

ATI Intercept Roadmap Goals and Recommendations Tables

**Only goals and recommendations are featured in this document. For further analysis please refer to the Interim Report Recommendations Combined Document and reference pages in parenthesis.*

Intercept 0: Holistic and Decentralized Community-Based System of Care

Goal 1: Increase Access and Remove Barriers to Community Based Services by addressing the Social Determinants of Health, A (pg.3)

Description: Develop policies and expand programs that ensure that people with mental health disorders and substance use disorders, their loved ones, and community members have multiple points of access to the full continuum of services and that match the individual's current needs (from low to high levels of care) through a combination of County- operated and not-for-profit community-based organizations services throughout Los Angeles County while creating alternatives to incarceration at every level of the criminal justice system. This recommendation impacts intercept zero (which enables people to access services before any contact or involvement with the criminal justice system has occurred) and intercept five (prevent recidivism). All services should be implemented in a need-aligned and equitably distributed manner.

Goal 1: Increase Access and Remove Barriers to Community Based Services by addressing the Social Determinants of Health, B (pg.4)

Description: Remove barriers to accessing all necessary and complimentary integrated not for profit community-based services related to mental health disorders, substance use disorders, and poor social determinants of health while providing community members with the necessary tools, support, and incentives to attend and participate in services.

A. 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).

B. Families and Support Network

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

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| 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. |

C. Restorative Justice

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| 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. |
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D. Mental Health, Substance Use, and Co-Occurring Disorder

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| 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. |

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| 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 <u>record of past convictions</u> through state legislative intervention or updating County policies. |

E. Housing and Services

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| 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 an individualized/personalized master transition plan for displaced individuals. |
| 17. Expand or refine affordable successful <u>housing models</u> 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. |

F. Education, Economic, and Employment

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| 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 client’s 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

Goal 3: Reduce and Improve Interactions between Law Enforcement and Mental Health; Increase Diversion Opportunities and Expand Training for Law Enforcement (pg. 19)

Description: *Scale up mental health and community-based response to behavioral health crises to substantially reduce contact between people with behavioral health disorders who are in crisis and law enforcement. When there is contact between people with behavioral health disorders who are in crisis and law enforcement, ensure that law enforcement has the training and partnership with behavioral health personnel to respond appropriately to each situation and to divert many more people into community-based treatment and services.*

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

Goal 3: Reduce and Improve Interactions between Law Enforcement and Mental Health; Increase Diversion Opportunities and Expand Training for Law Enforcement (pg. 19)

Description: Scale up mental health and community-based response to behavioral health crises to substantially reduce contact between people with behavioral health disorders who are in crisis and law enforcement. When there is contact between people with behavioral health disorders who are in crisis and law enforcement, ensure that law enforcement has the training and partnership with behavioral health personnel to respond appropriately to each situation and to divert many more people into community-based treatment and services.

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| 33. Substantially increase number of police/mental health collaborative 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, whenever possible, addresses and releases people with clinical behavioral health disorders at the time of contact and ensures a warm handoff to a provider. |
| 36. Strengthen, diversify, and expand decentralized cross-functional teams to coordinate behavioral health assessments pre-booking and connect individuals with clinical behavioral health disorders to community-based systems of care. |
| 37. Expand pre-arrest and pre-booking diversion programs for people whose justice system involvement is driven by unmet behavioral health needs, in coordination with law enforcement and community-based providers. |

Intercept 3: Initial Detention and Court Hearings

Goal 2: Reduce Pretrial Detention and Increase Services (p.15)

Description: *Substantially and sustainably reduce pretrial incarceration of people with clinical behavioral health disorders while strengthening public safety by instituting a presumption of release and using a public health approach that links accused persons to services and programs without additional justice system contact to reduce the financial burden on the accused by upholding the presumption of innocence. The broader intention is to reduce the entire pretrial population in comprehensive ways that recognize and address the disproportionate impacts of race, socioeconomic status, and other factors that contribute to pretrial detention.*

38. Improve, expand and incentivize cite and release policies to reduce failure to appear to court.

39. Create a front-end system with behavioral health professionals that enables prosecutors to provide diversion instead of filing charges or to file reduced charges.

40. Develop a strengths and needs-based system of pretrial release, by establishing an independent, cross-functional entity situated outside of law enforcement to coordinate voluntary needs and strengths assessments expeditiously upon law enforcement contact and/or initial detention, whenever possible, prioritizing pre-booking with a presumption of release, and linking individuals with clinical behavioral health disorders to the community-based systems of care.

41. Develop and expand pre-booking diversion efforts at local lockups by connecting individuals to treatment or other alternatives including at the earliest point possible connection to a personal advocate or community member to assist the individual through the process.

Intercept 4: Jails and Courts

Goal 1: Improve Diversion and Alternatives within the Court System (pg. 13)

Description: *Formally implement recent legislative opportunities for earlier diversion away from the justice system for people with behavioral health disorders, from the booking stage throughout the court process.*

Goal 4: Increase and Improve Access to Treatment Services for Court-Involved People (pg. 25)

Description: *Expand and ensure easy access and timely linkage to treatment services for clients involved in the court process to a broader range of behavioral health programs and expand the diversity and capacity of those programs. Create a flexible and integrative service model across the Departments of Mental Health, Health Services and Public Health, in order to provide the most responsive system possible to client's service and housing needs. Streamline the referral process from arraignment to disposition, and avail Judges and Attorneys of the general menu of options available to qualifying clients requesting mental health, substance use disorder, or co-occurring treatment services.*

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| <p>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. Expand capacity and remove archaic barriers at all levels of care.</p> |
| <p>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 mental 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.</p> |
| <p>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, and community-based organizations that work with departments to expand and integrate court-based services for as many individuals as possible.</p> |
| <p>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).</p> |
| <p>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</p> |

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.

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: Reentry and Intercept 6: Community Corrections

Goal 5: Improve Reentry Practices (pg. 28)

Description: *Improve pre-release and reentry practices to ensure that individuals, including those with co-occurring mental health and substance use disorders, can transition directly from jail into appropriate community-based treatment and services.*

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| 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. |

Infrastructure

Goal 2: Expand the Community Based System of Care, A (pg. 8)

Description: *Scale up effective culturally competent mental health and substance use models that are community based that already exist at critical intercepts with a priority on intercepts zero and five that enables people to access services before any criminal justice system involvement. Develop contracting policies and procedures that make it less difficult for culturally competent nonprofit community partners to become part of the funded integrated system of care and invest in those relationships long term. Develop capacity among local providers to compete for county contracts and provide high quality services. Address the distribution of resources by the geographic and racial impact of services equitably.*

Goal 2: Expand the Community-Based System of Care, B (pg. 9)

Description: *Remove barriers that prevent not for profit community-based service providers from accessing county funding, contracting opportunities, technical assistance, and incubation opportunities.*

Goal 3: Coordinate Community-Based Services (pg. 10)

Description: *Create an Alternatives to Incarceration Coordination Initiative within the county governance structure to oversee program implementation and equitable distribution of resources. The Initiative would create policies and procedures to connect all county capacity building and services provision efforts. This Initiative would create linkages in service provision for county departments, non-profit community-based service providers and the community at large so that mental health disorders, substance use disorders, and poor social determinants of health are supported and treated through an integrated model.*

Goal 4: Expand Community Health Worker and Peer Support Models to provide holistic support (pg.11)

Goal: Expand justice data transparency including access, analysis, and metric design involving those most impacted by the justice system (pg. 37)

A. Public Communication and 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 mechanism for 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. 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.

B. Data Collection and 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.

C. 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 process 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.

D. Organizational Capacity Building and 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.

E. Workforce Hiring and 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 (eg: 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.

F. Public Awareness and 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.
