FATAL OVERDOSES AND CRIME**

Deaths from opioid overdoses, including heroin overdoses, have skyrocketed nationwide.<sup>68</sup> One way to stem overdose deaths is to provide facilities where people can use opioids under the supervision of health care providers. About 100 of these facilities, known as safe consumption sites, exist in Canada, Australia, and Europe. They have demonstrated reductions in overdose mortality (no deaths have occurred at these facilities) and crime.<sup>69</sup> These facilities can also serve as an important access point for health services for people with substance use needs.

**Action:** Support statewide and local efforts to establish and fund safe consumption sites.

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62 DEBORAH BACHRACH, STEPHANIE ANTHONY & ANDREW DETTY, COMMONWEALTH FUND, *STATE STRATEGIES FOR INTEGRATING PHYSICAL AND BEHAVIORAL HEALTH SERVICES IN A CHANGING MEDICAID ENVIRONMENT* 15 (2014).

63 21st Century Cures Act, Pub. L. 114-255, § 12001, 130 Stat. 1033, 1272 (2016).

64 Nadia Kounang, *Opioid Addiction Rates Continue to Skyrocket*, CNN (June 29, 2017), <http://www.cnn.com/2017/06/29/health/opioid-addiction-rates-increase-500/index.html>.

65 CAL. CODE REGS., title 9, § 10270(d)(2).

66 See 42 C.F.R. § 8.12(e) (applying “two unsuccessful attempts” requirement only to people under the age of 18).

67 See Press Release, Cal. Dep’t Health Care Servs., *DHCS Expands Services to Fight Opioid Crisis with New \$90M Grant* (Apr. 27, 2017), <http://www.dhcs.ca.gov/formsandpubs/publications/opa/Documents/17-01%20SAMHSA%20MAT%20Grant%20FINAL.pdf> (explaining the Hub and Spoke systems to expand access to medications used to treat opioid use disorders).

68 Ctrs. Disease Ctrl. & Prev., *Opioid Overdose* (Oct. 23, 2017), <https://www.cdc.gov/drugoverdose/index.html>.

69 Keri Blakinger, *Safe Injection Facilities: Out of Harm’s Way*, THE FIX (Oct. 7, 2015), <https://www.thefix.com/safe-injection-facilities-out-harms-way>.

## O-J. LOWER FINANCIAL BARRIERS TO EDUCATION TO GROW THE MH/SU PROFESSIONAL WORKFORCE

California, like most states, has a shortage of MH/SU care professionals. Recognizing this problem, the state established the California State Loan Repayment Program and the Mental Health Loan Assumption Program. These programs provide financial assistance to students for loan debt accumulated while attending school to become a MH/SU professional.<sup>70</sup> State and local governments should expand these programs to incentivize more people to become providers of MH/SU care services. This can include expanding the eligibility criteria (e.g., to non-citizens and peer support specialists) and/or increasing award amounts. State and local governments should also incentivize

young people to choose careers as MH/SU care professionals through career preparation and with grants for education, beginning with undergraduate degrees. Financial assistance with these front-end costs is crucial to attracting future providers to communities experiencing the largest workforce shortages.

**Action:** Support expansion of student loan debt forgiveness/assumption programs for MH/SU care professionals by increasing eligibility criteria and award amounts. Advocate for career preparation and grant programs to support people pursuing an education in MH/SU. The state can establish such programs and/or provide funding. Local community college districts and/or individual universities can establish their own scholarship programs.

Elon Burns was first arrested at age 20 for marijuana possession. Over the next 11 years, he was frequently arrested and sentenced to prison for non-violent offenses related to his substance use disorders. Unfortunately, he did not receive treatment while incarcerated. Instead, he learned to inject heroin.

Burns survived the harsh criminal justice system. He survived the ravages of problematic substance use, including an accidental opioid overdose. After years with no effective interventions, Burns was finally able to break the cycle of incarceration. The ordeal took a severe toll on his family, but they have remained strong. Burns is now a drug and alcohol counselor. His mother runs a community-based nonprofit that promotes strategies to reduce harms associated with problematic drug use. These strategies include providing the opioid overdose reversal drug, Naloxone, to people who may be at risk or around others who are at risk of overdose.



<sup>70</sup> California State Loan Repayment Program (SLRP), CAL. OFF. STATEWIDE HEALTH PLANNING & DEV. (Aug 11, 2017), <https://www.oshpd.ca.gov/HWDD/SLRP.html>; Mental Health Loan Assumption Program, CAL. OFF. STATEWIDE HEALTH PLANNING & DEV. (Oct. 26, 2017), <https://www.oshpd.ca.gov/HPEF/Programs/MHLAP.html>.

# ESTABLISH COMPREHENSIVE HEALTH-BASED RESPONSES TO CRISES TO REDUCE LAW ENFORCEMENT CONTACT

## INTERCEPT 1: LAW ENFORCEMENT/EMERGENCY SERVICES

Intercept 1 encompasses the period when someone reports an individual experiencing a MH/SU-related crisis and an emergency response is deployed. This includes calls to 911, dispatching of law enforcement, paramedics, fire department, and other crisis response teams; and transportation to crisis services, emergency departments, and/or jail. The recommendations in this section aim to reduce involvement of the criminal justice system by improving health-based crisis responses and minimizing contact with law enforcement.

### 1-A. REQUIRE EMERGENCY DISPATCHERS TO RECEIVE TRAINING TO RECOGNIZE CALLS INVOLVING MH/SU-RELATED CRISES AND DISPATCH ACCORDINGLY

Emergency dispatchers are often the first line of response to MH/SU-related crises. However, there is no state requirement for standardized mental health training for dispatchers. According to a 2014 survey, only 20 percent of law enforcement agencies trained dispatchers on responding to calls

involving mental health crises.<sup>71</sup> State action is needed to ensure dispatchers receive standardized training to recognize and respond to calls involving MH/SU-related crises. Such training is supported by the Department of Corrections and Rehabilitation's Council on Criminal Justice and Behavioral Health (formerly the Council on Mentally Ill Offenders).<sup>72</sup> In jurisdictions with specialized MH/SU crisis response teams, trained dispatchers can notify the response team immediately to reduce delay in their deployment. Where such response teams do not yet exist, trained dispatchers can provide law enforcement and other emergency personnel with critical information they were able to gather because of their training.

**Action:** Support a state-standardized MH/SU basic training for all emergency dispatchers. This can be accomplished by mandating MH/SU training for certification as an emergency dispatcher through the Commission on Peace Officer Standards and Training,<sup>73</sup> the State Fire Marshal's Office, and the California Emergency

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<sup>71</sup> PAMELA LEW, JUNG PHAM & LESLIE MORRISON, *DISABILITY RIGHTS CAL. & EACH MIND MATTERS, AN OUNCE OF PREVENTION: LAW ENFORCEMENT TRAINING AND MENTAL HEALTH CRISIS INTERVENTION* 28, 29 (2014).

<sup>72</sup> CAL. DEP'T CORR. & REHAB., *COUNCIL ON MENTALLY ILL OFFENDERS, 15TH ANNUAL REPORT* 49 (2016).

<sup>73</sup> Peace officers are required to receive 15 hours of mental health training as part of the Peace Officers Standards and Training (POST) minimum requirements. CAL. PENAL CODE § 13515.26.



Medical Services Authority. Support the development of local MH/SU training protocols for dispatchers.<sup>74</sup>

## **1-B. AUTHORIZE PARAMEDICS TO TRANSPORT INDIVIDUALS EXPERIENCING MH/SU-RELATED CRISES TO COMMUNITY-BASED FACILITIES**

Under current regulations, paramedics are only allowed to transport individuals to hospital emergency departments.<sup>75</sup> Many people experiencing a MH/SU-related crisis do not need this level of intervention. In fact, a visit to a hospital emergency department can have a negative impact on people experiencing MH/SU-related crises (e.g., chaotic environment, long waits, etc.). With specialized training, paramedics can safely transfer many people experiencing MH/SU-related crises to community-based treatment facilities. In Stanislaus County, a pilot project received a waiver from state regulations to allow paramedics to transfer people experiencing MH/SU-related crises to community treatment facilities. The program safely diverted one-third of 911 MH/SU-related calls to community-based crisis centers, resulting in a net savings of \$8,913 per month.<sup>76</sup> The California Emergency Medical Services Authority (EMSA) oversees the Stanislaus County pilot project and can develop standard criteria for other counties to develop similar programs. Allowing paramedics to voluntarily transport people can improve the effectiveness of other “community paramedicine” models and facilitate the expansion of non-law enforcement outreach teams (see Recommendation O-C.). For example, the Resource Access Program (RAP) in San Diego uses paramedics to connect people with community-based services and reduce the likelihood that they will call 911 for

non-emergency assistance.<sup>77</sup> RAP reduced 911 calls from people they served by over 50 percent and saved over \$45,500 per month.<sup>78</sup> Allowing paramedics to transport people experiencing MH/SU crises to community-based treatment facilities will encourage the expansion of programs like RAP and provide a more caring hand off.

**Action:** Advocate to allow paramedics to provide voluntary transfers of individuals experiencing MH/SU-related crises to community-based MH/SU treatment facilities. Support local efforts to join the pilot program overseen by EMSA that permits paramedics to provide such transfers. To standardize paramedic response to MH/SU-related crises, EMSA can develop criteria to qualify local emergency medical service authorities that wish to participate.

## **1-C. INCENTIVIZE NON-LAW ENFORCEMENT CRISIS RESPONSE TEAMS TO REDUCE THE NEED FOR LAW ENFORCEMENT INVOLVEMENT**

The typical response to 911 calls reporting individuals experiencing MH/SU-related crises is to dispatch police officers. However, involving law enforcement increases risk of arrest, harm to the individual, costs, and time spent by responding officers. Deploying non-law enforcement-based response teams can provide better outcomes while allowing law enforcement to stay on their beats. The CAHOOTS program in Eugene, Oregon, is an excellent example. It pairs a crisis counselor and health professional (e.g., EMT, paramedic, or nurse) to respond to calls involving MH/SU-related crises. CAHOOTS regularly reduces the burden on local police by handling calls involving welfare checks, transport to services, intoxication, and suicide

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<sup>74</sup> For example, the California Highway Patrol now includes mental health training for all their dispatchers. See CAL. HIGHWAY PATROL, PUBLIC SAFETY DISPATCHER TRAINING – LESSON PLAN: MENTAL ILLNESS TRAINING FOR DISPATCHERS (2017).

<sup>75</sup> See CAL. HEALTH & SAFETY CODE § 1797.114; CAL. CODE REGS. title 22, §100170(a)(5).

<sup>76</sup> JANET M. COFFMAN, CYNTHIA WIDES, MATTHEW NIEDZWIECKI & IGOR GEYN, UNIV. CAL. S.F., EVALUATION OF CALIFORNIA’S COMMUNITY PARAMEDICINE PILOT PROJECT 26 (2017).

<sup>77</sup> Resource Access Program, CITY OF SAN DIEGO, <https://www.sandiego.gov/fire/services/ems/rap> (last visited Dec. 20, 2017).

<sup>78</sup> COFFMAN, WIDES, NIEDZWIECKI & GEYN, *supra* note 77, at 17-18.

risk, saving police over \$4.5 million and emergency departments over \$1 million annually.<sup>79</sup>

**Action:** Support seed and/or expansion funding for non-law enforcement-led crisis response teams. Support incentives for these teams, including the use of bundled Medi-Cal payments that don't require traditional billing procedures (similar to the Whole Person Care Pilot structure) and incentive payments to hospitals and/or insurance companies that fund these teams. At the local level, MHSA funding can support these services. Advocates can also urge local hospitals to invest in non-law enforcement-led teams as part of their community benefit plans.<sup>80</sup>

## 1-D. EXPAND ACCESS TO MH/SU CRISIS SERVICES TO CREATE INFRASTRUCTURE FOR DIVERSION

MH/SU crisis services can be provided in a variety of settings where people experiencing a MH/SU-related crisis can access immediate, specialized care without being admitted to a hospital. One type of crisis facility is the mental health urgent care center.<sup>81</sup> Such facilities are located across California, and an additional five are planned for Los Angeles County.<sup>82</sup> However, more are needed to ensure adequate access. Requisite capacity in these facilities include 24/7 operating

hours, the ability to provide detox services, and “no-refusal” agreements with law enforcement that allow police to rapidly connect people with health services and return to their beat, improving health and safety while saving both time and money.<sup>83</sup> In fact, in a 2014 survey, 63 percent of California law enforcement agencies indicated the need for better availability of crisis mental health services.<sup>84</sup> The California Health Facilities Financing Authority will soon administer \$67.5 million for facilities to assist in the diversion of people with MH/SU needs from jail, presenting advocates with an opportunity to engage local policymakers to apply for these funds.<sup>85</sup> Even so, greater investment is necessary to provide access to crisis mental health services in all parts of the state, especially in rural counties. The Judicial Council also recommends expanding these resources.<sup>86</sup>

**Action:** Support funding for MH/SU crisis services, including mental health urgent care centers. Explore fiscal incentives for hospitals and insurance companies to finance these resources. Advocate for a statewide assessment of available and planned crisis facilities to determine the remaining shortage and develop recommendations for additional funding and/or other action. At the local level, support funding for and prioritize permitting of these facilities. Mobilize local stakeholders to leverage state funding, including

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79 WHITE BIRD CLINIC, CRISIS ASSISTANCE HELPING OUT ON THE STREETS: WHITE BIRD CLINIC'S MOBILE CRISIS INTERVENTION PROGRAM 3-4 (2015).

80 See *supra* note 47.

81 Two model programs exist in San Antonio, Texas, and Tucson, Arizona. See Kym Klass, *Restoration Center: San Antonio's Answer to Mental Health*, MONTGOMERY ADVERTISER (Jan. 27, 2017), <http://www.montgomeryadvertiser.com/story/news/2017/01/27/restoration-center-san-antonios-answer-mental-health/96457170/>; Dennis Grantham, *Tucson Works Together, Gets Crisis Center and Care System Right*, July/Aug. 2012 BEHAVIORAL HEALTHCARE 54 (2012), available at, <https://www.behavioral.net/article/tucson-works-together-gets-crisis-center-and-care-system-right>.

82 LEW, PHAM & MORRISON, *supra* note 72, at 35; see STEINBERG INST. & CTY. BEHAVIORAL HEALTH DIRS. ASS'N CAL., *supra* note 44, at 4-5.

83 Amy C. Watson & Anjali J. Fulambarker, *The Crisis Intervention Team Model of Police Response to Mental Health Crises: A Primer for Mental Health Practitioners*, 8 BEST PRACTICES MENTAL HEALTH 71, 74 (2012).

84 LEW, PHAM & MORRISON, *supra* note 72, at 35.

85 See GOV. EDMUND G. BROWN JR., 2017-18 CALIFORNIA STATE BUDGET 27 (2017) (noting the 2017-18 budget includes \$67.5 million for “one-time community infrastructure grants to promote public safety diversion programs and services by increasing the number of mental health, substance use disorder, and trauma related services facilities”).

86 JUD. COUNCIL CAL., ADMIN. OFF. CTS., TASK FORCE FOR CRIMINAL JUSTICE COLLABORATION ON MENTAL HEALTH ISSUES: FINAL REPORT 19 (2011).

the \$67.5 million that will soon be available through the Health Facilities Financing Authority.

### 1-E. INCREASE PRE-BOOKING DIVERSION OPPORTUNITIES TO REDUCE JAIL BOOKINGS

Law enforcement should have options to divert individuals experiencing MH/SU-related crises prior to taking them to jail (this is known as “pre-booking diversion”). Various pre-booking diversion programs exist across the state and country, but are typically small. One example of a successful pre-booking diversion program is the Law Enforcement Assisted Diversion (LEAD), pioneered in Seattle, Washington. LEAD allows pre-booking diversion to social services for people arrested for certain drug and sex offenses (e.g., drug possession, prostitution).<sup>87</sup> Los Angeles and San Francisco have begun their own LEAD programs with state seed funding.<sup>88</sup> The state and local governments should continue to encourage these programs through additional funding. (Note: for pre-booking diversion programs to succeed, adequate resources like MH/SU crisis services and permanent supportive housing must be in place, as well.) If structured appropriately, these programs can access Medi-Cal funds for reimbursement of services they provide, including health assessments for service referrals.

**Action:** Support the implementation and funding of pre-booking diversion programs. Urge county health and mental health departments to support the development of pre-booking diversion programs, highlighting that these programs can be reimbursed for health assessments and referral to services through Medi-Cal.

### 1-F. EXPAND POST-CRISIS RESOURCES, INCLUDING STEP-DOWN TEAMS, TO MAINTAIN HEALTH STATUS AFTER CRISIS

Even when a person experiences a MH/SU-related crisis connects with community-based crisis services, there often is no post-crisis care to ensure the person’s health status continues to improve (or at least does not return to crisis). To prevent further crises, it is necessary to provide post-crisis services, including step-down teams that utilize intensive case management and peer-specialists to connect people with community resources for sustained stability. Several counties have utilized available funding to implement step-down teams.<sup>89</sup> The Medi-Cal Whole Person Care Pilot program is also a potential funding source for post-crisis care.<sup>90</sup> California can expand access through allocating additional funding and/or clarifying how Medi-Cal may be used to fund these services. Because hospitals and insurance companies are major beneficiaries of post-crisis services via reduced admissions, the state can induce these institutions to establish and/or fund such post-crisis care programs, potentially through payments for demonstrating reduced utilization of emergency department and inpatient admissions that are directly attributable to these programs.

**Action:** Support funding allocations to expand post-crisis services across the state. Incentivize their implementation through Medi-Cal payments and/or incentive payments to hospitals and insurance companies that demonstrate a reduction in admissions and costs due to post-crisis care programs. At the local level, support funding for these resources, including through MHSA. Advocates can also urge local hospitals to invest in these programs as part of their community benefit plans.<sup>91</sup>

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87 See LEAD: LAW ENFORCEMENT ASSISTED DIVERSION, <http://leadkingcounty.org> (last visited Jan. 10, 2018).

88 Law Enforcement Assisted Diversion LEAD Grant Program, CAL. BD. STATE & CMTY. CORR., [http://www.bscc.ca.gov/s\\_cpplleadgrant.php](http://www.bscc.ca.gov/s_cpplleadgrant.php) (last visited Nov. 22, 2017).

89 See MENTAL HEALTH SERVS. OVERSIGHT & ACCOUNTABILITY COMM’N, TOGETHER WE CAN: REDUCING CRIMINAL JUSTICE INVOLVEMENT FOR PEOPLE WITH MENTAL ILLNESS 35 (2017) (describing step down services in Butte, San Bernardino, and Napa counties).

90 See CAL. DEP’T HEALTH CARE SERVS., *supra* note 49, at 13.

91 See *supra* note 47.



# QUICKLY DIVERT PEOPLE LIVING WITH MH/SU NEEDS OUT OF DETENTION

## INTERCEPT 2: INITIAL DETENTION/INITIAL COURT HEARINGS

Intercept 2 begins after a law enforcement officer has decided to take an individual with MH/SU needs to jail. It involves booking into jail, pretrial decision-making (including whether someone will remain detained or be released while awaiting trial), arraignment, and charging decisions (including pretrial diversion). The recommendations in this section are intended to reduce length of detention and connect people with community-based services as quickly as possible.

### 2-A. ESTABLISH UNIFORM STANDARDS FOR MH/SU NEEDS SCREENING AND REQUIRE SCREENING AT JAIL INTAKE TO IMPROVE ABILITY TO MAKE INFORMED DECISIONS

Screening for MH/SU needs during the booking process will help jail administrators to better understand their populations and the resources necessary to serve them; to identify individuals to be diverted to community services (or, at a minimum, directed to a more detailed assessment of MH/SU needs); and to provide a more complete picture of how many people with MH/SU needs are in California's jails. Title 15 of the California Code of Regulations requires screening for mental health

needs at intake.<sup>92</sup> However, state regulations provide no standards for that screening (e.g., there is no requirement that the screening be done using a validated tool). Further, only 25 percent of California counties report that they conduct universal screening for MH/SU needs in jail.<sup>93</sup> Several national organizations, including the National Association of Counties, the Council of State Governments Justice Center, and the American Psychiatric Association Foundation, as well as the California Department of Corrections and Rehabilitation's Council on Criminal Justice and Behavioral Health (formerly the Council on Mentally Ill Offenders), the Mental Health Services Oversight and Accountability Commission, and the California Judicial Council advocate for counties to implement uniform, validated MH/SU needs screening at jail intake.<sup>94</sup> A mandate to implement validated universal MH/SU needs screening in all jails must be accompanied by the requirement that counties share their aggregate data with the state for analysis. The Board of State and Community Corrections, which already conducts annual surveys of jails, may be the appropriate body for collection and analysis of these data.

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<sup>92</sup> CAL. CODE REGS. title 15, § 1207.

<sup>93</sup> COUNCIL OF STATE GOVTS. JUSTICE CTR., STEPPING UP CALIFORNIA UPDATE 31 (2016), available at, [http://www.cdcr.ca.gov/COMIO/Uploadfile/pdfs/2016/Nov2/Stepping\\_Up\\_Initiative\\_pt.pdf](http://www.cdcr.ca.gov/COMIO/Uploadfile/pdfs/2016/Nov2/Stepping_Up_Initiative_pt.pdf).

<sup>94</sup> RISE HANEBERG, TONY FABELO, FRED OSHER & MICHAEL THOMPSON, STEPPING UP INITIATIVE, REDUCING THE NUMBER OF PEOPLE WITH MENTAL ILLNESS IN JAIL: SIX QUESTIONS COUNTY LEADERS NEED TO ASK 4-6 (2017); MENTAL HEALTH SERVS. OVERSIGHT & ACCOUNTABILITY COMM'N, *supra* note 90, at 71; CAL. DEP'T CORR. & REHAB., *supra* note 43, at 18; JUD. COUNCIL CAL., *supra* note 87, at 32.

**Action:** Support efforts to establish uniform state standards requiring counties to implement validated MH/SU needs screening at jail intake and report their aggregate data to the state for annual analysis. This can be accomplished through revision of Title 15. At the local level, support the implementation of universal screening using a validated screening tool at all detention facilities.

## **2-B. REFORM MONEY BAIL AND PRETRIAL DECISION-MAKING TO DRAMATICALLY REDUCE PRETRIAL DETENTION OF PEOPLE LIVING WITH MH/SU NEEDS**

People living with MH/SU needs are grossly over-represented in California's criminal justice system, largely due to our money bail system. Once booked into jail, people with MH/SU needs often struggle to gather money needed to pay for their freedom while waiting for trial. In one study, people living with mental health needs were about half as likely to make bail as those who did not have mental health needs, even though bail amounts were comparable.<sup>95</sup> That same study found that it took five times longer for people living with mental health needs to post bail.<sup>96</sup> Even short jail stays can lead to interruption in treatment and loss of employment and/or housing. In California, 80 percent of all jail deaths occur during pretrial detention, with suicide making up a quarter of these deaths.<sup>97</sup> While money bail reform will benefit the entire criminal justice population, it is included here because such reform would significantly

reduce the number of people living with MH/SU needs in jails. California Senate Bill 10 (Hertzberg), currently in the Assembly, will reform money bail and require pretrial detention decisions to be based on risk.<sup>98</sup> The governor and chief justice have expressed their willingness to work with Senator Hertzberg to make bail reform happen in 2018.<sup>99</sup>

**Action:** Support passage of SB 10 in 2018. At the local level, support implementation of robust pretrial service programs to conduct risk/needs assessments<sup>100</sup> and connect people with community-based services.

## **2-C. INCREASE POST-BOOKING DIVERSION PROGRAMS TO QUICKLY CONNECT PEOPLE IN JAIL TO COMMUNITY-BASED TREATMENT RESOURCES**

Post-booking diversion occurs after a person has been booked into jail and before sentencing (typically before trial begins). Pre-booking diversion (see Recommendation 1-E.) should be prioritized over post-booking diversion, however, post-booking diversion should be an option for those not diverted at an earlier stage as it significantly reduces jail time and costs associated with jail stays and court proceedings. The Nathaniel ACT program in New York City is an example of a successful post-booking diversion program. This program is particularly noteworthy because it explicitly focuses on people charged with felony offenses, including offenses where violence was involved.<sup>101</sup> Through the 24-hour availability of intensive

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95 COUNCIL OF STATE GOV'TS JUSTICE CTR., IMPROVING OUTCOMES FOR PEOPLE WITH MENTAL ILLNESSES INVOLVED WITH NEW YORK CITY'S CRIMINAL COURT AND CORRECTION SYSTEMS 1-2 (2013).

96 *Id.* at 2.

97 *Open Justice: Death in Custody, Side-By-Side Interactive Charts*, CAL. DEP'T OF JUSTICE, <https://openjustice.doj.ca.gov/death-in-custody/custody-stages> (last visited Nov. 22, 2017). The 80 percent figure was calculated by removing CDCR and State Hospital deaths, then adding Pretrial/Booking deaths (1,104) to Sentenced/Incarcerated deaths (291) to get 1,395 total jail deaths from 2005 to 2014. Then, dividing 1,104 by 1,395, you get 79.1 percent (rounded up to 80 percent) of jail deaths that occur in pretrial detention.

98 See S.B. 10, 2017-18 Sess. (Cal. 2017).

99 Governor Brown, Chief Justice Cantil-Sakauye, Senator Hertzberg and Assemblymember Bonta Commit to Work Together on Reforms to California's Bail System, OFF. CAL. GOV. (Aug. 25, 2017), <https://www.gov.ca.gov/news.php?id=19917>.

100 It is important that these risk/needs assessments are locally validated (currently a requirement of SB 10) and do not over-value risk associated with mental health needs. Presence of mental health needs has not been found to be a strong predictor of rearrest, failure to appear, new crime, or any pretrial failure. KRISTIN BECHTEL, CHRISTOPHER LOWENKAMP & ALEX HOLSINGER, IDENTIFYING THE PREDICTORS OF PRETRIAL FAILURE; A META-ANALYSIS 13 (2011).

101 Nathaniel ACT, CASES, <https://www.cases.org/programs/nathaniel-act/> (last visited Nov. 22, 2017).

support services, program graduates since 2013 have had no new felony convictions and participants enjoy increases in employment, education, and housing.<sup>102</sup> The Eleventh Judicial Circuit of Florida's (Miami-Dade County) Criminal Mental Health Project is another potential model for California courts. Floridians charged with misdemeanors who meet the program criteria are transferred from jail to community-based crisis stabilization units within 48 hours of booking.<sup>103</sup> Individuals charged with felonies may be eligible if they satisfy stricter criteria. The Los Angeles County District Attorney's Office's Sequential Intercept Mapping Report includes expansion of post-booking diversion for both misdemeanors and felonies as a priority recommendation.<sup>104</sup>

**Action:** Advocate for post-booking diversion programs in conjunction with pre-booking diversion. Funding for post-booking diversion should primarily support increases in intensive support services for program participants, as opposed to administration costs. Support efforts to make post-booking diversion programs available to more people.

## 2-D. CHANGE LOCAL CHARGING CRITERIA TO REDUCE PROSECUTIONS AGAINST PEOPLE WITH MH/SU NEEDS

Prosecutors contribute to the over-incarceration of people with MH/SU needs by bringing charges when the alleged offenses are clearly attributable to individuals' health statuses. For example, prosecutors have brought resisting arrest charges against people detained by law enforcement officers who were knowingly responding to MH/SU-related crises, and even charged people held in

treatment facilities. Prosecutors may also pursue misdemeanor charges even after people are found incompetent to stand trial. Prosecutors should institute more nuanced policies that discourage the filing or continuation of charges against individuals better served by community-based MH/SU services. The criminal justice system is not the appropriate place for these individuals and there is a severe shortage of resources for people found incompetent to stand trial (see Recommendation 3-A).

**Action:** Urge district attorneys to implement charging policies that prioritize referral to treatment over prosecution of people with MH/SU needs. These can include guidelines that favor declining prosecution in cases of resisting arrest when a MH/SU-related crisis is involved and for misdemeanors when an individual is found incompetent to stand trial.

## 2-E. ENROLL ELIGIBLE PEOPLE IN MEDI-CAL AT JAIL INTAKE TO MAXIMIZE HEALTH COVERAGE

People should be given the opportunity to enroll in Medi-Cal as part of the jail intake process. Medi-Cal coverage increases access to community-based MH/SU treatment services and is an important resource after release from jail. California law allows people to apply for Medi-Cal regardless of incarceration status.<sup>105</sup> Medi-Cal enrollment is a critical resource for reentry and those leaving jail after only a few days often miss the opportunity to enroll while incarcerated. Enrollment at jail intake can significantly increase the number of people with health coverage and expand access to services when they leave jail. Cook County jail in Chicago, the largest single-site jail in the country, has provided Medicaid enrollment at intake since 2014.<sup>106</sup> From July 2016 to June 2017,

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<sup>102</sup> *Id.*

<sup>103</sup> *Post-Booking Diversion, Eleventh Judicial Cir. of Fla.*, <http://www.jud11.flcourts.org/Post-Booking-Diversion> (last visited Nov. 22, 2017).

<sup>104</sup> HANK STEADMAN, DAN ABREU & TRAVIS PARKER, POL'Y RESEARCH ASSOCS., *SEQUENTIAL INTERCEPT MAPPING REPORT – LA COUNTY, CA 21* (2015).

<sup>105</sup> CAL. PENAL CODE § 4011.11(e).

<sup>106</sup> NAT'L ASS'N PRETRIAL SERVS. AGENCIES, *THE PATIENT PROTECTION AND AFFORDABLE CARE ACT AND THE PRETRIAL SYSTEM: A "FRONT DOOR" TO HEALTH AND SAFETY* app. A, at 5 (2014).



over 10,000 individuals initiated Medicaid applications at the Cook County jail.<sup>107</sup> The California Department of Corrections and Rehabilitation's Council on Criminal Justice and Behavioral Health (formerly the Council on Mentally Ill Offenders) supports screening and enrollment at jail intake.<sup>108</sup>

**Action:** Support efforts to ensure Medi-Cal enrollment is offered at jail intake. Advocate for California to provide guidance on automated processes to streamline applications by using jail intake data to autofill the Medi-Cal application and to provide technical assistance.

<sup>107</sup> E-mail from Laura Brookes, Director of Policy, TASC, Inc., to Kellen Russoniello (Sept. 19, 2017, 14:45 PST) (on file with author).

<sup>108</sup> CAL. DEP'T CORR. & REHAB., *supra* note 43, at 20.



Pharoh Degree has lived with a serious mental illness and substance use disorder for 20 years. Behaviors associated with these health conditions have led to multiple arrests. With each arrest Degree spent up to 2 months in pretrial detention before his case was adjudicated. Degree's mother was unable to get her son out of San Diego County jails and into mental health treatment because of the high cost of bail.

If Degree had been released prior to trial, he could have received much needed mental health care and restored his cognitive ability to mount a defense. Instead, he accepted plea deals after being threatened with the highest charges and harshest sentences. While in pretrial detention, Degree was classified as not needing mental health-care because he did not self-report to the jail clinicians. He was physically abused by other incarcerated people while in general population due to his health conditions.

With the support of his family, Degree eventually found treatment that worked for him. This past April, Pharoh Degree celebrated his 40th birthday and four years without substance use.

# IMPROVE COURT PROCESSING AND PREVENT OVERUSE OF SANCTIONS TO REDUCE TIME IN JAILS AND PRISONS AND RECIDIVISM RISK

## INTERCEPT 3: COURTS/JAILS/PRISONS HEARINGS

Intercept 3 encompasses court proceedings, including participation in a “collaborative court” such as drug court or mental health court. This intercept also includes conditions and services provided in jails and prisons, both while a court case is underway and after an individual has been convicted and sentenced. This section is split into two subsections: the first provides recommendations to improve the competency restoration process; the second focuses on improving outcomes for people with MH/SU needs in court and in jails/prisons.

### 3-A. INCREASE COMMUNITY-BASED OPTIONS AND REDUCE STATE HOSPITAL BACKLOG TO IMPROVE COMPETENCY RESTORATION

The majority of people charged with felonies and found incompetent to stand trial are ordered to

undergo competency restoration at a state hospital.<sup>109</sup> Numerous factors have led to a long waitlist for a treatment slot at a state hospital, forcing those referred for competency restoration to wait months in jail until a bed becomes available. The recommendations in this subsection are intended to address this problem.

### 3-A(I). EXPAND ACCESS TO COMMUNITY-BASED COMPETENCY RESTORATION TO REDUCE THE NEED TO SEND PEOPLE TO STATE HOSPITALS

Restoring competency in a community-based setting is already an option for people found incompetent to stand trial, regardless of the severity of their charges.<sup>110</sup> The benefits of community-based restoration include freeing up inpatient beds, reducing costs (outpatient being 20 percent less expensive than inpatient), and less restrictive,

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109 See MAC TAYLOR, CAL. LEG. ANALYST’S OFF., AN ALTERNATIVE APPROACH: TREATING THE INCOMPETENT TO STAND TRIAL 6 (2012).

110 CAL. PENAL CODE § 1370(a)(1)(B)(i). People charged with a felony offense under Section 290 or a “violent felony” under Section 667.5(c) face more barriers to competency restoration in the community, but it is not totally prohibited. See CAL. PENAL CODE §§ 1370(a)(1)(B)(ii)-(iii), 1370(a)(1)(D)-(F), 1601(a). DISABILITY RIGHTS CAL., PLACEMENT OF INDIVIDUALS FOUND INCOMPETENT TO STAND TRIAL: A REVIEW OF COMPETENCY PROGRAMS AND RECOMMENDATIONS 22 (2015).

more recovery oriented services.<sup>111</sup> Despite these benefits, few community-based restoration services are available in California. Individuals therefore remain in jail or are sent to a state hospital (often after a lengthy stay in jail). In fact, California has increased the troubling use of jail-based competency restoration wings, where the state contracts with counties to provide competency restoration inside jails. There is a great need to increase community-based restoration options to reduce reliance on state hospitals and reduce the trend of keeping people in jail to restore competency. A promising model of community-based restoration exists in Los Angeles, though it is currently limited to misdemeanors.<sup>112</sup> The Department of Corrections and Rehabilitation's Council on Criminal Justice and Behavioral Health (formerly the Council on Mentally Ill Offenders), the Mental Health Services Oversight and Accountability Commission, and the California Judicial Council support the expansion of community-based restoration services.<sup>113</sup>

**Action:** Support the expansion of community-based competency restoration for both misdemeanors and felonies. At the state level, this can include funding for the implementation of these services or other financial incentives, including payments to counties for directing people to community-based restoration in lieu of placement in a state hospital or in jail. At the local level,

counties can use MHSA and/or general funds to expand community-based restoration.

### 3-A(II). SHORTEN THE TIME FRAME FOR COMPETENCY RESTORATION TO REDUCE THE BACKLOG OF STATE HOSPITAL BEDS

Under current law, people charged with criminal offenses but found incompetent to stand trial are ordered to competency restoration for up to three years if the alleged offense is a felony, or one year if the alleged offense is a misdemeanor.<sup>114</sup> According to the California Department of State Hospitals (DSH), the average time to restore competency in a state hospital in 2016 was six to seven months.<sup>115</sup> The Justice Policy Institute reported in 2011 that 90 percent of people found incompetent to stand trial nationwide will be restored within a year.<sup>116</sup> In 2016, DSH stated that the chances of restoring competency after 18 months are very remote.<sup>117</sup> One way to reduce the backlog of people in state hospitals is to reduce the time frame for restoration. The National Judicial College recommends a maximum of 120 days for a misdemeanor (unless that is longer than the maximum sentence for the pending charge) and 120 days for a felony with the option to extend up to one year.<sup>118</sup> According to DSH, at least 26 states have shorter competency restoration time frames than California, and five states have a maximum of one year.<sup>119</sup> Reducing the maximum term of competency

111 DISABILITY RIGHTS CAL., PLACEMENT OF INDIVIDUALS FOUND INCOMPETENT TO STAND TRIAL: A REVIEW OF COMPETENCY PROGRAMS AND RECOMMENDATIONS 22 (2015).

112 See PETER ESPINOZA & KRISTEN OCHOA, LA CTY. OFF. DIVERSION & REENTRY 4-7 (2017), available at, <http://file.lacounty.gov/SDSInter/bos/supdocs/107138.pdf>; Michael Wilson, For Jail Diversion 29 Enrollees, A Light through the Mist, FAST FACTS FROM DR. KATZ, Feb. 29, 2016, at 1-2, available at, [http://file.lacounty.gov/SDSInter/dhs/240469\\_fast\\_facts\\_02\\_29\\_16.pdf](http://file.lacounty.gov/SDSInter/dhs/240469_fast_facts_02_29_16.pdf).

113 MENTAL HEALTH SERVS. OVERSIGHT & ACCOUNTABILITY COMM'N, *supra* note 90, at 75; CAL. DEP'T CORR. & REHAB., *supra* note 73, at 22; JUD. COUNCIL CAL., *supra* note 87, at 29.

114 CAL. PENAL CODE §§ 1370(c)(1)(A), 1370.01(c)(1)(A).

115 CAL. DEP'T STATE HOSP., INCOMPETENT TO STAND TRIAL attach. 2, at 1 (2016), available at, <http://www.chhs.ca.gov/IST%20Workgroup/Attachment%20%20-%20IST%20July%202016.pdf>; TAYLOR, *supra* note 110, at 8.

116 JUSTICE POL'Y INST., WHEN TREATMENT IS PUNISHMENT: THE EFFECTS OF MARYLAND'S INCOMPETENCY TO STAND TRIAL POLICIES AND PRACTICES 2 (2011); see also PATRICIA ZAPF, WASH. STATE INST. PUB. POL'Y, STANDARDIZING PROTOCOLS FOR TREATMENT TO RESTORE COMPETENCY TO STAND TRIAL: INTERVENTIONS AND CLINICALLY APPROPRIATE TIME PERIODS 18 (2013) (discussing restoration time frames and noting that most people are restored within 180 days and even more within one year).

117 CAL. DEP'T STATE HOSP., INCOMPETENT TO STAND TRIAL 10 (2016), available at, <http://www.chhs.ca.gov/IST%20Workgroup/IST%20Memo%20July%202016%20FINAL.PDF>.

118 NAT'L JUDICIAL COLL., MENTAL COMPETENCY BEST PRACTICES MODEL 29-30 (2011).

119 CAL. DEP'T STATE HOSP., *supra* note 118, at 10-11. The five states are Georgia, Missouri, New Hampshire, Ohio, and Wisconsin. *Id.*



restoration is an option endorsed by DSH.<sup>120</sup>

**Action:** Support efforts to reduce the maximum amount of time for competency restoration for people found incompetent to stand trial to one year, in keeping with National Judicial College best practices.

### **3-A(III). ENSURE TRANSPARENCY AND ACCOUNTABILITY IN COMPETENCY RESTORATION PLACEMENT DECISIONS TO INCREASE REFERRALS TO COMMUNITY-BASED COMPETENCY RESTORATION**

Currently, the decision of where to place someone found incompetent to stand trial due to mental health needs – in a state hospital, jail-based competency program, community-based treatment facility, or outpatient status – is made by the court. The court’s decision is informed by the recommendation of a community program director or designee of the Department of State Hospital’s Conditional Release Program (CONREP) based on guidelines from the Department of State Hospitals.<sup>121</sup> In practice, it is unclear how these recommendations are reached and how often the court follows them. For example, there does not appear to be any means to determine how capacity affects placement. If a person otherwise meets the criteria for community-based treatment, but there is no space in a community-based facility, does CONREP refer that person to institutionalized care? Transparency and accountability in this process are necessary to ensure proper treatment placement in the least restrictive setting, which for many (if not most) will be in a community-based setting. Should risk/needs assessments become mandated as part of the pretrial decision-making process (see Recommendation 2-B.) these assessments may help inform placement decisions for competency restoration. Because mental health status is not significantly associated with committing an offense while on pretrial release or failing to appear for

court, validated risk/needs assessments should increase the safe and effective referral of people found incompetent to stand trial to community-based treatment.<sup>122</sup>

**Action:** Advocate for a transparent and accountable process for competency restoration placement determinations. Support processes that prioritize competency restoration placement in the least restrictive setting.

### **3-A(IV). PROVIDE STEP-DOWN SERVICES FOR PEOPLE UNLIKELY TO ATTAIN COMPETENCY TO TRANSITION THEM OUT OF STATE HOSPITALS AND PREVENT READMISSIONS**

The Department of State Hospitals reports the lack of community-based services available to people who are determined unlikely to regain competency contributes to individuals remaining in a state hospital longer than necessary.<sup>123</sup> Increasing step-down services (e.g., intensive case management teams) and community-based placements for people exiting state hospitals should reduce the likelihood of individuals overstaying their time in state hospitals and alleviate the backlog. The state and counties must ensure efficient transfer to community-based services, which may require clarification of roles and responsibilities.

**Action:** Support funding for post-state hospital discharge step-down services. Advocate for the clarification of roles and responsibilities of the state and counties to ensure efficient transfer to community-based services. At the local level, advocate for services for people exiting the state hospital, including housing and intensive case management. Local MHSA funding can be used to provide certain transition services.

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<sup>120</sup> *Id.*

<sup>121</sup> CAL. PENAL CODE § 1370(a)(1)(B)(i), 1370(a)(1)(F)(2)(A).

<sup>122</sup> See BECHTEL, LOWENKAMP & HOLSINGER, *supra* note 101, at 13.

<sup>123</sup> CAL. DEP’T STATE HOSP., *supra* note 118, at 9.



### 3-B. IMPROVE OUTCOMES FOR PEOPLE WITH MH/SU NEEDS IN COURT AND IN JAILS/PRISONS

The recommendations in this subsection target interventions to reduce depth and length of time in the criminal justice system. Included are suggestions to improve court processing, reduce sanctions and new offenses while incarcerated, and provide greater access to treatment that reduces likelihood of recidivism.

#### 3-B(I). INITIATE REENTRY PLANNING AT THE BEGINNING OF INCARCERATION TO FACILITATE A SUCCESSFUL RETURN TO THE COMMUNITY

Having a plan for connection to the community and services after release from jail or prison is crucial to an individual's successful reentry. However, many people do not have reentry plans when they are released, and those that do often develop them only one to three months before release. Reentry planning should begin as soon as someone is brought to jail. A robust pretrial services program, envisioned as a part of bail reform (see Recommendation 2-B.) can begin the process. For people who are detained pretrial or sentenced to incarceration, reentry planning should commence at the beginning of their stay. This allows more time to form support networks with family and friends, establish relationships with providers, and make concrete plans for connection to services upon release. Expanded reentry planning can be facilitated by increasing access to community-based organizations for in-reach to incarcerated people (see Recommendation 4-A.). The California Judicial Council recommends that judges require development of a reentry plan as part of court disposition and sentencing.<sup>124</sup>

**Action:** Support efforts to require jails and prisons to develop a reentry plan for individuals at the beginning of their incarceration. At the local level, urge the entity responsible for operating the jails (typically the sheriff's department) to institute a policy requiring reentry planning to commence at the beginning of a jail stay and to work with community organizations to facilitate planning.

#### 3-B(II). CREATE AND INCENTIVIZE STANDARDS FOR COLLABORATIVE COURTS TO IMPROVE COURT EFFECTIVENESS

Collaborative courts, also known as “problem-solving courts,” use probation and/or the threat of incarceration to coerce individuals living with MH/SU needs into treatment. Drug courts and mental health courts are two well-known examples of collaborative courts. These courts should be viewed with a critical lens to ensure they are not usurping the role of community healthcare providers and unnecessarily entangling people deeper in the criminal justice system.<sup>125</sup> Collaborative courts typically develop without much guidance or collective standards, even though some best practices have emerged nationally.<sup>126</sup> Collaborative courts may have restrictions based on previous convictions, current charges, whether the individual is using opioid medications (e.g., methadone),<sup>127</sup> or has co-occurring MH/SU needs. Additionally, courts may require individuals to accept a guilty plea and may dictate the terms of treatment. Statewide standards, best practices, and data collection can be beneficial to ensure these courts focus on the most appropriate participants and do not enforce onerous and unjustified conditions.

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<sup>124</sup> JUD. COUNCIL CAL., *supra* note 87, at 25; see also *id.* at 33 (recommending reentry plans for incarcerated individuals).

<sup>125</sup> See e.g., MARIANNE MOLLMANN & CHRISTINE MEHTA, PHYSICIANS FOR HUMAN RIGHTS, *NEITHER JUSTICE NOR TREATMENT: DRUG COURTS IN THE UNITED STATES* (2017); DRUG POL'Y ALLIANCE, *DRUG COURTS ARE NOT THE ANSWER: TOWARD A HEALTH-CENTERED APPROACH TO DRUG USE* (2011).

<sup>126</sup> See e.g., NAT'L ASS'N DRUG COURT PROF'LS, *ADULT DRUG COURT BEST PRACTICE STANDARDS* (2013), available at <http://www.nadcp.org/Standards>; *Developing a Mental Health Court: An Interdisciplinary Curriculum*, COUNCIL OF STATE GOV'TS JUSTICE CTR. (2012), <https://learning.csgjusticecenter.org/>.

<sup>127</sup> States have begun to pass legislation prohibiting specialty courts from denying participation if the individual is using SUD medications. See MO. REV. STAT. §§ 478.004, 487.200; N.Y. CRIM. PROC. LAW § 216.05(5), 216.05(9)(a) (prohibiting removal from a judicial diversion program if participant uses addiction medications under the care of a physician).

**Action:** Support the development and implementation of statewide standards and best practices for collaborative courts. At the local level, urge the adoption of best practices for collaborative courts, including standards intended to reduce justice-involvement such as not requiring a guilty plea to participate.

### **3-B(III). FACILITATE ACCESS TO MEDICATIONS FOR PEOPLE WITH SUBSTANCE USE NEEDS TO REDUCE NEGATIVE OUTCOMES IN PRISONS AND JAILS**

Methadone and buprenorphine are very effective medications for reducing opioid use, opioid-related overdose deaths, crime associated with opioid use, and infectious disease transmission.<sup>128</sup> Access to these medications in prison and jail is severely limited.<sup>129</sup> Facilitating incarcerated individuals' access to addiction medications will help keep people on their treatment regimens and will likely reduce the chances of overdose death after release.<sup>130</sup> Research has demonstrated that access to addiction medications in correctional settings reduces disease transmission, injection drug use, overdoses, solitary confinement, and recidivism.<sup>131</sup> Further, denial of these medications may be grounds for legal liability.<sup>132</sup> Nearly 30 jails across the country have begun to make these medications available.<sup>133</sup> The Department of Corrections and Rehabilitation and county jails should not deny individuals access to addiction medications while incarcerated. They should instead facilitate their access.

**Action:** Support state efforts to prohibit prisons and jails from denying access to medications for people with substance use needs and require these facilities to make the medications available. At the local level, support interventions to facilitate access to addiction medications in jails.

### **3-B(IV). EXPAND THE REQUIRED CRISIS INTERVENTION TRAINING FOR CORRECTIONS OFFICERS TO REDUCE SANCTIONS AND NEW CHARGES**

With the implementation of California Senate Bill 11 (Beall, 2015), new jail and prison corrections officers will receive 15 hours of crisis intervention training (CIT) as part of the Peace Officer Standards and Training certification process. CIT is essential for corrections officers as they have sustained contact with incarcerated individuals and are responsible for getting the incarcerated population to comply with facility rules. The ability to respond appropriately to MH/SU-related crises in incarceration settings is an important skill that keeps both incarcerated individuals and correctional staff safe and improves the operations of the facility. It is an important skill to reduce the application of sanctions when people with MH/SU needs fail to comply with facility rules, as sanctions can contribute to more time in jail/prison. It can also reduce the likelihood of new charges brought against incarcerated people with MH/SU needs in response to behaviors related to their health status.

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<sup>128</sup> *Effective Treatments for Opioid Addiction*, NAT'L INST. DRUG ABUSE (Nov. 2016), <https://www.drugabuse.gov/publications/effective-treatments-opioid-addiction/effective-treatments-opioid-addiction>.

<sup>129</sup> Timothy Williams, *Opioid Users Are Filling Jails. Why Don't Jails Treat Them?*, N.Y. TIMES (Aug. 4, 2017), <https://www.nytimes.com/2017/08/04/us/heroin-addiction-jails-methadone-suboxone-treatment.html> (noting fewer than 30 of the nation's 5,100 jails and prisons provide access to methadone or buprenorphine).

<sup>130</sup> J. Marden et al., *Does Exposure to Opioid Substitution Treatment in Prison Reduce the Risk of Death after Release? A National Perspective Observational Study in England*, 112 ADDICTION, no. 8, 2017, at 1408 (finding that use of medications for opioid use disorders in prison was associated with a 75 percent reduction in all-cause mortality and an 85 percent reduction in fatal overdoses in the first month after release).

<sup>131</sup> LEGAL ACTION CTR., *LEGALITY OF DENYING ACCESS TO MEDICATION ASSISTED TREATMENT IN THE CRIMINAL JUSTICE SYSTEM* 7 (2011).

<sup>132</sup> *Id.* at 8-19.

<sup>133</sup> Matthew Reisen, *BernCo Jail Offers Methadone Program to Inmates*, ALBUQUERQUE J. (Nov. 18, 2017), <https://www.abqjournal.com/1094949/county-jail-fights-opioid-addiction-from-the-inside-out.html>.



The Board of State and Community Corrections plans to propose additional hours of CIT training for corrections officers in jails and juvenile detention facilities as part of a comprehensive revision to the training standards for local entry-level correctional positions.<sup>134</sup>

**Action:** Support efforts to increase the required amount of crisis intervention training for corrections officers to a minimum of 40 hours at the state and local levels.<sup>135</sup>

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<sup>134</sup> E-mail from Evonne Garner, Deputy Director, Cal. Bd. State & Comm. Corr., to Kellen Russoniello (Nov. 16, 2017, 14:36 PST) (on file with author).

<sup>135</sup> 40 hours has become the standard minimum requirement for CIT. See RANDOLPH DUPONT, SAM COCHRAN, SARAH PILLSBURY, UNIV. MEMPHIS, CRISIS INTERVENTION TEAM: CORE ELEMENTS 14 (2007).



**The California Judicial Council recommends that judges require development of a reentry plan as part of court disposition and sentencing.**



# IMPROVE SUCCESSFUL TRANSITION FROM INCARCERATION TO THE COMMUNITY

## INTERCEPT 4: REENTRY

Intercept 4 includes the actions taken to prepare for release from incarceration and connection to the community. Typically, this intercept begins from one to three months before release and ends shortly after release. The recommendations in this section are intended to increase chances of a successful transition to the community and reduce the likelihood of return to the criminal justice system.

### 4-A. INCREASE THE ABILITY OF INDIVIDUALS WITH PAST CRIMINAL JUSTICE-INVOLVEMENT TO PROVIDE PEER SUPPORT AND IN-REACH SERVICES TO IMPROVE CONNECTION TO THE COMMUNITY

Individuals with lived experience with MH/SU needs can be effective mentors for people exiting prisons and jails by connecting them with community resources that foster successful reentry. The California Judicial Council recommends expansion of peer in-reach services.<sup>136</sup> Many of the most effective peers will have past criminal justice experience and may be unable to pass a correctional facility's background check required to provide services

to people exiting the system. This severely limits the viability of peer-led in-reach programs, like the "First Day Out" program in San Luis Obispo, which connects peers with lived experience with people living with mental health needs in jail to support them through reentry.<sup>137</sup> Jails and prisons should reform policies that prevent qualified peers from providing these services. The Department of Corrections and Rehabilitation's Council on Criminal Justice and Behavioral Health (formerly the Council on Mentally Ill Offenders) would be an appropriate body to study and propose guidelines on this issue, and in fact, this council recommended exploring this issue in its most recent annual report.<sup>138</sup>

**Action:** Advocate for the expansion of opportunities for qualified peers, especially individuals with past involvement with the criminal justice system, to provide in-reach services. Urge the Council on Criminal Justice and Behavioral Health to study the issue of excluding people with lived criminal justice experience from providing in-reach services in prisons and jails. Support the

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<sup>136</sup> JUD. COUNCIL CAL., *supra* note 87, at 42.

<sup>137</sup> TMHA Receives Grant from the Community Foundation SLO County, SAN LUIS OBISPO CHAMBER OF COMMERCE (Oct. 30, 2015), <https://slochamber.org/tmha-receives-grant-from-the-community-foundation-slo-county/>.

<sup>138</sup> CAL. DEP'T CORR. & REHAB., *supra* note 43, at 28.



development of guidelines to increase peer-led services. At the local level, support efforts to review and revise policies regarding peer in-reach services.

#### **4-B. CONNECT PEOPLE WITH HEALTH NAVIGATORS PRIOR TO RELEASE TO LINK THEM TO COMMUNITY HEALTH SERVICES**

Connecting individuals living with MH/SU needs with programs to help navigate complex health and social services systems prior to release can increase their engagement in services and help them get reestablished in the community. Some jurisdictions have programs like this, including the Transitions Clinic in San Francisco and Project In-Reach in San Diego. Transitions Clinic utilizes culturally-competent primary care providers and community health workers with lived criminal justice system experience to assist individuals returning from jail and prison.<sup>139</sup> Project In-Reach goes into jails 60 to 180 days prior to an individual's scheduled release date to assist with reentry planning and then provides case management services in the community.<sup>140</sup> The California Judicial Council recommends connection with health navigators prior to release.<sup>141</sup> Funding allocations or other fiscal incentives can encourage more of these programs.

**Action:** Support implementation and funding for health navigation services to be provided to people with MH/SU needs both before and after release from incarceration. Counties can combine MHSA, Medi-Cal, Public Safety Realignment, and other funds to support these services.

#### **4-C. REQUIRE COUNTIES TO PROVIDE 30 DAYS' WORTH OF MEDICATION AT RELEASE FROM JAIL TO PREVENT DETERIORATION OF HEALTH STATUS**

Individuals in jails tend to be unhealthier than the general population, both in terms of physical health and MH/SU needs. Access to medication at release is an important intervention to ensure continuity of care as individuals reenter the community. State prisons provide a 30-day supply of medication to exiting individuals.<sup>142</sup> However, counties vary on their discharge medication policies. San Diego County, for example, only provides a 10-day prescription for psychotropic medications (prescriptions for physical medications, like insulin, are not provided) that must be filled at one of a few approved pharmacies.<sup>143</sup> People may only refill their medications by appointment, potentially after their 10-day supply runs out. Providing a month's supply of medication (rather than just a prescription) at release will help ensure individuals have medication until they can see a healthcare provider and may reduce the likelihood of deterioration of health status.

**Action:** Support efforts to require all counties to provide 30 days of discharge medication (for both physical health conditions and MH/SU needs) to individuals leaving jail. Support revision of county discharge medication policies to provide 30 days of medication to people exiting local facilities.

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<sup>139</sup> TRANSITIONS CLINIC NETWORK, <http://transitionsclinic.org/> (last visited Nov. 22, 2017).

<sup>140</sup> Project In-Reach, NEIGHBORHOOD HOUSE ASSOC., <http://www.neighborhoodhouse.org/project-in-reach/#sthash.pJ4yXndS.dpbs> (last visited Nov. 22, 2017).

<sup>141</sup> JUD. COUNCIL CAL., *supra* note 87, at 41.

<sup>142</sup> *Wakefield v. Thompson*, 177 F.3d 1160 (9th Cir. 1999).

<sup>143</sup> SAN DIEGO CTY. SHERIFF'S DEP'T, MED. SERVS. DIV., MSD.P.1, POLICY AND PROCEDURE MANUAL 12-13 (2010).

#### 4-D. MAINTAIN MEDI-CAL COVERAGE FOR PEOPLE WHO ARE INCARCERATED FOR MORE THAN ONE YEAR TO ENSURE THEY EXIT INCARCERATION WITH THEIR HEALTH BENEFITS

If a Medi-Cal beneficiary is incarcerated for over one year, the state or county (depending on where the beneficiary is incarcerated) will terminate their coverage. While many counties do attempt to enroll incarcerated people into Medi-Cal before their release, the practice of terminating Medi-Cal due solely to length of incarceration is unnecessary, counterproductive, and illegal.<sup>144</sup> A better solution is to allow individuals to maintain Medi-Cal coverage for the duration of their incarceration. This will ensure there are no interruptions in coverage and enable Medi-Cal beneficiaries to access health care services when they return to the community. The Department of Corrections and Rehabilitation's Council on Criminal Justice and Behavioral Health (formerly the Council on Mentally Ill Offenders) and the California Judicial Council support this recommendation.<sup>145</sup>

**Action:** Advocate for an end to counterproductive Medi-Cal terminations based solely on length of incarceration.

**Individuals with lived MH/SU needs experience can be effective mentors for people exiting prisons and jails by connecting them with community resources that foster successful reentry. The Department of Corrections and Rehabilitation's Council on Criminal Justice and Behavioral Health has recommended exploring this issue.**

#### 4-E. INCREASE SSI/SSDI ENROLLMENT ASSISTANCE IN JAILS TO IMPROVE ACCESS TO NEEDED BENEFITS AFTER RELEASE

Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) are critical resources to help people with disabilities access food, clothing, and housing. Receipt of these benefits can assist incarcerated people with MH/SU needs in their successful reentry to the community. The SSI/SSDI application process can be challenging, but working with enrollment assisters greatly improves success rates and reduces delay. Embedding enrollment assistance in jails and prisons can help improve reentry for some of the most vulnerable people. In fact, the Social Security Administration (SSA) encourages detention facilities to enter into prerelease agreements with the agency to simplify processing of applications for people leaving those facilities.<sup>146</sup> While the Department of Corrections and Rehabilitation claims it screens 100 percent of people for benefits prior to their release,<sup>147</sup> many, if not most county jails do not have SSI/SSDI enrollment assisters helping people navigate the process.

**Action:** Support state funding for SSI/SSDI enrollment assistance in county jails that agree to enter into a prerelease agreement with the SSA. At the local level, advocate for prerelease agreements in all local jails and support local funding for assistance in the enrollment process.

144 Letter from Kellen Russoniello, Staff Attorney, ACLU of Cal., to Jennifer Kent, Director, Cal. Dept. Health Care Servs., 3-7 (Aug. 12, 2015) (on file with author).

145 CAL. DEP'T CORR. & REHAB., *supra* note 43, at 20; JUD. COUNCIL CAL., *supra* note 87, at 42.

146 SOC. SEC. ADMIN., SI 00520.910, PRERELEASE AGREEMENTS WITH INSTITUTIONS, PROGRAM AND OPERATIONS MANUAL SYSTEM (POMS) (Feb. 9, 2015), available at, <https://secure.ssa.gov/poms.nsf/lnx/0500520910>.

147 Karen J. Cusack et al., *Criminal Justice Involvement, Behavioral Health Service Use, and Costs of Forensic Assertive Community Treatment: A Randomized Trial*, 46 CMTY. MENTAL HEALTH J., no. 4, 2010, at 356.

# REDUCE REINCARCERATIONS FOR VIOLATIONS OF SUPERVISION REQUIREMENTS

## INTERCEPT 5: COMMUNITY CORRECTIONS

Intercept 5 concerns parole and probation supervision after people have exited incarceration. The recommendations in this section are intended to reduce returns to incarceration for noncompliance with strict supervision requirements by providing additional support to people with MH/SU needs.

### 5-A. TAILOR CONDITIONS TO THE NEEDS AND CAPABILITIES OF THE INDIVIDUAL TO REDUCE SUPERVISION VIOLATIONS

Title II of the Americans with Disabilities Act (ADA) protects individuals with disabilities, including people with mental health needs, from discrimination on the basis of their disability in services, programs, and activities provided by state and local governments, including by criminal justice agencies.<sup>148</sup> Probation and parole departments are therefore required to make reasonable accommodations in policies, practices, and procedures to avoid disability discrimination. Such accommodations may include flexibility in punctuality requirements for individuals who have difficulty showing up to appointments on time due to their disability. To ensure ADA requirements are being satisfied, a system to identify people with disabilities and allow early and better planning for probation and parole would be beneficial.

This can be similar to the “child find” requirement of the Individuals with Disabilities Education Act, which requires schools to proactively identify students with disabilities for evaluation and connection with appropriate services.<sup>149</sup> The state can also play a role in developing and disseminating ADA training and information about common types of accommodations to be expected in the probation/parole context.

**Action:** Advocate for a statewide system to identify individuals with disabilities in the criminal justice system who may need reasonable accommodations while on parole. Support ADA training for parole officers in coordination with disability rights advocates. At the local level, support implementation of a system for identifying and supplying reasonable accommodations for people under their supervision. Encourage collaboration between local probation departments and disability rights advocates to provide training to probation officers. Support better guidance, developed in coordination with disability rights advocates, on ADA compliance in the supervision context and expand enforcement of this important law.

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<sup>148</sup> See *supra* note 47.

<sup>149</sup> See MAC TAYLOR, CAL. LEG. ANALYST'S OFF., *IMPROVING CALIFORNIA'S CRIMINAL FINE AND FEE SYSTEM* 6 (2016).



## 5-B. EXPAND FORENSIC ASSERTIVE COMMUNITY TREATMENT TEAMS TO SUPPORT SUCCESSFUL REENTRY

Assertive Community Treatment (ACT) Teams provide high-intensity case management and support services for people with serious MH/SU needs. ACT teams that provide services to people in the criminal justice system are known as forensic ACT (FACT) teams. Recent research from the California Central Valley has shown that participation in FACT can reduce jail bookings and improve health outcomes.<sup>150</sup> Increasing FACT teams can improve outcomes for participants and reduce workload on overburdened probation departments.

**Action:** Support funding for forensic assertive community treatment teams and the creation of fiscal incentives to encourage implementation of these teams. At the local level, support the implementation of FACT teams with MHSA, Public Safety Realignment, Medi-Cal, and/or general funding. Advocates can also push local hospitals to invest in these programs as part of their community benefit plans.<sup>151</sup>

**Recent research from the California Central Valley indicates that people living with MH/SU needs who receive Forensic Assertive Community Treatment case management and supportive services have improved health outcomes and fewer jail bookings.**

## 5-C. ELIMINATE FEES FOR MANDATED TREATMENT TO FACILITATE ACCESS TO HEALTH SERVICES

People who become involved in the criminal justice system typically reenter the community burdened with fines and fees, both state and county that have accumulated throughout their involvement.<sup>152</sup> Fees for participation in mandated treatment programs are typical.<sup>153</sup> People living with MH/SU needs are more likely to enter the criminal justice system and return to it, increasing the chances that fines and fees will pile up. These fees hinder reentry for several reasons: the court may deem nonpayment by those who cannot pay as willful and return them to incarceration; people may not participate in treatment because they cannot pay for it; and people may have difficulty making ends meet because of their debt obligations to pay the fines and fees. In 2017, the California Legislature eliminated several fines levied on youth involved in the juvenile justice system.<sup>154</sup> Advocates can seek to capitalize on this progress by supporting efforts to reduce and/or eliminate fees charged to adults, especially fees to participate in mandated MH/SU treatment programs.

**Action:** Advocate for the prohibition of fees for participation in mandated MH/SU treatment programs. At the local level, work with local probation departments, courts, and treatment providers to bring an end to the practice of charging people for mandated treatment.

<sup>150</sup> *Id.*

<sup>151</sup> S.B. 190, 2017-18 Sess. (Cal. 2017).

<sup>152</sup> CAL. GOV'T CODE § 12525.5; CAL. CODE REGS., tit. 11, § 999.226(a)(9)(D).

<sup>153</sup> COUNCIL OF STATE GOV'TS JUSTICE CTR., *supra* note 94, at 33.

<sup>154</sup> *Id.* at 32

# IMPROVE FUNCTIONING ACROSS THE CRIMINAL JUSTICE SYSTEM

## INTERCEPT 6

The recommendations in this section either do not squarely fit into one of the intercepts or can apply to multiple intercepts. Nonetheless, they are important to ensuring a comprehensive approach to reducing criminal justice-involvement among people with MH/SU needs.

### **6-A. COLLECT DATA THE ON NUMBER OF PEOPLE LIVING WITH MH/SU NEEDS IN JAILS/PRISONS, THEIR LENGTH OF STAY, AND THEIR RECIDIVISM RATES TO IMPROVE BASELINE KNOWLEDGE**

Recent changes in the law will require law enforcement agencies to collect and report data on the number of stops involving people with perceived mental health needs, allowing more clarity into just how often police interact with people living with these needs.<sup>155</sup> However, fewer than half of California's counties currently take measures to produce baseline data on the number of people with MH/SU needs in their jails.<sup>156</sup> These measures include the prevalence of people living with MH/SU needs in jails, their length of stay, connections to community-based services, and recidivism rates.<sup>157</sup> Without collecting and analyzing these data, it is impossible to understand the scope of the problem. Counties

should collect this data and report it to the state for analysis (a portion of this would be addressed if the state required standardized universal MH/SU needs screening (see Recommendation 2-A.). The state should provide standards for collecting and reporting these data, as well as provide technical assistance. The Board of State and Community Corrections already conducts annual jail surveys, so it may be appropriate to include this data reporting as part of that process. The state may also need to provide funding for counties to update their data collection systems.

**Action:** Support requirements to collect standardized critical data relating to people living with MH/SU needs in jails and to report to the state at least annually for analysis. The state can support these efforts through technical assistance and funding to upgrade county data collection systems. At the local level, support data collection on the number of people living with MH/SU needs in jails, their length of stay, and recidivism rates among this group. Advocate for local law enforcement agencies to begin early collection and reporting of stop data, including perceived MH/SU needs of individuals who are stopped.

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155 Mia Bird & Ryken Grattet, Pub. Pol'y Inst. Cal., Do Local Realignment Policies Affect Recidivism in California? 20 (2014).

156 Malaika Fraley, Alameda County Agrees to Allocate More Realignment Funds to Community-Based Organizations, MERCURY NEWS (Mar. 24, 2015), <https://www.mercurynews.com/2015/03/24/alameda-county-agrees-to-allocate-more-realignment-funds-to-community-based-organizations/>.

157 CAL. WELF. & INST. CODE §§ 5847, 5848(c)

## 6-B. REQUIRE REINVESTMENT OF SAVINGS FROM DIVERSION OF PEOPLE WITH MH/SU NEEDS TO COMMUNITY HEALTH SERVICES TO ENSURE LONGEVITY OF REFORM

Sustainability and expansion of pilot diversion programs are crucial to ensuring they grow to the scale needed to assist all Californians who could benefit from these services. One way to encourage this is to establish a fund that allocates incentive payments to counties that demonstrate a need and/or success in reducing incarcerations of people living with MH/SU needs. In turn, these incentive payments can be used for expanding existing, or implementing new, MH/SU diversion services.

**Action:** Support reinvestment of savings from diversion efforts into expanding these services to assist all Californians living with MH/SU needs. At the local level, support implementation of a tracking system for money saved from diversion programs and the reinvestment of cost savings into expansion of MH/SU support services.

## 6-C. REQUIRE PUBLIC SAFETY REALIGNMENT FUNDS TO BE SET ASIDE FOR COMMUNITY-BASED MH/SU SUPPORT SERVICES TO EXPAND THESE PROGRAMS

Public Safety Realignment provided counties with a dedicated and permanent revenue stream to help them respond to their additional responsibilities, including provision of MH/SU services to people who previously would have been the responsibility of the state. County Community Corrections Partnerships are tasked with recommending how these funds should be allocated, subject to the approval of county boards of supervisors. Counties choose to spend these funds in different ways. Some counties focus more on community-based services while others focus more on supervision and enforcement. Research suggests counties that

spend more of their Public Safety Realignment funding on services tend to experience lower recidivism rates.<sup>158</sup> In Alameda County, advocates succeeded in convincing their board of supervisors to allocate at least 50 percent of Public Safety Realignment funds to community-based organizations that service people in reentry.<sup>159</sup>

**Action:** Advocate for counties' Public Safety Realignment funding to mostly be allocated for community-based services, including MH/SU treatment. This may require asking local Community Corrections Partnership to provide accurate accountings for how these funds are currently expended, as well as increasing opportunity for public input into decision making in this regard.

## 6-D. ENFORCE DATA COLLECTION AND REPORTING TO MEASURE IMPACT OF MH/SU FUNDS ON REDUCING CRIMINAL JUSTICE-INVOLVEMENT

Counties are required to submit three-year plans and annual updates on Mental Health Services Act (MHSA) spending and outcomes to the Department of Health Care Services (DHCS) and Mental Health Services Oversight and Accountability Commission (MHSOAC).<sup>160</sup> As part of each county's MHSA three-year plan and annual update, they are required to consider ways to provide services to people with serious mental health conditions who are at risk of involvement in the criminal justice system.<sup>161</sup> DHCS, in consultation with MHSOAC and the County Behavioral Health Directors Association, is responsible for developing instructions for counties' annual updates.<sup>162</sup> DHCS can issue guidance clarifying the information that counties should submit regarding MHSA funds used to reduce criminal justice-involvement. Guidance should include, at a minimum, how much was spent in this regard, the types of services funded, how many people were reached, outcomes for program

158 Mia Bird & Ryken Grattet, Pub. Pol'y Inst. Cal., Do Local Realignment Policies Affect Recidivism in California? 20 (2014).

159 Malaika Fraley, *Alameda County Agrees to Allocate More Realignment Funds to Community-Based Organizations*, MERCURY NEWS Mar. 24, 2015), <https://www.mercurynews.com/2015/03/24/alameda-county-agrees-to-allocate-more-realignment-funds-to-community-based-organizations/>.

160 CAL. WELF. & INST. CODE §§ 5847, 5848(c)

161 *Id.* § 5813.5(f).

162 *Id.* §§ 5899(a)-(b).



participants (e.g., arrest reductions, jail days avoided, and costs saved), and what additional funds are needed to expand the program to all who can benefit. DHCS and MHSOAC can then enforce collection of this data from counties and use the data to evaluate overall outcomes.<sup>163</sup>

**Action:** Urge the Department of Health Care Services, in consultation with the Mental Health Services Oversight and Accountability Commission and the County Behavioral Health Directors Association, to issue guidance on the information pertaining to criminal justice-involvement that counties should include in their MHSA annual reports. Hold DHCS accountable if compliance with these reporting requirements is lax. At the local level, advocate for county mental health departments and mental health advisory boards to include robust data on MHSA spending for populations involved in the criminal justice system.

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<sup>163</sup> DHCS already has the authority to do this under CAL. WELF. & INST. CODE § 5848(e).



A San Diegan living with acute mental health needs, Edward Vega has cycled in and out of the criminal justice system for several years. When inside, medical staff often neglected to order Vega's medications, putting him at risk of crisis. Correctional officers, untrained on how best to respond to people with mental health needs, repeatedly isolated Vega in solitary confinement, worsening his health conditions.

Fortunately, Vega found Project In-Reach, a program that engages with incarcerated people prior to their release to assist with reentry planning and to provide community-based case management services. Project In-Reach has helped Vega to find mental health care in his community; and it helped him to find his current position as a mechanical engineer. Vega is thankful for Project In-Reach and fears what would have happened to him if the program wasn't available: "Without this help, I would be trapped in the vicious cycle of going in and out of jails. Or worse, I would be dead."



# CONCLUSION

**T**he drastic over-incarceration of people living with mental health and/or substance use needs is a major humanitarian crisis resulting in profoundly negative safety and health outcomes for individuals and society at-large.

This report presented more than 40 recommendations for state and local advocacy to put California on the road to ending the over-incarceration of people living with MH/SU needs. We emphasize a focus at earlier stages of the criminal justice system, as these recommendations will reduce the depth of criminal justice system involvement, including the possibility of avoiding involvement entirely. The included recommendations are not an exhaustive list of what must be accomplished. They are intended to provide concrete suggestions to assist advocates seeking to instigate progressive action on this critical issue.

We've reached the turning point. It's time to turn towards a society that prioritizes community-based health services, fiscal responsibility, and human dignity rather than incarceration. Courageous advocates, particularly those with lived experience, will surely be the driving force toward this worthy goal.