Los Angeles County
Alternatives to Incarceration
Work Group

Interim Report – Goals, Recommendations and Analysis

Ad Hoc Committee Recommendations:

Community-Based System of Care
Justice System Reform
Community Engagement
Funding
Data & Research

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Note: The following goals, supporting analysis, and proposed recommendations to achieve those goals, were created by each of the ad hoc committees through multiple meetings and consensus-building activities. The ATI Work Group endorsed each of the goals and will further develop the recommendations during implementation planning. These goals were summarized in the Executive Summary and are provided in full detail below.

COMMUNITY BASED SYSTEM OF CARE
AD HOC COMMITTEE

Part 1: Issues, Analysis, and Recommendations

A. Issue

There is inadequate access to care and insufficient treatment capacity in Los Angeles County's mental health system. As a result, our jails have become a major provider of mental health services. In fact, it is estimated that roughly 1/3 of the LA County Jail population (over 5,000 people) has significant mental health needs. In particular, for decades now the acute and sub-acute systems of mental health care have been starved of resources and poorly managed leaving them woefully unprepared to meet current demands. In addition, outpatient clinical services and much needed reintegration programs that provide connections to community, housing and jobs are few and far between thereby setting up the jail system to become a default setting for people with serious mental health needs.

The County's current system of community-based alternatives to incarceration for people living with mental health needs is not equipped to prevent the criminalization of their illness. Instead, there is a revolving "system of care" that flows from crisis and hospitalization to homelessness and jail- and sometimes death. Our system is difficult to navigate, exists in silos, and does not meet the whole person needs of people with mental health and substance use disorders in our communities. The current approach can often isolate people with harmful results, rather than helping them integrate into our communities using systems that prioritize dignity, promote wellbeing, and provide meaningful opportunities to be active community members of Los Angeles County.

B. Analysis

The lack of community-based services and alternatives to incarceration in the County for people with mental health needs has resulted in overburdened emergency rooms and jail towers full of people suffering from varying mental health symptoms. The delivery of mental health services in jail, and other carceral settings exacerbate mental health needs and often times subjects' people to additional trauma. The Federal Department of Justice (DOJ) acknowledges that people confined to the county jails who have mental health needs were failed by other systems, and these people would be safely and more effectively served in community-based settings at a lower cost to the County.[1]

Currently, people with behavioral health needs are not provided with the holistic care that address all the social determinants of health. We must invest in prioritizing access to health care services, availability of resources to meet daily needs (e.g., safe housing and transportation), as well as access to educational, economic, and employment opportunities with family and community reintegration. An integrated, decentralized system of care that addresses mental health needs and the social determinates of health will create social and physical environments that promote good health for all community members which has been supported by public health experts across the nation. The American Public Health Association "recommends the following actions by federal, state, tribal, and local authorities: (1) eliminate policies and practices that facilitate disproportionate violence against specific populations (including laws criminalizing these populations), (2) institute robust law enforcement accountability measures, (3) increase investment in promoting racial and economic equity to address social determinants of health, (4) implement community-based alternatives to addressing harms and preventing trauma, and (5) work with public health officials to

[1] U.S. Department of Justice, letter to Anthony Peck, Esq. Deputy County Counsel and Stephanie Jo Reagan, Esq. Principal Deputy County Counsel for Los Angeles County, 04 Jun. 2014.

comprehensively document law enforcement contact, violence, and injuries".[2] Developing a system of care that is easily accessible, decentralized, and has the capacity to serve thousands of people throughout the County can end the County's reliance on jails and law enforcement while ensuring that people with behavioral health needs are thriving with dignity and living lives that are restored, not restricted, by ecosystems of care. Care first, and jail only as a last resort.

C. Recommendations

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

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 1A – Potential Strategies:

1. Incorporate Families and Social Support Network
    a. Expand family reunification models and connect families to low cost or no cost parenting groups.
    b. Train people interested in learning how to support their loved ones while incentivizing this training with compensation, certificates, etc. Trainings can include how to access services, identify various degrees of crisis or intervention responses, identify resources while in the justice system, and others.
    c. Compensate family members and caregivers for covering the cost of housing their loved one through a tax credit or stipend.
    d. Create a system so that family members can participate in partial pay options for community housing (motel conversions, bridge, board and care, intentional community, shelter, scattered sites).
    e. Support LPS mental health conservatorship and create a temporary conservatorship process for family members to support system navigation when appropriate. Training is not currently offered by OPG to assist family member conservators on system navigation. Refer families and clients coping with the challenges of living with serious mental health disorders to organizations that provide those services.

2. Educational, Economic, and Employment Support
    a. Coordinate efforts with WDACS to think through other economic and employment opportunities.

[2] Ryan A. Crowley, and Neil Kirschner. "The Integration of Care for Mental Health, Substance Abuse, and Other Behavioral Health Conditions into Primary Care: An American College of Physicians Position Paper" f *Health and Public Policy Committee of the American College of Physicians:*: *Annals of Internal Medicine.* (2015) https://www.integration.samhsa.gov/Integration_of_BH_into_primary_care_Annals_of_Internal_Medicine.pdf.

b. Create a flexible fund for basic client needs such as obtaining birth certificates, transportation, identification, food, co-pays, and other client services, court fees, probation fees, legal documents, medication co-pays, DMV services, meeting co-pays, proper clothing, and other needs to support education and employment.
c. Expand supported employment opportunities, training, Psychological Testing and evaluation of clients' abilities for people with mental health disorders, substance use disorder and co-occurring disorders.
d. Establish a partnership with the state Department of Occupational Rehabilitation.

3. Prevention, Health, and Social Services
    a. Housing
        1. Create a master plan transition for individual when displaced.
        2. Scale up Assembly Bill (AB) 109 bed capacity and Forensic Full-Service Partnership resources.
        3. Expand successful housing models for individuals with mental health needs, including:
            1. Improve concept of, and number of beds for board and care facilities (also known as ARFs).
            2. Expand acute inpatient beds.
            3. Expand IMD sub-acute beds.
            4. Expand Enriched Residential Services (ERS) beds.
            5. Contribute to and/or offset the cost of families providing housing for their loved one.
            6. Expand the number of Forensic Inpatient Beds (FIP) in the community-based settings.
            7. Develop sober living homes that understand the needs of individuals with mental health treatment needs and are willing to work with these clients.
            8. Develop Clubhouse living facilities for people with severe mental disorders that can also act as intermediaries for supported employment.
            9. Expand interim and permanent supportive housing.
            10. Develop and expand subsidized housing alternatives for people with serious mental disorders enabling them to live with dignity on their SSI and/or disability checks.
            11. Scale up innovative programs that comprehensively provide housing, wraparound services, and career-track employment for justice-impacted individuals.
        4. Landlord Support:
            1. Make it attractive for landlords to enter into partnership with County departments and providers.
            2. Provide staffing on housing site with an understanding of the neighborhood while resourcing the landlord and client.
            3. Increase relationship management for landlords and support landlord liaisons.
    b. Mental Health:
        1. Attract and support development of a workforce capable of delivering integrated health, mental health, substance use treatment through strategies such as recruitment and training of more health professionals; support of livable wages at community-based organizations to better enable parity with County-operated facilities; and expand community-based intervention teams to respond to the spectrum of mental health crisis that enable the warm handoff to give people access to supportive services rather than jail or the hospital.

2. Direct 911 calls about behavioral health crises that do not require a law enforcement agency response toward the Department of Mental Health's ACCESS line in order to redirect individuals to intercept 0 services and mental health practitioners like PMRT, HOME, and E6 Homeless Teams. A system approach beyond 911 or ACCESS could be developed as an alternate destination for non-law enforcement calls.
3. Integrate and coordinate such efforts with One Degree – the health and wellness resource linkages website and app-based tool utilized by Whole Person Care in Los Angeles County.
4. Create coordinated service hubs in strategic locations across the 8 Service Planning Areas (SPA) where people can seek referral and/or immediate admission to a spectrum of services. These services, include but are not limited to, mental health, supportive housing via the coordinated entry system, triage to appropriate level of care, and/or substance use disorder services such as withdrawal management (formerly known as detox), Medications for Addiction Treatment (MAT), and recovery intake centers (also known as sobering centers); and explore opportunities to leverage similar existing sites operated by other County departments that advance these same goals.
5. Expedite the expansion of Psychiatric Urgent Care Centers across all 8 SPAs while connecting them to aforementioned service hub network for warm handoffs to optimal services.
6. Increase capacity of the Office of the Public Guardian to investigate and manage Mental Health Conservatorships for individuals considered gravely disabled as a result of a mental health disorder.
7. Expand the Mental Health Court Linkage Program with additional staffing and beds for clients. Expand resources and case workers to every courthouse in county.

c. Substance Use Disorder Treatment:
    1. Require that mental health clinicians build their capacity and expertise to provide integrated substance use disorder care with psychiatric treatment, including support for cross training efforts for all levels of clinicians.
    2. Support risk reduction strategies when patients with mental health disorders continue substance use rather than removing psychiatric medications; and educate patients who use alcohol and/or opioids on MAT options (e.g., methadone, buprenorphine), and prescribe such medications and/or refer to an Opioid Treatment Program (OTP) when indicated.
    3. Deliver integrated mental health and substance use disorder (SUD) services, rather than parallel services such as adding on a psychiatrist to a SUD treatment plan.
    4. Build partnerships between DPH-SAPC and DMH for residential Co-Occurring Disorder (COD) services.
    5. Expand and create a decentralized system of recovery intake centers (also known as sobering centers) available to patients with only mental health disorder, only SUD, or co-occurring disorder service needs.
    6. Support parity in substance use disorder as a chronic disease like other long-term physical and mental health conditions by implementing similar enhancements in the SUD system to better address the prevention and treatment needs of individuals with SUD only, which may include those with mild or moderate mental health conditions.
d. Primary Care:
    1. Build a decentralized system of health campuses similar to the Martin Luther King Behavioral Health Center (MLK BHC) or the restorative care village at Olive View-UCLA Medical Center in Sylmar at other county hospitals, rehabilitation centers, and/or community service hubs.

4. Alternatives and Diversion
    a. Scale up the District Attorney Mental Health Division's partnership with the Office of Diversion and Reentry to successfully divert hundreds of individuals into permanent housing and long-term case management while partnering with community-based organizations as part of a comprehensive approach to addressing individuals' holistic needs.
        1. Partnership with families, ensure workforce is trained to address the continuum of need, ensure that the individuals plans are culturally sensitive and include those not eligible for community-based diversion (i.e., violent felony charges).
        2. Recovery Bridge Housing (Sober Living) and licensing should be included in the spectrum of offerings as well as in-patient and outpatient services.
        3. In coordination with law enforcement and community-based service providers, expand pre-arrest / pre-booking diversion programs for people whose justice system involvement is driven by unmet behavioral health disorders.
    b. Develop and expand diversion efforts at local jails within the county and sheriff sub-stations by connecting individuals to treatment or other health and social services in their local neighborhoods as an alternative to incarceration and as soon as intercept zero.
    c. Establish effective restorative justice programs for the adult population by learning from existing County programs especially those serving youth. New funding should be aligned to scale-up these models, and County departments should change their practices to employ them instead of an arrest-and-incarceration approach wherever possible. Monitor to ensure restorative justice programs are fairly applied and culturally responsive.
    d. Connect every individual who is diverted to DMH for care.
    e. Frame as Whole Person Care, which includes: funding mental health services and substance use services, fund whole person services for justice involved individuals like violence prevention, gang intervention, art therapy, occupational therapy and other programs.

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

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.*

Goal 1B – Potential Strategies:

1. *Mental Health Disorder, Substance Use Disorder, Housing and other Health and Social Programs:*
    a. Remove time limits to service provisions that prevent access to long term treatment plans. For example, many Medi-Cal funded programs have short durations of service, leaving gaps when people lose eligibility. Gaps also exist around transportation to and affordability of services.
    b. Integrate peer support organizations by working with them and sharing information, schedules and meeting information.
    c. Work with families to help assess client's needs, provide one to one assistance for each client through various stages of treatment needs, connect them with County wide resources and housing programs, to various housing opportunities and programs, to employment and volunteer opportunities, to occupational therapy, to vocational rehabilitation, to LATC classes and to transportation to various appointments and meetings.

d. Work with various Housing State Funding (HCD), DHS Housing programs and Housing projects such as Villages of Cabrillo for people experiencing homeless and mental health disorders to address housing needs.
e. 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.
f. Establish a family feedback database to track services, providing information on what works and what doesn't to prevent incarceration and recidivism and promote recovery.
g. Incentivize organizations to expand services beyond 9am-5pm weekday only operating models through establishment and management of contract.
h. Remove barriers to treatment, employment, and recovery housing based on record of past convictions through state legislative intervention or updating county policies. For example, those with felony charges working through 5-year probation plea bargains can't get jobs and can't find housing outside of the county system. Even when they have stabilized and are doing well background checks will show they have a conviction record.
i. Advocate for payment reform within contracts to ensure providers can deliver treatment and support for all needs (mental, physical, housing, etc.) concurrently.
j. Create incentives for clients and support network to follow prevention and treatment plans. To help clients adhere to treatment plans, psychiatric and therapy services need to work with the client's personal needs and obstacles. Family involvement is crucial to treatment adherence and needs to be part of provider policy. This will require DMH to modify its HIPAA policy to provider contracts to allow practitioners to talk to families. HIPAA allows practitioners to talk to families when the patient/client is incapacitated, and it would be in the best interest of the client to do so. California law follows HIPAA closely regarding the protection of personal health information.

Goal 2: Expand the Community Based System of Care, A

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.*

a. Create less challenging and more reasonable procedures for not for profit agencies to contract with the County of Los Angeles
b. Fund Organizational Development and Capacity Building as an investment in building and sustaining the community-based system of care
c. Create equitable and diverse resources and target investments that address racial, cultural, gender and special population needs county-wide.
d. Re-orient systems and services to support a client-centered model of service.

Goal 2A – Potential Strategies

1. Incubate New Organizations, Services and Innovative Practices
    a. Utilize and coordinate with the DMH Incubation Academy, WPC Capacity Building Program, LAHSA and other Capacity Building Programs to find and support smaller organizations in different service areas to qualify for and access county funding for reentry, mental health and substance use disorders, and co-occurring services through a long-term investment.

b. Provide training and technical assistance on how to become services providers which can include MediCal Fee Waiver information, Accessing County Funding, Accessing State Funding, Organizational Coaching, etc.
c. Generate seed funding for new organizations as incubatees (i.e. Acumen-patient capital/micro-loans, For Us by Us).
    1. Utilize partnerships with philanthropy, business loans, flexible government dollars, pay for success models, and/or zoned area investment like in South Los Angeles
d. Promote existing service providers as potential incubators for smaller, newer service providers that have specialized expertise: cultural competence, neighborhood relationships, connections, etc.
e. Provide ongoing infrastructure support and professional development.
f. Incubate new innovating employment programs for people with serious mental health disorders.

2. Support Existing, Effective Models
    a. Support effective models that are servicing people 24 hours a day, 7 days a week with a specialization. Support should be based on intensity, staffing, language and culture needs, lived experience staff, quality, accountability and attracting pay differential.
    b. Gather feedback from service providers currently receiving County funding, and those who are not, to better understand continuing participatory hurdles as well as identifying County innovations that are making a positive impact.
    c. Connect existing contractors to current and new capacity building resources that support them in sustaining their organizations and expanding best practices.
    d. Generate flexible service delivery rules and payment reform to move to performance-based contracts instead of fee for service.
    e. Dedicate funding to long-term and sustainable infrastructure support for community-based systems of care beyond service component like workforce development, basic infrastructure, incentives to grow, training, recruitment, and organizational development (administrative, contracting, finance, budgeting, etc.).

3. Promote Organizational Partnerships and System Integration
    a. Insure a public private collaboration in all phases of planning, system oversight, implementation and evaluation.
    b. Develop a uniform client data database across all county services that follows the person regardless of system access point.
        1. Practical interface
        2. Info following the client
        3. Address clinician/privacy issues/consent around HIPAA
        4. Create uniform database for different points of entry
        5. Real-time data available to providers and public
    c. Incentivize programs that work in strong partnership with other service providers to ensure more access to a wide variety of support systems that include large, medium, and small non-profits.

Goal 2: Expand the Community-Based System of Care, B

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

Goal 2B – Potential Strategies

1 Create a process for equitable resource and contract distribution with program offices across health and social service departments that take into account racial and cultural needs, gender, special populations and geographic needs.

2 Standardize a simplified, more accessible contracting process across agencies and departments while engaging in an outreach plan to connect service providers who might benefit from this reform. Following the lead of the Department of Health Services' work to drastically simplify its Master Services Agreement, all reentry-related County units should adopt this qualifying template and go further to reduce barriers.

3 Prioritize funding to organizations that work with special populations (people with sex offenses, transgender individuals, etc.).

4 Through the Community Engagement Workshops and the Reentry Health Advisory Collaborative develop dialogue and the creation of community-based alternatives.

Goal 3: Coordinate Community-Based Services

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 3 – Potential Strategies:

1. Equitable Distribution of Resources:
    a. Develop a way to assess and improve racial equity and resource distribution by analyzing and utilizing a tool (Race Forward's Community Benefits Agreement, Racial Impact Tool, or Advancement Project's JENI/JESI, etc.) while involving county and community stakeholders in the process.
    b. Support system impacted communities in equitably distributing and leveraging additional resources to sustain the health of the community.

2. Service Coordination
    a. Create service connections with community-based organizations, county departments, and community members through regional coordination, information sharing, and providing toolkits and training resources for multi-agency case conferencing.
    b. Set up a quarterly meeting with multiple stakeholders to communicate up to date ATI progress, discuss service and communication gaps, and highlight best practices.
    c. Establish a recurring meeting with county departments to discuss policy impacts, resolve policy conflicts, and assess service eligibility barriers.
    d. Develop an online mechanism for tracking identified problems and response progress through an accessible dashboard.

3. Education and Outreach

a. In conjunction with the Community Engagement Ad Hoc Committee work on asset mapping activities to increase the awareness of available CBOs and county resources, their specialty, and their capacity through online information and written outreach materials.
b. Develop on-line interface linking service providers and tracking service availability to elevate the tremendous amount of resources across LA that never get brought to bear and are disconnected (employment, housing, economic resources).
c. Develop a communications plan that focuses on campaign messaging, webinars, and social media tools to educate and inform community and county stakeholders about the different types of community based solutions such as supportive prevention services, pre-release services, stabilization services, mental health crisis (including and excluding law enforcement), overdose prevention programs and diversion opportunities available through CBOs and the County Health Agency.

Goal 4: Expand Community Health Worker and Peer Support Models to provide holistic support.[3]

Description: *To be developed at a later point.*

Goal 4 – Potential Strategies

1. Increase CHW Employment:
    a. Create education training and career advancement pathways by working with institutions like local community colleges and universities to create a certification or education credential for CHWs.
    b. Create pathway for CHWs to move up into full-time, salaried County jobs with benefits (i.e., Eligibility Workers, Peer Support Group Facilitators, etc.) in order to support themselves and limiting contact with the justice systems

2. Increase the number of Community Health Workers (R-ICMS CHWs, WPC CHWs) and other peer navigators by hiring and training individuals with lived experiences (including justice involvement, mental health needs, substance use disorder, and/or people who are experiencing homelessness) to follow through via warm handoff to immediate services needed when returning home. There is a significant need to expand the use of CHW's to ensure warm handoff to services.

3. Explicitly tailor County contracting to incentivize service providers to incorporate the community health worker model in their service delivery work which would expand service capacity, build cultural competency, improve client/provider trust, and provide vital career track possibilities for the formerly-incarcerated – as well as addressing the significant workforce needs of a scaled-up alternatives-to-incarceration infrastructure.

4. Increase points of contact/engagement for CHWs to connect with clients outside of justice involvement

5. Expand CHW case management to include the individual's family and loved ones who play the role of immediate support pre and post incarceration.

6. Support training resources for Community Health Worker Model

[3] Before moving forward with strategies for CHW policies, procedures, and implementation, it is essential that this piece be informed and developed by CHW's in the County. Below is a draft of recommendations that we will utilize to engage CHWs on best practices and areas in need of restructure.

JUSTICE SYSTEM REFORM
AD HOC COMMITTEE

Part 1: Issues, Analysis, and Recommendations

SUB-TOPIC A: CASE PROCESSING SUBGROUP

Goal 1: Improve Diversion and Alternatives within the Court System

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.*

Item 1: Improve Equal Access to Treatment Resources

A. Issue

There are insufficient community-based mental health treatment placements available, including locked facilities, to provide an alternative to custody for people with behavioral health disorders who have been arrested and charged with a crime but who are eligible for Penal Code section 1001.36/1370 Mental Health Diversion, and/or could be released from jail to an appropriate treatment program pending trial or disposition.

B. Analysis

Remapping the criminal justice path of an individual with a clinical behavioral health disorder who was arrested and is in jail requires access to sufficient community-based placements and to sufficient forensic psychiatrists and psychologists to conduct timely/expeditious mental competency evaluations and/or Penal Code sections 1001.36 and 1370 Diversion assessments. Additionally, there is an insufficient number of doctors who speak non-English languages to evaluate non-English speaking people who are currently incarcerated.

C. Recommendations

Item 1 – Potential Strategies

1. Improve equal access to all treatment resources for justice-involved individuals, wherever they may be (in or out of custody).
    a. Encourage the Board of Supervisors to direct DPH/DMH/DHS to change eligibility criteria to ensure that all existing and future mental health placement resources are available to all people with mental health disorders in all stages of the criminal justice process.

    b. To conduct intensive and extensive outreach at medical schools and professional organizations for qualified mental health forensics, providing incentive bonuses for bilingual experts.

    c. Create a front-end system with behavioral health professionals that enables the prosecutor to make a determination to provide diversion instead of filing charges or filing reduced

charges, including, but not limited to, coordinated sharing of behavioral health disorders without harming rights.

2. Involve the public more in the court/justice system, obtain input from community.

Item 2: Education of Justice Partners on Mental Health Diversion

A. Issue

Notwithstanding legislative enactment of Penal Code sections 1001.36 and 1370 Mental Health Diversion which allows the court to divert/place into community treatment an individual with a mental health disorder arrested and charged with a crime for behavior that was related to the individual's mental health disorder, justice partners are slow to address this change of legislative policy.

C. Recommendation

Item 2 – Potential Strategies

1. Increase collaboration (not adversarial process) to enable better outcomes that are trauma informed and respect individual care and rights.

    a. Conduct educational seminars for justice partners about mental health disorders and mental health treatment as a first step in changing the culture of the criminal justice system to one that seeks treatment first whenever possible, not incarceration and punishment for people.

Item 3: AB 1810 – Mental Health Diversion

A. Issue

The criminal justice system does not currently have a robust system to truly provide AB 1810 Diversion.[4]

B. Analysis

Persons with mental health and/or substance use disorders spend longer times in jail due to the time it takes prosecutors and/or defenders to identify potential mental health diversion. There are insufficient mental health assessment and diversion teams for the caseload and multiple criminal court locations.

Arraignment stage is a missed opportunity for the mental health evaluations and off-ramping into a potential AB 1810 diversion analysis. The Court requires a trusted set of mental health experts to provide an analysis of AB 1810 or post-plea diversion, robust warm handoffs for the success of the programs and persons involved, and good court reporting. The Office of Diversion and Reentry is crafting an AB 1810 pilot but this really needs to be in all of the courts. It is critical to have all of the properly curated group of prosecutors, defenders, courts, and mental health team to ensure success (mental health teams). The

[4] *AB 1810: establish a procedure of diversion for defendants with mental health disorders through which the court would be authorized to grant pretrial diversion, for a period no longer than 2 years, to a defendant suffering from a mental health disorder, on an accusatory pleading alleging the commission of a misdemeanor or felony offense, in order to allow the defendant to undergo mental health treatment. The bill would condition eligibility on, among other criteria, a court finding that the defendant's mental health disorder played a significant role in the commission of the charged offense. The bill would authorize a referral for mental health treatment to be made to a county mental health agency, existing collaborative courts, or assisted outpatient treatment only if that entity has agreed to accept responsibility for the treatment of the defendant, as specified.* California Legislative Information. "Assembly Bill No. 1810. (June 2018). https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201720180AB1810.

specialized mental health teams should receive joint trainings and jointly develop policies, etc. to establish trust and comradery.

C. Recommendations

Item 3 – Potential Strategies

1. Create a robust AB 1810 and PC 1001.36 diversion system led by mental health teams in every courthouse or judicial district that starts the identification of eligible persons as early in the court process as possible and connects them to individualized community-based treatment services. Access to these diversion programs should be available to any individual eligible for diversion, without regard to the location of the judicial district in which the person was arrested.

Item 4: Filing Stage Diversion

A. Issue

The criminal justice system does not currently consider care and services at the Intercept 2 point (Initial Charges) through diversion/non-filings against persons exhibit substance abuse and/or mental health disorders.

B. Analysis

Inequities exist at the pre-filing stages. The pre-filing stage is an opportunity to divert people out of the criminal justice system into treatment. The prosecutor has discretion to file charges and at what level. However, most of the time, the prosecutor is not aware of the person's health conditions. However, many times the law enforcement agencies do have information that could assist with the prosecutor's filing versus diversion determination.

C. Recommendations

Item 4 – Potential Strategies

1. Create a front-end system with mental health professionals that enables the prosecutor to make a determination to not file but to instead allow diversion.

Note – Divergence Point**:** Approaches for diversion opportunities for people with serious high-level violent felonies.

SUB-TOPIC B: PRETRIAL / BAIL REFORM

Goal 2: Reduce Pretrial Detention and Increase Services

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.*

A. Issue

Forty-four percent of the Los Angeles County jail population is pretrial, which means they are incarcerated without a conviction.[5] There is also an average daily population of 5,300 people in the County Jail who are classified as having a mental health disorder. The overlap within these two populations gives rise to a subset of people who are not convicted, yet incarcerated, and require a system of care to treat their mental health needs. Approximately half of the people in jail mental health housing (which does not include people who may be taking psychotropic medications but who are housed in the general population) are considered to be pretrial.[6]

LA County has seen an increase in the number of people held in the County Jail who need holistic behavioral health treatment and services in a therapeutic environment. It is widely agreed that a jail-based system of care is not conducive to improving mental health or treating substance use disorders; rather, it often exacerbates conditions.[7] The following discussion and analysis led to the proposed recommendations below which aim to meet the above stated goal of substantially and sustainably reducing pretrial incarceration of people with clinical behavioral health disorders.

B. Analysis

Pretrial detention exacerbates wealth and racial disparities by causing job loss; loss of housing; isolation from family and community, even the loss of children to the foster care system; destabilization of low-income communities of color; and threats to the health and safety of our most vulnerable populations, particularly of those with behavioral health disorders.[8] Short-term jail confinement causes trauma, exacerbates current mental health disorders, and can even cause mental health disorders where they were previously absent. The additional financial burden of release through money bail and fines and fees further destabilizes accused individuals.

For those without the financial means to afford bail, this means a loss of freedom and pretrial incarceration while legally innocent. This impact is much worse on people with clinical behavioral health disorders, particularly those that are poor and whose financial conditions often lead to justice system contact.

Risk of failure to appear in court is also often cited as a reason to detain people pretrial. Sometimes people simply forget they must go to court, don't plan for it or do not fully understand the consequences of staying home. Others may have clinical conditions that impact their ability to appear in court but who would be able to do so with the right clinical supports.

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[5] LASD, Custody Report.

[6] LASD Report for May 20, 2019: "2,115 'M' people in jail mental health custody who were sentence status 1, which was about 12% of the whole population (17,303). If we were to look at the mental health population only, which was 4,211, the percentage would be about 50% of the mentally ill are sentence status 1. It should be noted that an inmate who is sentence status 1 could be in trial, or even completed trial, but just not fully sentenced, but most are likely pretrial."

[7] For a review of the health impacts of incarceration see David Cloud, *On Life Support: Public Health in the Age of Mass Incarceration* (New York: Vera Institute of Justice, 2014); Julia Acker, Paula Braverman, Elaine Arkin, Laura Leviton, Jim Parsons, and George Hobor, *Mass Incarceration Threatens Health Equity in America* (Princeton, NJ: Robert Wood Johnson Foundation, 2019), https://www.rwjf.org/en/library/research/2019/01/mass-incarceration-threatens-health-equity-in-america.html; and Dora M. Dumont, Brad Brockmann, Samuel Dickman, Nicole Alexander, and Josiah D. Rich, "Public Health and the Epidemic of Mass Incarceration," *Annual Review of Public Health* 33 (2012):325-339.

[8] Saneta deVuono-powell, Chris Schweidler, Alicia Walters, and Azadeh Zohrabi. Who Pays? The True Cost of Incarceration on Families. Oakland, CA: Ella Baker Center, Forward Together, Research Action Design, 2015; see also *Christopher T. Lowenkamp, Marie VanNostrand and Alexander Holsinger, Hidden Costs of Pretrial Detention, Laura and John Arnold Foundation (November 2013).*

Los Angeles County does not have a separate, independent pretrial entity tasked with reducing pretrial detention and connecting accused people with the services they need. Although the County has successfully launched diversion and reentry programs, these services provide for post-conviction assistance or for those who are incompetent to stand trial. The County has yet to fully address the conditions that cause continued law enforcement and justice system contact for people with behavioral health disorders earlier on in their legal proceedings.

We can look to models of pretrial reform in San Francisco County and Santa Clara County, jurisdictions which established independent pretrial services departments in 1976 and 1969 respectively. San Francisco County pretrial services is held by The San Francisco Pretrial Diversion Project (SF Pretrial), an independent nonprofit organization.[9] Santa Clara County's Office of Pretrial Services is an independent county agency established in 1969 which also compiles monthly statistics by tracking judges' release rates and defendant outcomes. These reports are shared with the courts, system partners, and the Board of Supervisors, allowing for continuous improvement, communication, and coordination. In 2013, Santa Clara expanded their court reminder system to use text and email notices (after they surveyed defendants on communication preferences), resulting in a 3% decrease in its failure to appear (FTA) rate. They have also been developing a pretrial app for defendants that will provide information on court dates, times, locations, supportive services, and other information.

[9] *See* San Francisco Pretrial Diversion Project. http://sfpretrial.org/ and https://www.sccgov.org/sites/pretrial/Pages/Office-of-Pretrial-Services.aspx. (Accessed May 24, 2019).

C. Recommendations

Goal 2 – Potential Strategies

1. Develop a Needs and Strengths-Based System of Pretrial Services: Establish decentralized cross-functional teams[10] to coordinate behavioral health needs and strengths assessments *pre-booking* and connect individuals with clinical behavioral health disorders to community-based systems of care through warm handoffs. Establish an independent cross-functional entity that is situated outside of any law enforcement agency. This cross-functional entity should be centered on a human centered, value-based, coordinated care model by incorporating personnel from various health departments, housing, employment, education, service providers, etc. to conduct needs and strengths assessments and connect people to a holistic set of services tailored to individual behavioral health disorders.

2. Expand Cite and Release Practices and Policies: When law enforcement agencies do come into contact with someone with clinical behavioral health disorders, they should cite and release at the point of contact and ensure a warm handoff to service providers whenever possible. For people with those needs who are taken to a police station, they should be assessed *prior to booking* for release, utilizing a needs and strengths assessment, with the presumption of release with a warm handoff to service providers.

3. Reduce Failure to Appear: Support the return to court, especially for those with clinical behavioral health disorders, with:
    a. Text and telephone reminders (provide cell phones and/or service as needed making sure correct number is on file), explaining potential consequence of non-appearance (and making sure to address any issues that may prevent lack of understanding);
    b. Transportation (via vouchers, ride sharing, etc.);
    c. Childcare;
    d. Evening court hours so employment is not impacted;
    e. Clear verbal and written instruction that assure that the person truly understands what they need to do and where they need to be (if they are unable to comprehend link with social services or advise PD);
    f. A good line of communication with their public defender, who will also require more support. (the PD should, from interviews with the client, be determining a need for mental health support pre-trial); and
    g. A speedy court date, especially for those needing long term services. (specifically, behavioral health treatment).

[10] Cross-functional teams are defined as a team of professionals from various health departments, service providers, community-based organizations, and others without any law enforcement component.

SUB-TOPIC C: MENTAL HEALTH AND LAW ENFORCEMENT

Goal 3: Reduce and Improve Interactions between Law Enforcement and Mental Health; Increase Diversion Opportunities and Expand Training for Law Enforcement

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.*

Item 1: Crisis Response

A. Issue

Expanding access to effective crisis response that reduces the number of people with mental health and substance use disorders interacting with law enforcement, getting arrested, booked into jail, being charged, etc.

B. Analysis

The Subcommittee agreed that there were substantial barriers to people accessing effective non-law enforcement response for behavioral health crises, including significant wait times for callers calling DMH's ACCESS (Access to Community Care and Supportive Services) 24/7 line. These barriers are a problem because many situations do not need law enforcement response, law enforcement response may increase the likelihood of the situation escalating, and law enforcement responders are more likely to make arrests and book people into jail, thereby increasing the number of people with behavioral health disorders in the jails.

One best practice/model is Eugene, Oregon's CAHOOTS program in which 911 operators funnel almost 20% of 911 calls to teams of psychiatric social workers rather than to law enforcement. There are, however, significant barriers to implementing this model in Los Angeles. One is that DMH has a separate ACCESS line that is not integrated into Los Angeles County's 911 system, and also 911 operators who conclude that calls to their system would be best handled by DMH Psychiatric Mobile Response Teams (PMRT) cannot directly contact a DMH ACCESS operator, but must instead go through the same automated phone tree that members of the public encounter when they call the ACCESS line.

C. Recommendations

Item 1 - Potential Strategies

We propose a number of options for increasing non-law enforcement responses to behavioral health crises.

1. Improving staffing of DMH ACCESS line to minimize caller wait times;

2. Integrating DMH ACCESS line with 911, or alternatively providing a mechanism whereby 911 dispatch can gain direct access to DMH ACCESS line so they can expeditiously refer calls they conclude do not require law enforcement response;

3. Increase the number of DMH Psychiatric Mobile Response Teams (PMRT) to reduce service wait times;

4. Increase the number of crisis beds available in the County and implement a data base that tracks the beds available at each treatment facility to avoid delays and calling multiple hospitals to secure a bed;

5. Increase the ambulance contracts to improve response time;

6. Ensure 911 operators are sufficiently trained in mental health crisis assessment to identify behavioral health crisis calls that do not require a law enforcement response. 911 operators should be trained about LAPD-Mental Evaluation Unit (MEU) Line, LASD-MET Triage Desk, 211, ACCESS Line, Public Health Line and DHS Call line resources;

7. Creating a third option for behavioral health crises, e.g., increase level of mental health services provided by CBOs possibly accessed through mobile app or dedicated phone line; and

8. Invest in public education campaign to encourage people to use DMH ACCESS line, CBO network, or suicide prevention hotlines when appropriate rather than 911 for behavioral health crises.

Item 2: Collaborative Law Enforcement and Mental Health Clinician Teams

A. Issue

While there has been an increase and additional expansion is underway, there are not enough MET / SMART/Independent Police Departments co-response[11] teams to respond to all of the mental health-related calls received that require a response that includes law enforcement personnel. Some other Los Angeles County law enforcement agencies have no DMH/law enforcement co-response teams and other have co-response teams available only during daylight hours. Slow response time means fewer officers in the field will call the teams, not wanting to wait for them to arrive, and many people will not benefit from this effective intervention.

B. Analysis

Ideally, there should be enough SMART, MET and other co-response teams to respond to 90% in crises and arrive in time to help positively impact the outcome of the incident. Mental Evaluation Teams (MET) receive more than 700 hours of formal training and certifications to two (2) national standards with regard to nonviolent crisis intervention. MET personnel are trained to such a degree that they are nationally certified instructors in crisis de-escalation. Having a MET unit available and able to respond with patrol deputies to reported crises is like sending the equivalent of a mental health SWAT team to help patrol officers/deputies. It is no surprise then why crises are generally resolved more favorably, without uses of force, when MET or SMART units are on scene to help de-escalate.

For the Sheriff's Department, more than half (53%) of all 6,755 crises that resulted in a WIC §§ 5150 or 5585 "hold" in 2018 were handled by patrol deputies alone *without* MET support, due to insufficient

[11] We are using MET teams to refer to teams comprising law enforcement personnel and a mental health clinician. These are also known as co-response teams.

MET staffing. The Civilian Oversight Commission has recommended a minimum of 60 MET units; whereas, today LASD MET comprises just 33 regional units. A similar number of crises calls that did not rise to the level of a WIC §§ 5150 or 5585 "hold" in 2018 were also handled by patrol officers without MET support.

MET and SMART law enforcement/DMH co-response teams are *extremely effective* in de-escalating conflict between law enforcement and individuals with mental health needs and can help connect people to appropriate (and ongoing) treatment and services, instead of further justice system involvement. In its 2018 report, LASD MET teams demonstrated a significant decrease in use of force incidents and cost savings to the County. Fewer than 5% of calls handled by MET, SMART, and other Independent Police Department/DMH co-response teams resulted in arrest while 95% of cases received community-based referrals or services.

C. Recommendations

Item 2- Potential Strategies

1. Substantially increase the number of police / mental health collaborative response teams (SMART/MET) throughout the County – LAPD, LASD (60 minimum) and all other law enforcement agencies, to meet the growing need, as well as increase the availability of co-response teams in departments where such teams are currently available only during daytime hours. The majority of all mental health involved crisis calls to law enforcement should be responded by co-response teams on a 24-hour basis, seven days a week (24/7). This includes LASD/MET, LAPD/SMART, and Independent Police Departments' MET teams.

2. Implement non-crisis mobile response teams to address the gaps, as they have been identified:

    a. To provide timeliness of response, follow through with clients in crisis who do not meet criteria for involuntary hospitalization. An important need for these teams is to intervene at the earliest moment possible, responding out into the field to support and take action on client and family needs. If the teams are able to address an urgent crisis and begin to provide services, supports and linkage, emergent crises and involuntary psychiatric hospitalization can be averted, thus achieving decreased trauma on the clients and families and decreased inpatient costs for the County and Law Enforcement.

    b. Have peers as members of the mobile response teams, as long as it is clinically warranted. The teams will respond to clients and families with the position of attempting to keep the client out of the hospital/jail and providing ongoing support and linkage to services. Peers will create an additional level of trust from the clients and allows strong relationships to develop between the teams and clients.

Item 3: Alternative Clinical Settings

A. Issue

Individuals, families and law enforcement officers need more options for where to bring or refer people experiencing behavioral health crises. The County lacks a range of options for most communities all over the County, for people who do not meet 5150 criteria but need treatment and services of some kind.

B. Analysis

From service providers to law enforcement, there is a critical need to have accessible centers where people can go for services, be dropped off in times of need and or/crisis, and check in with health professionals with whom they are more likely to report accurate details about current needs, thus enabling better services and notifications to loved ones if possible. For example, the County does not have a behavioral health Urgent Care Center in all the Service Area Locations; there is none in Service Area 1, 3 or 7, and the one in Service Area 2 operates only 12 hours. These centers should be able to receive patients quickly and efficiently, so law enforcement and collaborative teams can immediately return to the field to provide services.

C. Recommendations

Item 3 – Potential Strategies

1. Develop and expand a decentralized range of clinical spaces throughout the county, including building a behavioral Urgent Care Center in Service Area Locations 1, 3, and 7 and having the one in Service Area 2 operate 24 hours a day, as well as the resourcing of current sites where there is capacity, that are accessible to law enforcement, families and individuals and provide a holistic service-based model informed by various health departments (DHS, DMH, Public Health) as well as CBO's identified by the work group. These spaces should be run solely by health and community-based organizations and include some combination of expanded sobering/detox centers, cooling off and respite centers, and mental health urgent care centers. Community health workers could conduct outreach to encourage individuals to utilize these centers and become engaged in a range of services (substance use treatment, housing, employment, etc.). Law enforcement and community members should be educated to understand these options as alternatives to 911 and arrest and jail.

Item 4: Community Education Campaign

A. Issue

Members of the public sometimes treat homelessness and mental health and substance use disorders as a law enforcement issue and seek law enforcement intervention to deal with the normal consequences of experiencing homelessness, such as living life in public on the street. This includes such things as movement into residential neighborhoods, sleeping and drinking in public, lack of sanitary facilities, lack of storage and cooking facilities, etc.

B. Analysis

Some of these issues can be addressed through supportive housing, shelters, substance use and mental health treatment, but the fact is that there is not enough affordable housing and many individuals are forced to live on the street or in their cars. So how do we accommodate the competing needs/desires of individuals experiencing homelessness and local residents / business owners and de-escalate the friction that can develop in these situations?

C. Recommendations

Item 4 – Potential Strategies

Work with community-based organizations and impacted individuals to develop a public awareness campaign to educate the public on what it means to be experience homelessness or have a mental health needs and to reduce the stigma associated with both. Incarceration should not be viewed as a solution to homelessness. The public should be educated as to non-law enforcement resources, such as the

Department of Mental Health Access lines and community-based organizations; de-escalation teams such as the MET teams; the possibility of mediating disputes between people who are experiencing homelessness/residents/business owners, building relationships between the local community, law enforcement, community based organizations, schools and mental health professionals. It would also be beneficial to have additional outreach workers to respond to these types of calls, with the support of law enforcement when required. There are a number of resources already in place, including the LA HOP Line which allows anyone in the community to make referrals for people who are experiencing homelessness or issues related to homelessness. LA HOP triages the referrals to determine who is the best entity to handle it, i.e. LAHSA, E6, HOME, etc.

Item 5: Crisis Intervention Team (CIT) Training

A. Issue

Provide specialized training to law enforcement first responders and 911 dispatchers and desk personnel to improve responses to behavioral health calls, with the goal of improving the safety of people experiencing crises, officers and others and connecting people with appropriate treatment and care instead of arrest and booking into jail custody.

B. Analysis

To date, only 20% of Sheriff's Deputies in patrol have completed CIT training. This training must be prioritized as a mandate for officers/deputies new to patrol (within their first year) as with the LAPD Mental Health Intervention Training. DeVRT (De-Escalation and Verbal Resolution Training) should continue to be a requirement for all custody deputies.

Continued training and refresher training is of the utmost importance for LASD, LAPD and all local law enforcement officers, both custody and patrol. There is not always the option of back-up and MET units, which makes the training of individual sworn officers/deputies essential in their responses to people in behavioral health crisis, to identify signs of a behavioral crisis, de-escalate potentially volatile situations, provide appropriate treatment and services to those in crisis and to prevent injury and loss of life. CIT training should connect police officers to community-based resources and peer responders and focus on developing those relationships so that officers can connect families and individuals to appropriate services and see these services as a treatment-first alternative to punitive responses such as arrest and jail. It has been proven that a training by an officer/deputy and clinician is highly effective as it demonstrates a unified effort.

C. Recommendations

<u>Item 5 – Potential Strategies</u>

1. All law enforcement officers in Los Angeles County should be trained in a formal CIT curriculum that incorporates connections and networking with neighborhood-specific community-based resources with a treatment-first approach. LAPD has a 40-hour training that is taught by Officers and Clinicians. Other municipalities have a 16-hour training similar to LAPD's training.

2. New curriculum should be developed for 911 dispatchers and desk personnel. CIT refresher courses are needed to help ensure first responders practice the skills every year or two after the initial CIT training. Mandated refresher training should include the use of training simulators and/or live

scenario training where officers/deputies must probably demonstrate their ability to de-escalate patients to ensure they are capable of doing so when on patrol.

SUB-TOPIC D: MENTAL HEALTH COURT PROGRAMS

Goal 4: Increase and Improve Access to Treatment Services for Court-Involved People

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.*

Item 1: Client Access to Appropriate Level of Treatment

A. Issue

Client access to the appropriate level of treatment based on a clinical determination regardless of court program.

B. Analysis

The group consensus was that when developing a treatment plan for each client it is most important that decision-making be "client-focused" rather than "court program" focused. Clients should be able to access the appropriate personal level of care as the priority. Court programs should be able to choose from the county's available treatment resources what services will be in the clients' best interest clinically regardless of where the referral is originated.

Today's diversion and alternatives to incarceration programming is comprised of different entities (ODR, DMH, SAPC, etc.) that have different resources and treatment responses under their specific jurisdictions. Therefore, someone in an ODR program might not have easy access to another level of program or treatment not provided by ODR. For example, if one needed a secure facility environment for appropriate treatment services such as provided by Olive Vista in Pomona, it may not be easily included for the ODR client. Likewise, someone graduating from a Court Linkage program may not have adequate access to DMH or ODR housing. These are bureaucratic and funding roadblocks that do not put the client first.

C. Recommendations

Item 1 – Potential Strategies

1. Increase the capacity of alternative treatment programs for individuals with justice involvement (Intensive Outpatient, secure Mental Health Residential Treatment Facilities, Dual Diagnosis Residential Treatment Facilities, IMDs). Expand and integrate court-based services in terms of "staffing on the ground" in order to service as many individuals as possible as rapidly as possible.

Item 2: Consistent Diversion Practice

A. Issue

There is currently no coherent strategy that clearly identifies protocols to refer individuals to the diversion programming that will assist that person most effectively. Current placements appear to the public as random and not based on clinical or other individual needs.

B. Analysis

Our workgroup could not identify a coherent strategy that explains why cases "land" where they do.

Should there be a protocol that identifies best practices in referring diversion cases to a specific program? Current practice appears almost random and, again, does not put the needs of the client first, but rather the needs of the criminal justice system first. Such protocols should be clear and transparent to the community, so the right individual is referred to the appropriate entity that can assist that individual with the most effective resources for that person.

C. Recommendations

Item 2 – Potential Strategies

1. Develop a coherent strategy for directing clients to the appropriate court-based program at the inception of the diversion dialogue. The decision to refer an individual with serious mental health needs to a particular program or service should be based upon the best fit available and amenable to the client.

Item 3: Real-Time Data System Depicting Diversion Resources

A. Issue

Our existing mental health courts have carefully planned for the resources (housing, treatment, etc.) that will be required to adequately serve their participants. The linkage that connects our designated mental health courts to treatment resources is defined by the development of the program. This is not the case for the remainder of the county's criminal justice courts.

B. Analysis

We spent most of our discussion on the Court Linkage Program and general concepts. Time constraints did not allow us to brainstorm how, under AB 1810, all Superior Courts will need to access treatment resources for their participants. There has been no initial preparation linking treatment, housing, mental health and SUD treatment resources to the overall criminal court system that will be participating in PC 1001.35-.36 cases. How will all of the non-Mental Health Courts cope with the complexity and geography of our county's treatment resources?

As defendants pass through our regular criminal court system, there has been no advance linkage of treatment, housing, and other resources to all of the county court houses. How will a judge and the court team be advised of what resources are available in their area and the availability of a particular program in real time? Who will arrange for easy access by the court and the individuals to be served?

C. Recommendations

Item 3 – Potential Strategies

Improve awareness of existing Mental Health Court Program resources (and availability thereof) among judicial officers and court personnel (e.g. utilize software to develop a real-time map of all existing alternative placements)

Item 4: Underutilization of Conservatorships

A. Issue

Conservatorships and temporary conservatorships are underutilized to transition currently incarcerated people to long-term care in the community.

B. Analysis

Historically, the Los Angeles County Conservatorship Investigator refused to initiate conservatorships for people in jail custody, arguing that jail is a "suitable alternative" to Lanterman-Petris-Short (LPS) conservatorship (see W.I.C. §5354). This meant that conservatorship could not be established until an individual was released from custody. Many, if not most, of these individuals would not receive discharge and transition services and the establishment of a conservatorship would require new 5150/5250 hospitalizations.

Two significant statutory changes in 2018 support early intervention with conservatorships. W.I.C. §5352.5(a) was amended to provide that "The custody status of a person who is subject to the conservatorship investigation shall not be the sole reason for not scheduling an investigation by the conservatorship investigator." In addition, Penal Code §1001.35 implemented a new state policy favoring diversion of criminally charged people with mental health needs into local treatment services. These changes call for increased initiation of LPS conservatorships for qualified individuals.

C. Recommendations

<u>Item 4 – Potential Strategies</u>

1. Formalize and implement the link between jail and conservatorships through a Board of Supervisors order stating a policy directing the use of LPS conservatorship for people in custody and people who have been diverted who, because of mental health needs, are considered gravely disabled under the statute.

2. Designate additional agencies (as permitted by current statute) to directly apply to the court for LPS conservatorship.

3. Separate the conservatorship investigator and public conservator functions so that each is independent and free from conflicts of interest.

4. Explore expanding forensic full-service partnerships under the aegis of additional County agencies.

Item 5: Conservatorship Processes

A. Issue

The current processes used to establish LPS conservatorships are mired in counterproductive tasks and are ill-suited to current clinical practice.

B. Analysis

The current processes used to establish conservatorship are based on a 50-year old model driven by a care system that no longer exists.

State hospitals are no longer the essential initiator of conservatorships. Institutions for Mental Disease are no longer a primary tool for long-term care and are largely disconnected from modern approaches to care such as the recovery model, supported decision-making and community supports.

C. Recommendations

Item 5 – Potential Strategies

1. Conservatorship recommendations should be initiated by provider sources. Hospitalization should not be required to do this as sufficient statutory authority currently exists for the local mental health director and/or the director's designee(s) to initiate the conservatorship process. However, legislative change should be sought if there is resistance to initiating conservatorships from the community.

2. The current LPS conservatorship investigator should be required to collect and track efficiency and effectiveness data. Based on these data, process simplification and task reduction should be undertaken to improve the initiation and establishment of conservatorships. The metrics currently collected should be examined to determine whether they are adequate to serve this purpose. The DMH should establish a pilot project to test and validate these approaches. Process and outcomes data should be compared to current practices.

3. Support-based placement and wrap-around services may be considered as an alternative to IMD placement for conservatees. Similar options should be explored for placement during the conservatorship investigation and court process to facilitate clients being treated in the appropriate level of care. T-Con powers may be adequate to accomplish these tasks.

4. The statutory requirement of an individualized treatment plan within 10 days of the establishment of a conservatorship should be strictly enforced by the court (see W.I.C. §5352.6). That plan should be developed by the treatment provider and its tasks, deadlines and outcomes should be enforced by the court.

SUB-TOPIC E: REENTRY

Goal 5: Improve Reentry Practices

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.*

Item 1: Release Dates

A. Issue

Unpredictability of release dates and after-hours releases of currently incarcerated.

B. Analysis

Release planning for currently incarcerated people who are experiencing mental health needs, substance use disorders, homelessness, medical conditions and other issues has expanded significantly in the last two years, with over 3,000 people at a time in LA County jails now receiving release planning services. One of the biggest barriers to success for these programs is the unpredictability of release dates and after-hours releases. Release planners expend considerable effort to secure a client's linkage to a community-

based treatment or housing bed, only to discover that the client has been unexpectedly released early, and often in the middle of the night. In many cases, the bed is never accessed, the client is lost to follow up, and the opportunity for connection to services missed.

Approximately 40% of currently incarcerated people are pre-sentence, and approximately 20% are partially sentenced; for these people in custody, release dates are not predictable because their court process is ongoing. They may be released at any upcoming court date, and in many cases are released directly from court without returning to jail. People with mental health needs are required to return to jail to be cleared for release by a mental health clinician. While this is meant to help ensure safety, this often results in people with mental health disorders being released from jail late at night, after returning from court in the early evening and waiting to be cleared and processed out.

For currently incarcerated people who are sentenced, the Sheriff's Department (LASD) lists an expected release date on its web-based portal, but this date often turns out to be incorrect. In some cases, it may not reflect any additional open charges. Sentences may be shortened after milestone credits are applied from jail work programs and educational programs, and the credits are applied at irregular intervals depending on when class providers submit attendance information. In some cases, the application of these credits triggers immediate release. LASD also reduces sentences for many people in custody due to overcrowding, based on a percentage of time to be served (current percentage is 10%). Individuals in custody who are sentenced in court to a short sentence may be released the same night due to the percent time calculation. There is no mechanism for an alert to be sent to release planning staff notifying them of changes in predicted release dates. Currently, release planners must manually look up each case individually on the LASD portal to check whether a date has been added or the prior date has been changed.

Releases during evenings, nights and weekends pose challenges for linking clients directly to services, because even though some services such as interim housing and residential treatment programs operate 24/7, almost none accept new clients for intakes after normal business hours.

Coordinated releases can be requested to schedule a release for a specific date and time window in cases where the person is being picked up by a community program, Probation, or is being transported directly to a program. These releases are arranged by social workers, medical case workers, and in-reach staff from community-based organizations, and are facilitated at the point of release by the LASD Community Transitions Unit (CTU). A CTU Custody Assistant hand-walks the person individually through each step of the release process to the waiting provider outside the jail door.

In 2014, California Senate Bill 833 was passed, which required jails to offer people the option of staying up to an additional 16 hours or until normal business hours, whichever is shorter. Jail release planners encourage currently incarcerated people to take this option if they are released at night; however, when offered, few people choose to stay longer. Century Regional Detention Facility (CRDF) which houses women does not conduct releases after 10:00 p.m. unless the person is being picked up by a verified person. However, men are released from LA County jails around the clock.

C. Recommendations

Item 1 – Potential Strategies

1. Change release time policies for men to match those of women at CRDF, in order to ensure that people are not released overnight without the ability to link directly to programs or interim housing. As with women, men would be able to leave overnight if they have a safe place to go and verified transportation.

2. Provide funding to community-based organizations to expand intake hours for interim housing programs and treatment programs to include overnight and weekend hours.

3. Fund a transition center within a few blocks of the downtown jails, operated by a community based organization and providing a welcoming place to stay overnight for people released after hours, with beds, food, showers, telephones, clothing, service navigation and transportation.

4. Implement more frequent LASD recalculation of release dates for fully sentenced clients receiving release planning services, or provide data needed for release planning staff to better calculate the dates. Develop and implement an automated mechanism to notify release planning staff of release date updates/changes for clients receiving release planning services.

5. Reallocate resources to allow for an increase in coordinated releases for clients exiting directly to programs, so that a specific time and date for release can be set and linkage facilitated.

Item 2: Co-Occurring Disorder (COD) Treatment Services in Jail

A. Issue

To provide currently incarcerated people with co-occurring mental health needs and substance use disorders with a better chance at successful reentry, specifically to reduce the likelihood of substance use relapse and increase linkage and adherence to treatment in the community.

B. Analysis

Per the Bureau of Justice Statistics, 64 and 63 percent of currently incarcerated people in the United States met clinical criteria for mental health needs and substance use disorders (SUD), respectively. Furthermore, 76 percent of currently incarcerated people with mental health needs also met clinical criteria for SUD. In Los Angeles County Jail, the Department of Health Services (DHS) Correctional Health Services (DHS-CHS) estimates that among the approximately 5,000 people with mental health needs in the jails on any given day, 76% have a co-occurring SUD, for an estimated 3,600 people with co-occurring disorders (COD). They also estimate that many more currently incarcerated people on any given day report issues with alcohol and/or opioid use.

Prior to May 2017 there were no addiction services in the jails. DHS-CHS now operates the Substance Treatment and Reentry Transition (START) program, which provides in-jail SUD treatment to approximately 500 clients on any given day. The START program operates in 4 different facilities: at Pitchess-South Facility serving the general male population, Men's Central Jail serving the gay and transgender population, CRDF serving the general female population, and Twin Towers serving men with co-occurring mental health and SUD diagnoses (COD). The program uses evidence-based practices including cognitive behavioral therapy and motivational interviewing.

There are currently 95 COD treatment slots in START. Given the estimate of 3,600 people with COD, if half of those people agreed to start services while incarcerated, a total of 1,800 slots at a time would be required to meet the need. Starting treatment in jail takes advantage of the time in custody to begin services and better sets up clients to successfully continue treatment in the community.

Medication Assisted Treatment (MAT) can help clients with alcohol and/or opiate use disorder better engage in treatment, reduce cravings and avoid relapse. Comprehensive MAT services have been shown to reduce death from overdose, HIV transmission, and ongoing substance use. Studies in re-entry

populations have consistently demonstrated that offering MAT to correctional populations increases engagement in SUD treatment and MAT on release.

Currently in LA County jails, patients with alcohol and/or opiate use disorder are offered oral naltrexone, and pregnant women are offered buprenorphine. This is a good start but does not meet the level of a comprehensive MAT program. Community and correctional standards of care strongly recommend offering comprehensive MAT services, including buprenorphine, methadone, and long acting naltrexone, to correctional populations. These services can be safely implemented in the correctional setting and are evidence-based treatment and harm reduction strategies.

Finding SUD treatment beds in the community for individuals leaving jail is challenging. Many community providers have not previously accepted clients directly from jail. The Department of Public Health – Substance Abuse Prevention and Control program has been working to develop special referral mechanisms for this population and to identify agencies to accept them; however, only a very few agencies will accept clients with significant mental health needs.

C. Recommendations

Item 2 – Potential Strategies

1. Explore ways to incentivize community treatment facilities to accept patients from jail with co-occurring mental health needs and SUD.

2. Expand access to START program SUD treatment services in County jails from the current 500 people in custody to at least 1,000 people in custody, with the goal of expanding to serve all those in need and an emphasis on currently incarcerated people with co-occurring mental health needs and SUD.

3. Expand and enhance MAT treatment services in the jails to provide:
    a. A comprehensive withdrawal management program, including methadone and buprenorphine
    b. Full spectrum MAT for opiate use disorder, including buprenorphine, methadone, and long-acting naltrexone
    c. Specialty MAT clinics to allow patients to access patient-centered, harm reduction services on-site in the jail

COMMUNITY ENGAGEMENT
AD HOC COMMITTEE

Issues, Analysis, and Recommendations

A. Issue

The Community Engagement Ad Hoc Committee has been tasked to plan a series of community mapping and listening sessions in selected communities to hear, elevate, and empower community members and gather information from community members and community organizations about available and needed services, supports, and policies that promote alternatives to incarceration. We seek to understand what services and supports prevent incarceration and assist those re-entering their communities after incarceration. Where services are currently offered, we are interested in understanding who is being served and who has limited or no access to support. We recognize that community members need access to health, services, good employment, affordable housing, and thriving communities and seek to understand inequities in the distribution of resources and opportunities that promote well-being.

The Committee will organize workshops in seven communities that have been identified through the Million Dollar Hoods and Advancement Project assessments as a sample of areas where there are significant needs and gaps in resources available to prevent and address high rates of incarceration. Workshops will be held in the following communities: South LA with a connection to Compton, the Antelope Valley with a connection to Lancaster, East LA, Long Beach, Pacoima, the San Gabriel Valley, and Pomona.

Community members living in these communities and surrounding neighborhoods, along with service providers, will be invited to elevate their own concerns and suggestions for improvements. Although these workshops are not able to touch every region impacted by incarceration, the hope is that we will be able to continue these conversations with others in different areas of the county as we envision, improve, and implement the Alternatives to Incarceration Roadmap.

B. Analysis

The ad hoc committee is focused on designing workshops that create a meaningful, intentional, and respectful environment for individuals and families that have been directly and indirectly impacted by incarceration to share information, identify challenges, and suggest opportunities for efforts aimed at preventing incarceration and addressing the needs of people re-entering after incarceration. Worship participants also include key stakeholders such as service providers, advocacy organizations, and county health departments. The workshops will focus on soliciting and incorporating community feedback to shape recommendations for the final report and inform the full implementation of the roadmap for years to come.

To design a workable, effective alternative system to incarceration, it is necessary to meaningfully engage key stakeholders – primarily justice-impacted individuals & their families, though also including service providers and advocacy entities – in highly-impacted areas. This engagement will not function as a one-way, reporting-out process nor to simply gather assent to solutions prepared by others. The ad hoc committee's submission of findings from the community workshops should not stand alone and apart in the final report but, rather, be woven throughout the report – and directly inform (or reshape) interim recommendations drafted by the other ad hoc committees in advance of the community engagement.

C. Recommendation(s)

A. Workshop Process and Logistics

1) Elevate and honor community voices: The Alternatives to Incarceration Work Group and the Board of Supervisors affirm their intent to use community voices to inform choices and drive actual reform. Explicit commitments to follow-through – in terms of continuous community engagement on findings, recommendations, and implementation as the process moves along – would be an important step signaling that this community involvement is not an exercise but will drive change for the betterment of the entire County. Such assurances will not only build community goodwill and trust in the process – likely improving both the workshop's outreach efforts and quality of responses – but will, ultimately, lead to alternatives that best suit local circumstances and are most apt to succeed in preventing, diverting from, and healing from incarceration here in Los Angeles County.

2) Include those most impacted by incarceration: The community engagement strategy will utilize a strength-based asset mapping approach while identifying gaps in services and resources. The ad hoc committee will connect to existing organizations, community advisory boards, and/or community facilitators to co-host workshops in the prioritized communities with a goal to elevate the leadership of people that have been impacted by the justice system. Outreach efforts will aim to ensure that vulnerable subpopulations such as formerly incarcerated people, LGBTQ, youth, family members of people who are incarcerated, houseless community members, and line staff in service organizations, are invited and able to fully participate in the workshops. Unions, schools, churches, service providers, and community organizations will be enlisted to both support outreach efforts to those most impacted by incarceration and to participate in the workshops. The workshops will also invite members of the Sheriffs Oversight Committee, DPH Regional Health Teams and DMH Service Advisory Coordinating Committees (SACC) to participate, and build on recent outreach efforts of LAHSA, the DPH Office of Violence Prevention, WPC Collaboration Team, and other community- based organizations. While law enforcement will not be invited to attend the workshops, they will be informed about the meetings and asked to support community members wishing to participate. The workshop will include discussions on how to best work effectively with law enforcement and recommendations from the workshops with be subsequently shared with police and sheriff departments.

3) Support participants and equitable participation: To maximize community participation, stipends should be offered to community members to cover costs related to workshop participation, including childcare and transportation. The workshops will be held after work hours or on weekends to support greater involvement in the process, and healthy food should be offered. There is also a need to have childcare available during the workshop so that parents and caregivers are able to participate. The workshops will also follow ADA requirements and provide language translation. Resource tables and resource staff will be present at each workshop to link participants to available services related to housing assistance, legal assistance, entitlement programs, and health services.

   The format at each workshop will include interactive activities so that all participants can fully engage and share their ideas, perspectives, and concerns. An opening speaker will ground the workshop and set the tone for the work we will try to accomplish. Community members will be recruited to serve as facilitators and facilitation training will be provided.

4) Provide on-going communication: Use social media and outreach activities to advertise the community workshops, and employ various strategies including robotic calls and emails to communicate with workshop participants. Ensure that appropriate feedback loops and media communication plans are developed in partnership with workshop participants so that individuals

are engaged and aware of how information will be utilized for the ATI reports, as well as for any additional planning documents.

B. Engagement of Currently Incarcerated People

Hold 3 workshops in the county and/or local jail system and 1 workshop in a juvenile hall to solicit feedback from individuals that are currently incarcerated in LA County. Workshop attendees should be able to participate without any risks; information gathered at the workshop will be treated as confidential and will be shared without attribution or identifying information. Additionally, incarcerated individuals should be allowed to provide information through anonymous surveys or postings that will be managed by the Health Agency. The Office of Diversion and Reentry, Department of Mental Health, the Sheriff's Department, and other partners should help plan for workshops to be held between June and December. The outreach for engagement of currently incarcerated people may also include connecting to family members who currently have a loved one incarcerated in Los Angeles County.

C. Advisory Collaborative of Impacted People

The creation of an advisory collaborative is necessary to ensure there is continuous feedback and accountability to the prioritized communities and LA County at large in the implementation of the comprehensive roadmap. The advisory collaborative will communicate community solutions to the ATI work group and can serve to review recommendations and drafts of the final report. The advisory collaborative can also interface with local law enforcement to support the communication of community needs and feedback after the workshops. Possible sources of support for the Advisory Collaborative include the Whole Person Care Re-entry Health Advisory Collaborative and the DPH Office of Violence Prevention Community Council.

FUNDING
AD HOC COMMITTEE

The Alternatives to Incarceration Funding Ad Hoc Committee was established to assess and outline resources needed to implement recommendations by the Alternatives to Incarceration Work Group to scale up ATI services in the County.

While the funding needs assessment will be based on programmatic recommendations ultimately developed by partnering work groups, the Funding Ad Hoc Committee continues to lay the foundation for considerations that may be weighed and potential findings and recommendations. To that end, the Funding Ad Hoc Committee provides the following update for the ATI interim report.

Funding Landscape

In advance of recommendations from other work groups, the Funding Ad Hoc Committee has begun to draft an at-a-glance matrix of key funding streams that can potentially support the scaling up of ATI efforts. When developed, this document will identify funding streams, eligible uses, current county policy for utilization, and scale of funding available to the County. While the ad hoc committee is not positioned to line item budget recommendations from each fund, the matrix will help identify gaps and support the Board of Supervisors and Chief Executive Office in identifying potential sources of funding for this work.

Ad Hoc Committee Focus Areas

Based on initial discussions among its members and preliminary information from other ad hoc committees, the Funding Ad Hoc Committee has identified the following principles and areas for exploration that can guide funding recommendations.

Funding Principles – The Funding Ad Hoc Committee has developed a shared set of principles to guide its recommendations.

1. *Racial and Geographic Equity* – Does funding promote racial & geographic equity?
2. *Care Integration* – Do funding strategies adequately leverage multiple funding streams and support an integrated system of care?
3. *Transparency* – Does funding reflect transparency in public budgeting and spending, as well as input from stakeholders and communities?
4. *Fiscal Sustainability* – Are funding recommendations grounded in sound fiscal principles and practices that ensure the sustainability of programs and the overall county budget?

Scope of Services – A full spectrum of services will need to be funded to address ATI needs, including:

1. Substance use disorder treatment services, including medication assisted treatment
2. Mental health treatment services
3. Housing
4. Education and skills building
5. Employment development, placement, and ongoing support
6. Systems navigation services
7. Transportation
8. Family unification and support services
9. Community organizing to facilitate community education and engagement

Identifying and Leveraging Criminal Justice and Public Health Resources – To support the ATI effort, the County should continue to explore and review policies that maximize resource availability in order to meet the full scope of ATI recommendations. Areas that the work group and county can explore include, but are not limited to:

1. Partnerships across departments to maximize existing funding and integrate service delivery
2. Anticipated growth in funding streams that has not yet been allocated
3. The development of county policies and practices, when possible, that promotes the flexible use of funding in order to ensure that needed programming is provided to individuals, regardless of their case type or status
4. Legislative efforts and county advocacy strategies to maximize external funding, including Medi Cal funding
5. Partnerships with philanthropic organizations, particularly for supporting infrastructure development in the community
6. Net County Cost (NCC) budget allocations
7. Calculation and reinvestment of justice savings
8. Grant opportunities

Effective Distribution of Resources – In addition to direct services to ATI participants, funding will need to address key collateral needs:

1. Capacity building efforts
2. Contracting/procurement facilitation
3. Data sharing efforts
4. Support for crime survivors
5. Support for individuals impacted by the justice system
6. Continued research and evaluation

Item: Medi-Cal Coverage

Issue

To support the ATI effort, the County should continue efforts to maximize resource availability in order to meet the full scope of ATI recommendations, including advocacy at the state and federal level.

Analysis

The California Department of Health Care Services is beginning the process of identifying changes to the scope and populations covered by Medi-Cal as part of its new Medicaid waiver with the Federal Government that would take effect in 2021. The final waiver provisions will significantly impact the scope of services funded under the program and shape available resources for eligible individuals involved with the justice system.

Potential Strategies

1. The County should advocate for changes that would expand services and populations covered by Medi-Cal to support integrated service delivery to 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.

DATA & RESEARCH
AD HOC COMMITTEE

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

Recommendation

It is the recommendation of this Data and Research Ad Hoc Committee to expand justice data transparency including access, analysis, and metrics designed to prioritize continuous engagement of individuals and communities who are most impacted by both the justice system and systemic racism. The intended result of this recommendation is to provide real-time data sharing to build capacity in the communities most impacted by the justice system, to shift the power dynamic from government to community, increase the nimbleness of community responses, and improve accountability of agencies. As it stands now, the most impacted communities are not involved in the collection or analysis of the data which results in less meaningful and accurate information. The most impacted community members and providers can be the technologists, not just serve in a consultation role.

1. Provide paid training and employment to ensure that justice system impacted individuals are the technologists behind data collection and analysis;

2. Expand collaborative data collection to retrieve data necessary for services, programming, preventative measures, and alternatives to incarceration; Collect and promptly disseminate quality data – including diversion, alternatives to incarceration and reentry service scope, capacity, and funding support – necessary to enable public accountability. Likewise, capture and circulate relevant data to gauge how well Los Angeles County is diverting residents from incarceration or meeting their needs once incarcerated, with associated budgets. Data on individuals who have been diverted should be captured and analyzed in order to report accurate measurements of progress and to ensure the outcomes we are getting are both positive and sustainable. Ensure data is always disaggregated by race and ethnicity.

a. ***Data on pathways into and out of incarceration:*** There is a clear need for better understanding of who is being incarcerated in Los Angeles County, and therefore the level of capacity needed for a robust alternatives-to-incarceration approach. Notably, there are clear, direct, and well-substantiated links between mental health needs, homelessness, substance addiction, and incarceration, but public LASD data does not provide sufficient information to understand the overlap between these populations, their respective average lengths of stay, and demographic information including race and ethnicity. Likewise, more specific and timely data is needed on who is being diverted from incarceration, and the extent to which these approaches reduce race-based disparities as well as reducing incarceration overall. Data needs also extend beyond the County to all arresting agencies, including LAPD.

b. ***Data on services for system-impacted people:*** Comprehensive information regarding County-supported services – such as inventorying current County contractors and subcontractors, populations served, current vs. potential capacity, allocation (and unspent reserve) levels, and geographic distribution of all services funded by these County contracts – will make it possible for the County and advocates to better assess current practices' efficacy and equity while identifying clear opportunities for improvement. This data must include core diversion and re-entry services, but also the broader range of programs that serve people across all intercepts.

c. ***Tracking incarceration spending*:** The County's status quo largely funds services and alternatives to incarceration with restricted revenues, including grants and state and federal funding streams, while devoting the lion's share of flexible, locally generated revenues to incarceration. Better tracking and disclosure of the costs of the incarceration system, including per-bed spending, will help the County understand the tradeoffs of the current approach, and the potential advantages of scaling up non-incarceration alternatives that can free up savings for reinvestment. Cost savings, cost avoidance, and effectiveness can be also quantified in comparison to the costs of incarceration.

d. ***Additional Data****:* The Data and Research Ad Hoc Committee is compiling a comprehensive list of data needs to address for the final report that includes requests from the other ATI committees.