Alternatives to Incarceration

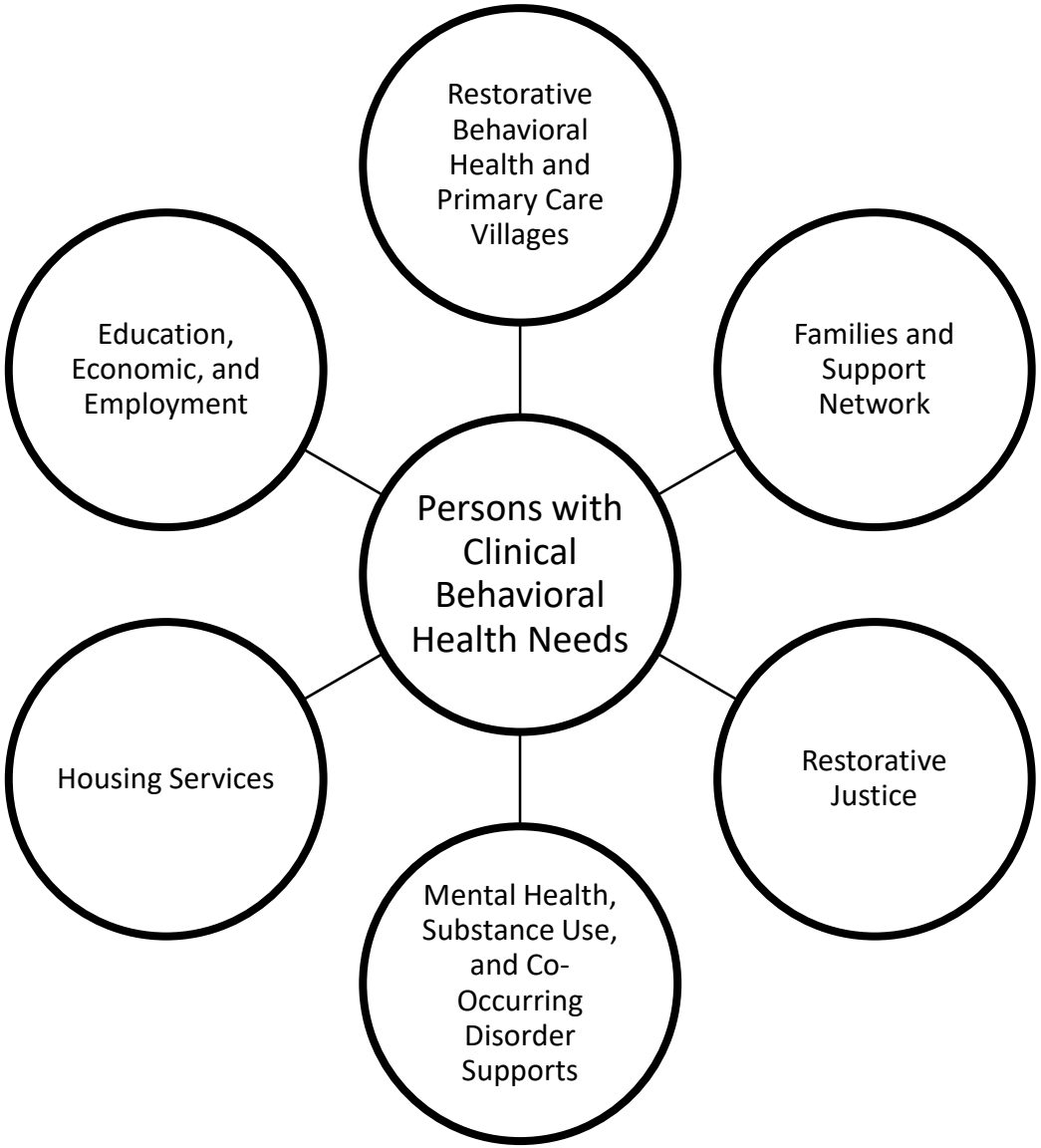
ATI Intercept Roadmap

A visual representation of the ATI Work Group's recommendations.

September 6, 2019

CONTENT

INTERCEPT 0: *Holistic and Decentralized Community-Based System of Care: Prevention and Reentry*



INTERCEPT 0: *Holistic and Decentralized Community-Based System of Care: Prevention and Reentry*

Restorative Behavioral Health and Primary Care Villages

1. Decentralize and develop cross-functional teams to coordinate behavioral needs before booking, with an emphasis on warm handoffs when connecting clients to optimal services.

2. Create and expand decentralized, coordinated service hubs (ex: MLK Behavioral Health Center) in strategic locations across the 8 Service Planning Areas (especially SPA 1, 3, and 7) where people can seek referral and/or immediate admission 24 hours a day to a spectrum of services that include but are not limited to mental health including Psychiatric Urgent Care Centers; supportive housing via a coordinated entry system; and substance use disorder services such as withdrawal management, medications assisted treatment (MAT) and recovery intake centers (aka sobering centers).

Families & Support Network

3. Expand family reunification models and connect families to low-cost or no-cost parenting groups.

4. Train families of people with clinical behavioral health disorders on how to support their loved ones, assess service needs, provide assistance through various stages of treatment, and follow prevention/treatment plans while incentivizing family/client involvement with compensation, certificates, etc.

5. Support meaningful exchange of information and clarity between provider, patient, and family/caregiver to improve patient care and health outcomes, including but not limited to modifying DMH's HIPAA policy for contractors.

6. Improve, enhance, and integrate case management opportunities, points of contact and engagement for Community Health Workers and peer support organizations to connect with clients and their families/loved ones outside of justice involvement and pre/post incarceration.

Restorative Justice

7. Establish effective restorative justice programs for the adult justice-involved population by learning from existing County programs and other programs, especially those serving youth.

Mental Health, Substance Use, Co-Occurring Disorder Supports

8. Advocate for changes to expand services and populations covered by Medi-Cal to support integrated service delivery for system-involved individuals and their families, which could provide a source of sustainable funding to support ATI recommendations related to an integrated system of care.

9. Greatly expand and improve the use and process for Mental Health Conservatorships, including increasing the capacity of the Public Guardian to investigate and manage conservatorship for individuals considered gravely disabled and creating a temporary conservatorship process for families.

10. Support and broaden implementation of community-based harm reduction strategies for justice involved individuals with mental health or substance use disorders and/or individuals who use alcohol/drugs, including but not limited to sustained prescribing of psychiatric medications.

11. Deliver integrated mental health and substance use disorder services rather than parallel services including building partnerships between DPH-SAPC & DMH for residential co-occurring disorder (COD) services.

12. Support parity between the mental health and substance use disorder systems and available services.

13. Remove time limits to service provisions that prevent access to long term health, mental health or substance use disorder treatment plans.

14. Remove barriers to treatment, employment, and recovery housing based on record of past convictions through state legislative intervention or updating County policies.

INTERCEPT 0: *Holistic and Decentralized Community-Based System of Care: Prevention and Reentry*

Housing and Services

15. Create a system that contributes to and/or offsets the cost to family members and caregivers for housing loved ones within their home or in the community through options such as tax credits, stipends, vouchers, motel conversions, or partial pay options.

16. Create a individualized/personalized master transition plan for displaced individuals.

17. Expand or refine affordable successful housing models designed for and tailored to justice involved individuals with mental health and/or substance use disorder needs, specifically: (a) short-term treatment inclusive of acute inpatient, AB 109 and forensic inpatient (FIP) and IMD subacute beds; (b) interim housing inclusive of clubhouse living with supportive employment, recovery bridge housing and sober living; and permanent subsidized housing inclusive of independent living and board and care facilities.

18. Create and scale up innovative programs that comprehensively provide housing, wraparound services, and career-track employment for justice-impacted individuals.

19. Develop partnerships with and between landlords, County departments, providers, and communities/neighborhoods that increase housing options and support residents in maintaining housing, including onsite management staff.

20. Work with Housing State Funding, DHS Housing Programs, and Housing projects for people experiencing homelessness and mental health and/or substance use disorders.

Education, Economic, Employment

21. Establish a partnership with the State Department of Occupational Rehabilitation and coordinate with other agencies, including but not limited to WDACS, regarding economic and employment opportunities.

22. Expand supported employment opportunities for persons with mental health, substance use, or co-occurring disorders, including flexible funds for basic clients needs to find employment (e.g., birth certificates, etc.).

23. Incubate new innovative employment programs for people with serious mental health disorders.

INTERCEPT 1: *Community Response and Intervention Services*

- CBO harm reduction, substance use and mental health services
- Recovery Intake Centers, Sobering, Detox, Cooling Off Centers
- Respite Care
- Urgent Care Centers

- Intensive Outpatient Facilities
- Secure MH Residential Facilities
- Dual Diagnosis Residential Facilities
- IMDs

29. Increase number of crisis beds and establish database for real-time bed availability for all justice and health system partners.

30. Develop and expand a decentralized range of clinical spaces countywide and ensure that current sites are sufficiently resourced.

Community Based System of Care: Prevention & Reentry

Alternative Clinical Settings

- Crisis Prevention
- De-Escalation
- Involuntary Hospitalization

Behavioral Health Team Response

Crisis Line

DMH Access Line; referral lines like SASH helpline, LAHSA-E6, LA HOP; etc.

Conservatorship Process

24. Significantly increase the number of DMH Psychiatric Mobile Response Teams (PMRTs) to reduce service wait times.

25. Increase ambulance contracts to improve response times.

26. Create another option for behavioral health crises, i.e., CBO behavioral health services through an app.

27. Expand, diversify, and strengthen non-crisis mobile response teams to address gaps, including: (a) following through with clients in crisis to avert involuntary hospitalization; (b) involving peers in mobile response teams; (c) developing system for outreach workers to respond to non-law enforcement calls.

31. Improve staffing of DMH ACCESS line to minimize caller wait times and ensure live operator coverage 24x7.

Crisis

Emergent

Non-Crisis

Person X Calls

911

28. Invest in public education and law enforcement education campaign to encourage the use of DMH ACCESS, SASH, suicide prevention and other helplines, and the CBO Network on homelessness, mental health, substance use and stigma.

Public Education Campaign

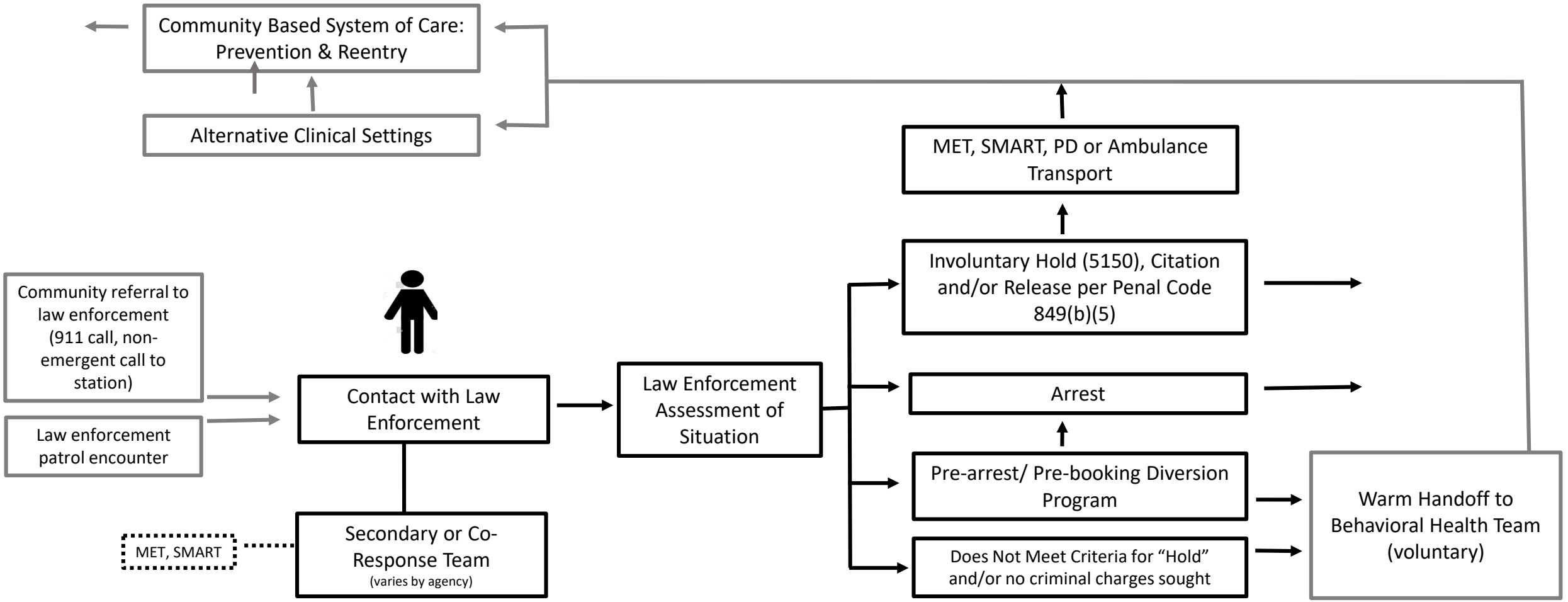
Community Health Education

- Homeless and Mental Health Awareness
- Law Enforcement Is Not Only Answer
- Non-Law Enforcement Alternatives
- Call Crisis Lines, Not 911

- Community Health Workers
- Non-911 Options
- Relationship Building (e.g., schools, churches, nonprofits, etc.)

32. Train 911 operators and dispatch on mental health screening to direct calls involving behavioral health crises that do not require a law enforcement response towards DMH's ACCESS line (e.g., integrate DMH line with 911 or allow direct access from 911 operators to ACCESS).

INTERCEPT 2: *Law Enforcement*



33. Substantially increase number of collaborative law enforcement and behavioral health co-response teams throughout the County (LAPD, LASD, and all other law enforcement agencies) to increase availability of co-response teams 24x7.

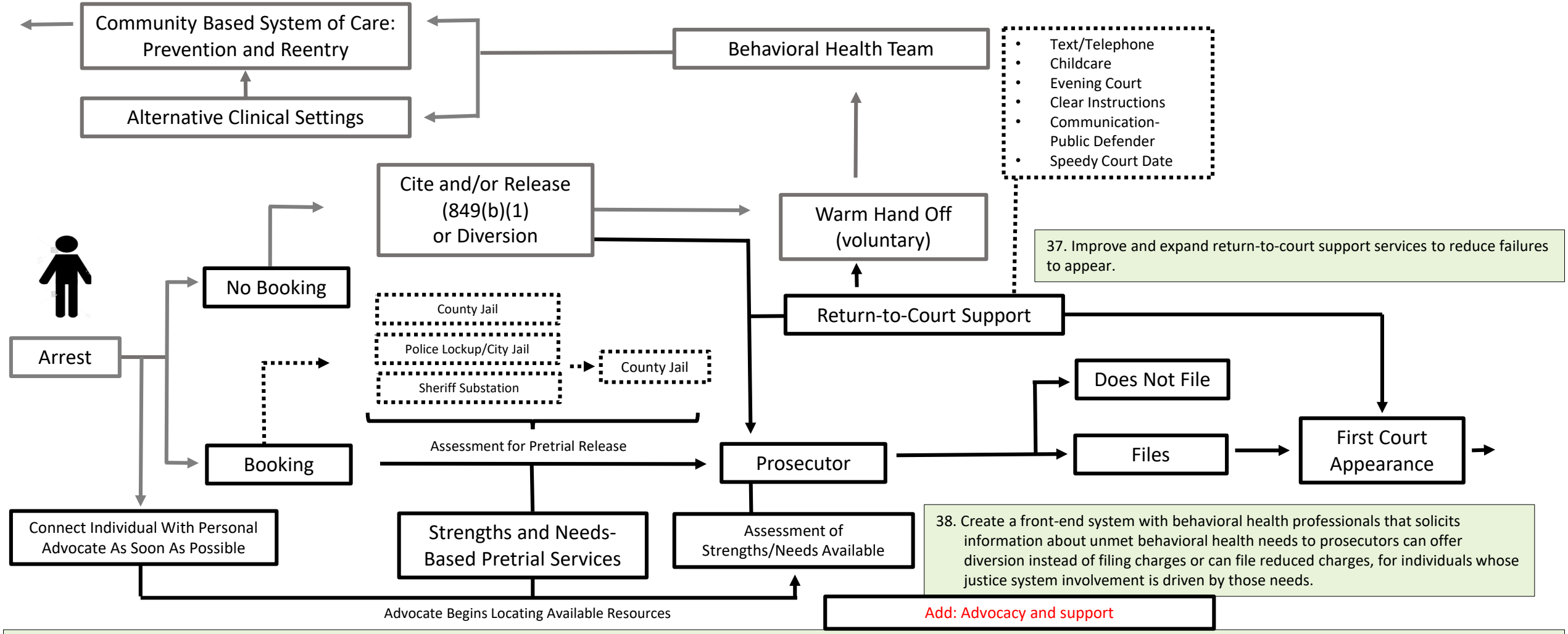
34. Train all law enforcement officers in Los Angeles County in a formal CIT curriculum, and refresher courses, that incorporate connections and networking with neighborhood-specific community-based resources with a treatment-first approach. SMART/MET teams to receive substantially more specialized training.

35. Promote a practice where law enforcement officers, whenever possible, release individuals with clinical behavioral health disorders at the time of contact and ensure a warm introduction to supportive services.

36. Develop and expand pre-arrest and pre-booking diversion programs, using decentralized cross-functional teams to coordinate behavioral health assessments and connections to community-based systems of care, for people whose justice system involvement is driven by unmet behavioral health needs, in coordination with law enforcement and community-based providers.

Slide 6

INTERCEPT 3: *Booking and First Court Appearance*



39. Develop a strengths and needs-based system of pretrial release through an independent, cross-functional entity, situated outside of law enforcement, to coordinate voluntary needs and strengths assessments expeditiously upon booking, and to provide relevant information to court officers to make informed release decisions.

40. Institute a presumption of pretrial release for individuals with clinical behavioral health disorders, whenever possible, coupled with warm handoffs to community-based systems of care, to provide targeted services to help individuals remain safely in the community and support their return to court.

41. At the earliest point possible, connect individuals to a personal advocate or community member to assist them in navigating the justice system process.

Slide 7

INTERCEPT 4: *Jail Custody and Court Process*

Community Based System of Care: Prevention & Reentry

Alternative Clinical Settings

Behavioral Health Team

Warm Hand Off

42. Improve equal access to all treatment resources for justice-involved individuals, wherever they may be (in or out of custody): Direct health agencies to change eligibility criteria and increase capacity and funding to ensure behavioral health treatment facilities are available in all stages of court process. Create a more rapid referral and response process for MH and Co-Occurring placements at all levels. Develop a coherent strategy and connect every qualifying individual to an appropriate court-based program at inception of diversion dialogue. Refine multiple points of entry within Intercept 3 for MH and SUD services. Ensure in-custody involvement of CBOs for services. Expand capacity and remove archaic barriers at all levels of care.

44. Increase 'staffing on the ground' across departments, including Public Defender/Alternate Public Defender, District Attorney/City Attorney, Department of Health Services/Office of Diversion and Reentry, Department of Mental Health/ Health Court Linkage Program, Department of Public Health, County Counsel, and community-based organizations that work with departments to expand and integrate court-based services for as many individuals as possible.

45. Train the court-based workforce to address the continuum of needs of incarcerated persons by partnering with families and creating individualized plans that are culturally competent and include those not eligible for community-based diversion (i.e., violent felony charges).

43. Create a robust AB 1810 Diversion scheme - PC 1001.36 and 1170(a)(1)(B)(iv) and 1370.01(a)(2) – to identify early on persons eligible for diversion and develop pathways countywide to connect individuals to appropriate behavioral health programs to accomplish the goals of pre-conviction Diversion and respond to all other present and future diversion opportunities, including pre and post conviction.

46. Expand access and enhance substance use treatment programs in the County jails, for example: the START program substance use disorder (SUD) treatment for currently incarcerated people with mental health need and SUD; and MAT services in the jails to provide: (a) comprehensive withdrawal management; (b) full spectrum MAP for opiate use disorder; and (c) specialty MAT clinics to allow clients patient-centered, harm reduction service on-site in jails.

First Court Appearance

Court System

Educational Seminars on Mental Health & Treatment

Mental Health Team Front-End of System

Conservatorship Process

Collaborative, Non-Adversarial Processes

Protocol to Direct Clients to Appropriate Court-Based Programs

Expand SUD Treatment in Jail

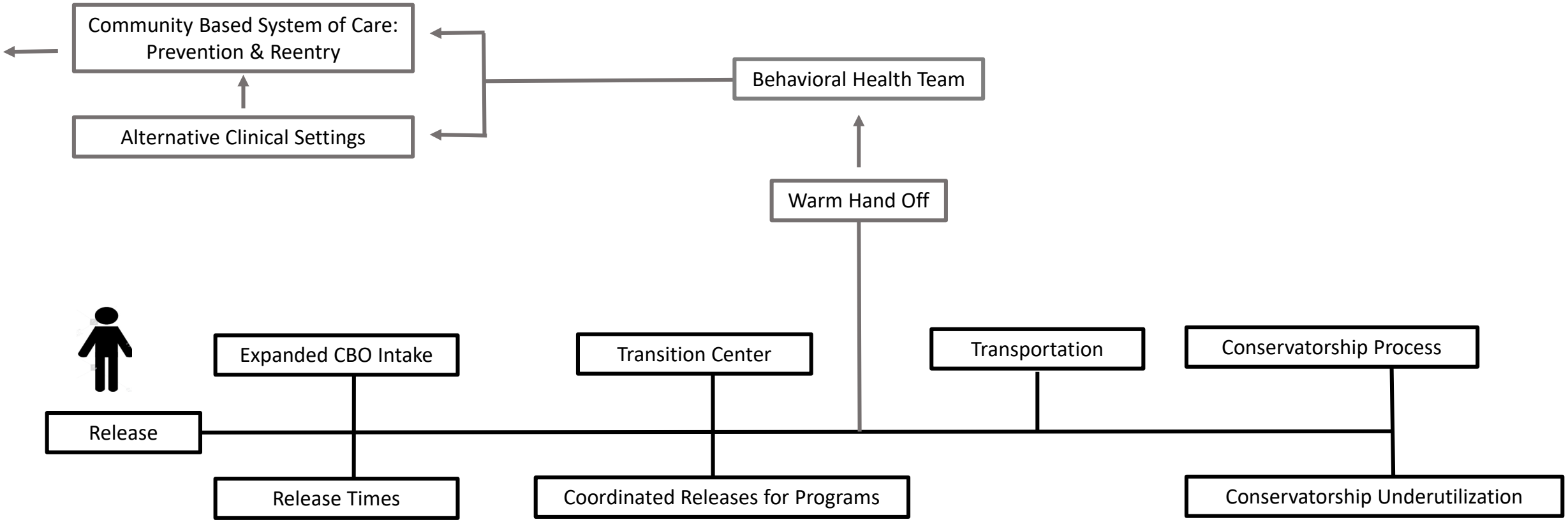
Real-Time Data on Treatment Availability

Release

47. Conduct educational seminars, led by service providers, for justice partners on mental health disorders and treatment; improve awareness of behavioral health court-related resources among judicial officers and court personnel (and provide real time mapping of alternative placements.)

48. Increase collaborative (non-adversarial process) in all courtrooms where diversion/alternate sentencing occurs, to enable better outcomes that are trauma informed and respect individual care and rights.

INTERCEPT 5: *Pre-Release Planning & Release*



49. Incentivize community treatment facilities to accept patients from jail who have clinical mental health needs, substance use disorders, and/or co-occurring disorders.

50. Change release time for men to match those of women from CRDF to avoid overnight release without direct link to programs, interim housing, safe place, or transportation. Increase coordinated releases for clients exiting directly to program, provide funding to expand CBO intake hours. If not exiting directly to program, notify family members of a person's release (with that person's permission) with enough time for family to pick them up, and increase use of coordinated releases to family.

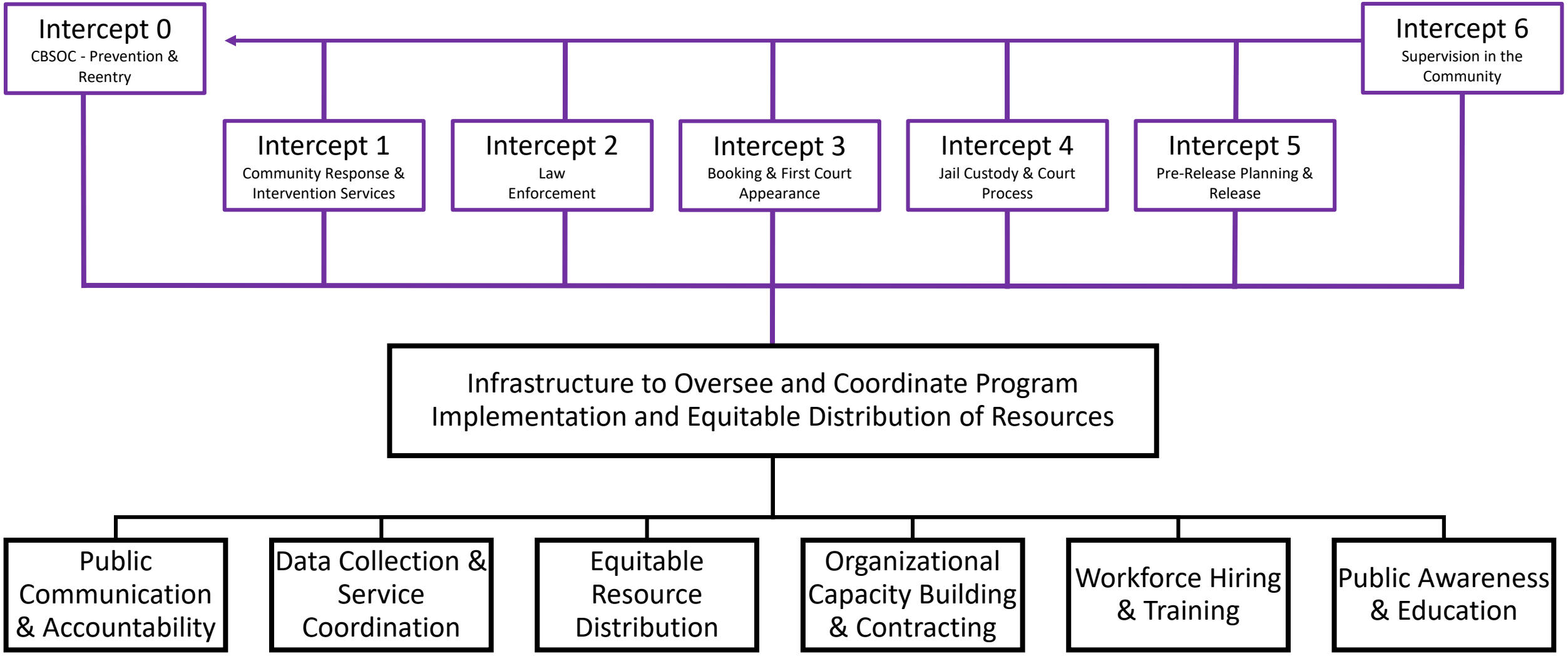
51. Develop and fund a transition shelter within a few blocks from downtown jails operated by community-based organization with safe, welcoming overnight stay for people released after hours with range of support.

52. Increase utilization of and improve the process for conservatorships.

INTERCEPT 6: *Supervision in the Community*

Recommendations and process map for Intercept 6 will be developed during the second planning phase.

INFRASTRUCTURE



INFRASTRUCTURE

Public Communication & Accountability

53. Increase, ensure, and fund public collaboration in in all phases of Alternatives to Incarceration planning, implementation, evaluation, and system oversight – across relevant County court, justice, health and social service systems. This collaboration can be piloted via the ATI Community Engagement Workshops and by instituting quarterly stakeholders meetings to communicate updated ATI progress, discuss service and communication gaps, and highlight best practices. Fund and staff post-ATI final report, i.e., the initiative should host recurring implementation meetings across the County and with relevant County departments to discuss policy impacts, resolve policy conflicts, monitor fiscal impacts, assess eligibility barriers, and develop evaluation metrics of success.

54. Establish online mechanisms for the public to get information and locate services to prevent incarceration and recidivism, and promote recovery. This tool should track identified problems and response progress through an accessible dashboard and should align with existing tools such as One Degree, etc.

55. Create, staff, and fund an Advisory Collaborative of Impacted People to ensure there is continuous feedback and accountability to the prioritized communities and LA County at large in the implementation of the comprehensive roadmap.

Data Collection & Service Coordination

56. Expand and coordinate data tracking/collection across all relevant County justice and health/social service entities to retrieve data necessary for services, programming, preventative measures, and alternatives to incarceration. Align this data collection with existing County data tools/portals such as One Degree, CHAMP, LANES, CES, etc. to inform a uniform client database

57. Develop a uniform client database across all relevant County services and justice entities to follow and support the justice-involved individual (longitudinally & latitudinally) regardless of system access point, with the following database features: (a) interface capabilities linking services providers as well as tracking service availability among LA County's considerable resources; (b) alignment with existing tools such as One Degree, CHAMP, LANES, CES, etc. to improve patient referral processes as well as to assist in performance tracking and accountability as individuals move between systems and services; (c) family and service provider feedback capacity to track problems and response progress; and (d) protects the privacy rights and interests of justice-involved individuals.

58. Provide real-time Full-Service Partnership (FSP) availability throughout all service areas, keep a real time database and track FSP successes and failures, and report these to DMH.

59. Track *and make public* all relevant County service and incarceration spending – both for those incarcerated and those reentering the community.

INFRASTRUCTURE

Equitable Resource Distribution

60. Utilize data-driven tools (e.g., Race Forward's Community Benefits Agreement and Racial Impact Tool, or Advancement Project's JENI/JESI, etc.). to create processes for equitable resource and contract distribution with program offices across health and social service departments. This processes should prioritize remedying racial and geographic disparities while also taking into account cultural, gender, and special populations' needs. Involve County and impacted communities in equitably distributing and leveraging resources to sustain community health.

61. Fund comprehensive rehabilitative, evidence-based mental health and substance use care, as well as violence prevention, gang intervention, art therapy, occupational therapy, and other programs in lieu of incarceration, i.e., interventions should take a holistic, whole person (or even family-centered) approach as their model in serving individuals while utilizing justice funds saved by decreased incarceration.

Organizational Capacity Building & Contracting

62. Create contract language that supports effective models that are servicing people 24/7, with appropriate specialization, intensity, staffing, language/culture, quality, and staff with lived experience, etc.

63. Institute payment reform to prioritize performance-based contracts (instead of fee-for-service) with flexible service delivery rules to ensure providers can deliver treatment and support all clients' needs concurrently.

64. Utilize County capacity-building programs, in conjunction with equity analysis, to expand the community-based system of care by: (a) finding and supporting smaller organizations in different SPAs to qualify and access funds while providing seed funding (i.e. philanthropic partnerships, business loans, flexible government funding, pay for success models, and/or zone area investments, etc.); (b) promoting existing providers as potential incubators; and (c) supporting training and TA to become service providers accessing Medi-Cal Fee Waiver, County and State funding, and organizational coaching.

65. Dedicate funding to long-term, sustainable infrastructure and professional development support for community-based systems of care beyond service delivery, and connect contractors to new and existing capacity-building resources.

66. Actively gather anonymous feedback from service providers contracted and not contracted with the county to ensure transparency in understanding participatory hurdles and identify innovations to make a positive impact.

67. Standardize a simplified, more accessible contracting process across agencies and departments and outreach to service providers who might benefit from such reforms.

INFRASTRUCTURE

Workforce Hiring & Training

68. Train all law enforcement officers along with 911 dispatchers and desk personnel in LA County in a formal CIT curriculum to aid in understanding alternatives to 911, arrest, and jailing.

69. Train justice officers and court personnel on mental health, substance use disorders and treatment to increase awareness and utilization of existing resources (e.g., Mental Health Court Program, real-time resource mapping) to change the culture of criminal justice system towards treatment first, not incarceration and punishment.

70. Require that mental health clinicians complete trainings that build their capacity to provide integrated SUD care with psychiatric treatment, including cross training.

71. Train social/health service workforce to address continuum of need and that individual's care plans are culturally sensitive and include those not eligible for community-based diversion (i.e., violent felony charges).

72. Provide paid training and employment to increase the number of justice system-impacted individuals working as the technologists behind data collection and analysis.

73. Design and implement curricula for all workforce trainings recommended herein by partnering with justice-impacted individuals and their families.

74. Attract and develop social/health service workforce capable of delivering integrated health, mental health, substance use treatment; and livable wages in partnership with justice-impacted individuals and their families.

75. Conduct intensive and extensive outreach to medical schools, schools of social work, professional organizations, and local educational institutions for qualified forensic mental health professionals and community health workers, while providing incentive bonuses for bilingual experts and developing certification or credential programs for CHWs with educational partners. .

76. Increase employment and retention of Community Health Workers (CHWs) to expand service capacity, cultural competency, and client/provider trust, by: (a) hiring, training and professionally advancing CHWs with lived experience of the justice system; (b) creating pathways for CHWs to move up to full-time, salaried County jobs with benefits; and (c) including continual evaluation and improvements made to ensure the CHW program is both effective and building this innovative workforce.

Public Awareness & Education

77. Develop a public education communications campaign to build awareness of treatment-first (not incarceration and punishment) model. Should stress use of DMH ACCESS line, CBO network, SASH helpline, suicide prevention hotline rather than 911 for behavioral crises, available non-law enforcement resources, and different types of community-based solutions.