DRAFT 11/18/15

Council on Mentally Ill Offenders (COMIO)

COUNCIL MEMBERS

Jeffrey A. Beard, Chair
Secretary, California Department of Corrections and Rehabilitation

Manuel Jimenez, Vice Chair
Behavioral Health Director, Alameda County

Pamela Ahlin
Director, California Department of State Hospitals

Jessica Cruz
Executive Director, National Alliance on Mental Illness (NAMI) California

Alfred Joshua
Chief Medical Officer, San Diego County Sheriff's Department

Jennifer Kent
Director, California Department of Health Care Services

Dave Lehman
Retired Chief Probation Officer, Humboldt County

Stephen V. Manley
Santa Clara County Superior Court Judge

David Meyer
Clinical Professor/Research Scholar, USC Keck School of Medicine

Lester P. Pincu
Professor Emeritus of Criminology, CSU-Fresno

Mack Jenkins
Chief Probation Officer, San Diego County Probation Department

Charles L. Walters
Retired Assistant Sheriff, Orange County

{DATE}

{NAME}, Chair
Assembly Budget Committee
State Capitol, Room 6023
Sacramento, CA 95814

Dear Assembly Member {NAME}:

Enclosed are a total of two copies of this letter and the 2015 annual report from the Council on Mentally Ill Offenders (COMIO) at the California Department of Corrections and Rehabilitation. COMIO is required by Penal Code Section 6044(h)(1) to file this report each year with the Legislature.

If you have any questions, please do not hesitate to contact me at {NUMBER}.

Sincerely,

{NAME}
{TITLE}

Enclosures

cc: Kristoffer Applegate, Assistant Secretary, Office of Legislation

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Council on Mentally Ill Offenders (COMIO)

California Department of Corrections and Rehabilitation

14th Annual Report, December 2015

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History and Purpose of the Council on Mentally Ill Offenders (COMIO)

On October 12, 2001, former Governor Gray Davis signed Senate Bill (SB) 1059 (Chapter 860, Statutes of 2001) (Perata), creating the Council on Mentally Ill Offenders (COMIO). The bill is codified as Penal Code Section 6044, which originally set forth a sunset date of December 31, 2006. In 2006, former Governor Arnold Schwarzenegger signed SB 1422 (Chapter 901, Statutes of 2006) (Margett), which eliminated the sunset date.

The Council's primary purpose is to "investigate and promote cost-effective approaches to meeting the long-term needs of adults and juveniles with mental disorders who are likely to become offenders or who have a history of offending." In pursuit of that goal, the Council is to:

- Identify strategies for preventing adults and juveniles with mental health needs from becoming offenders;
- Identify strategies for improving the cost-effectiveness of services for adults and juveniles with mental health needs who have a history of offending; and
- Identify incentives to encourage state and local criminal justice, juvenile justice, and mental health programs to adopt cost-effective approaches for serving adults and juveniles who are likely to offend or who have a history of offending.

The Council must consider strategies that improve service coordination among state and local mental health, criminal justice, and juvenile justice programs; and improve the ability of adult and juvenile offenders with mental health needs to transition successfully between corrections-based, juvenile-based, and community-based treatment programs.

Penal Code Section 6044(h)(1) requires the Council to "file with the Legislature, not later than December 31 of each year, a report that shall provide details of the Council's activities during the preceding year. The report shall include recommendations for improving the cost-effectiveness of mental health and criminal justice programs."

Composition of the Council

The Council is comprised of twelve (12) members. Existing law designates as permanent members: the Secretary of the California Department of Corrections and Rehabilitation (CDCR), the Director of the California Department of State Hospitals (DSH), and the Director of the California Department of Health Care Services (DHCS), with the CDCR Secretary serving as the chair. The vice chairperson is selected from the membership.

Other Council members are appointed as follows: three (3) by the Governor, at least one (1) representing mental health; two (2) each by the Senate Rules Committee and the Speaker of the Assembly, each appointing a representative from law enforcement and a representative from mental

health; one (1) by the Attorney General; and one (1) by the Chief Justice of the California Supreme Court. Six (6) members of the Council constitute a quorum.

As of this writing, the Council is currently comprised of the following individuals:

- Chairperson: **Jeffrey A. Beard**, Ph.D., Secretary, CDCR. The Secretary of CDCR is a statutorily required member and chair of COMIO. CDCR Undersecretary Diana Toche at times represented Secretary Beard on COMIO during 2015.

- Vice Chairperson: **Manuel J. Jimenez**, Jr., MA, MFT, Behavioral Health Director, Alameda County. Mr. Jimenez was appointed to COMIO by Governor Edmund G. Brown, Jr. in 2012.

- **Pamela Ahlin**, Director, DSH. The Director of DSH is a statutorily required member of COMIO. Dr. Mark Grabau at times represented Ms. Ahlin on COMIO during 2015.

- **Jessica Cruz**, MPA, Executive Director, National Alliance on Mental Illness – California. Ms. Cruz was appointed to COMIO by Governor Edmund G. Brown, Jr. in 2015.

- **Alfred Joshua**, MD, MBA, FAAEM Chief Medical Officer, San Diego County Sheriff's Department. Dr. Joshua was appointed to COMIO by Assembly Speaker Toni G. Atkins in 2015.

- **Jennifer Kent**, Director, DHCS. The Director of DHCS is a statutorily required member of COMIO. Ms. Kent was represented on COMIO by Brenda Grealish.

- **Dave Lehman**, Retired Chief Probation Officer, Humboldt County. Mr. Lehman was appointed to COMIO by the Senate Rules Committee (chaired by Senator Don Perata) in 2005.

- **The Honorable Stephen V. Manley**, Santa Clara Superior Court Judge. Judge Manley was appointed to COMIO by Chief Justice Ronald M. George of the California Supreme Court in 2010.

- **David Meyer**, J.D., Clinical Professor/Research Scholar, USC Keck School of Medicine. Mr. Meyer was appointed to COMIO by Assembly Speaker Robert M. Hertzberg in 2002.

- **Lester P. Pincu**, D.CRIM. Dr. Pincu was appointed to COMIO by the Senate Rules Committee (chaired by Senator Kevin de León) in 2015.

- **James W. Sweeney**, J.D., Legislative Advocate, James W. Sweeney and Associates. Mr. Sweeney was appointed to COMIO by Governor Gray Davis in 2002.

- **Charles L. Walters**, Ph.D., Retired Assistant Sheriff, Orange County Sheriff-Coroner Department. Dr. Walters was appointed to COMIO by Attorney General William Westwood "Bill" Lockyer in 2006.

Additionally, COMIO was supported by CDCR staff, including COMIO Executive Officer Kirsten Barlow, and Norine Occhipinti of the CDCR Office of the Secretary.

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Priorities of the Council in 2015

During its December 12, 2014 Council meeting, COMIO members identified a range of potential areas of focus and deliverables for 2015/16. In an effort to ensure COMIO's activities over the coming year yield products that are most timely, helpful, and relevant, the Council's Executive Officer conducted outreach to an array of key stakeholders to get their perspectives (including Administration, state agency, legislative, and judicial branch staff; county and non-profit behavioral health providers; state and local law enforcement; hospitals; and mental health and disability rights advocates). While the individuals consulted were not asked to provide a formal position on behalf of their organizational affiliations, they did provide helpful feedback. At its January 22, 2015 meeting, the Council unanimously approved prioritizing the following three areas of focus for 2015:

Identify and promote integrated, cost effective strategies to:

- ***Divert Persons with Mental Health Needs from the Criminal Justice System;***
- ***Improve First Responder Training for Encounters with Persons with Mental Illness; and***
- ***Prevent Youth with Mental Health Needs from Becoming Involved in the Juvenile Justice System***

In order to obtain information on each of these priority areas and to begin working to identify recommendations, COMIO established a committee for each of the three areas. The progress made and specific recommendations developed by each COMIO Committee are described in the remainder of this document.

COMIO recognizes that law enforcement personnel are not the only first responders needing additional mental health training. The Committee will continue to work with representatives from first responder organizations such as fire, corrections, emergency medical technicians, emergency medical services and hospital emergency room medical professionals to determine the increased levels of mental health training necessary in the future. It is anticipated that this work will focus on expanding on the training requirements established in Senate Bill (SB) 11 (Beall, Chapter 468, Statutes of 2015) and SB 29 (Beall, Chapter 469, Statutes of 2015), both relating to peace officer mental health training.

- *SB 11 - Added Sections 13515.26 and 13515.27 to the Penal Code, relating to peace officer training standards*
- *SB 29 - Added Sections 13515.28, 13515.29, and 13515.295 to the Penal Code, relating to peace officer training standards*

Pre-Trial Diversion of People with Mental Illness

Pre-Trial Diversion is Effective

One of the largest multi-site studies of jail diversion for persons with serious mental illness to date [which evaluated 14 grantees of the Substance Abuse and Mental Health Services Authority (SAMHSA) Targeted Capacity Expansion for Jail Diversion Program initiative][i] found that participants in jail diversion programs experience fewer arrests and less jail time in the one year following enrollment than in the prior year. Findings from an evaluation of six federal Jail Diversion Initiative sites found that jail diversion effectively reduces time spent in jail, does not increase public safety risk, links individuals to community-based services, and results in lower criminal justice costs.[ii] Connecticut's statewide "Supervised Diversionary Program" was implemented in 2008 to decrease the number of offenders who are incarcerated with a psychiatric disability and to keep them from recidivating. A recent evaluation found the program completion rate was 78%, and only 15% of program completers were rearrested within one year of discharge (compared to 42% of clients who did not complete the program). Nearly all (97%) program completers' criminal charges were dismissed.[iii]

When New York passed a state drug reform law in 2009, it provided a new "judicial diversion" option giving judges the discretion to link an expanded array of felony-level drug and property offenders to drug treatment -- without requiring the consent of the prosecutor. A study[iv] of the impacts of the new law found that it increased enrollment in court-ordered treatment by 77% and made treatment available to a higher risk/higher need population (i.e., individuals with longer and more serious drug use histories, more extensive criminal histories, and who faced more serious charges on their current cases). Over the first five years of the new law's implementation, more than 3,100 individuals were sentenced to diversion rather than jail. While treatment was found to be the largest cost driver in providing judicial diversion, New York projects the overall net benefit to have exceeded $16 million in the first five years of implementation. For every taxpayer dollar invested, there is a $3.56 rate of return.[v]

Recommendations

The COMIO Committee on Diversion, which was chaired by Council Member and Santa Clara Superior Court Judge Steven V. Manley, utilized the "Sequential Intercept Model" to approaching and organizing its research and recommendations. Developed by Mark R. Munetz, MD, and Patricia A. Griffin, PhD, the

Sequential Intercept Model provides a conceptual framework for communities to organize targeted strategies for justice-involved individuals with serious mental illness. Within the criminal justice system there are numerous intercept points — opportunities for linkage to services and for prevention of further penetration into the criminal justice system. Our recommendations generally fall within the first two, bolded categories below, offering recommended actions California can take to divert individuals with mental illness away from further criminal justice involvement:

(1) **Law Enforcement Contact**
(2) **Initial Detention/Initial Court Hearings**
(3) Jails/Courts
(4) Reentry
(5) Community Corrections

1. CALIFORNIA SHOULD EXPAND CRIMINAL JUSTICE - BEHAVIORAL HEALTH PARTNERSHIPS

Effectively keeping people with mental illness out of the criminal justice system can be a complex matter requiring substantial coordination, mutual agreement, information sharing, and clarified roles and responsibilities among local agencies. Therefore, California communities should create and highly utilize local task forces consisting of local agency leaders, consumers, and family members who share a commitment to: 1) keeping people with mental illness who do not need to be incarcerated living safely in the community and, 2) improving criminal justice-behavioral health service coordination. As noted in the Consensus Project[vi] report:

> *"The single, most significant common denominator shared among communities that have successfully improved the criminal justice and mental health systems' response to people with mental illness is that each started with some degree of cooperation between at least two key stakeholders—one from the criminal justice system and the other from the mental health system."* (Emphasis added)

Further, the Stepping Up Initiative toolkit[vii] on creating partnerships states, "Reducing the number of adults with mental illnesses in jails requires a cross-system, collaborative approach: no single system can accomplish this goal alone. It is essential to bring together the key decision makers and community leaders who can effect change."

Who should initiate the local partnership, and who should be at the table? Given the multiple demands, competing priorities, and day-to-day challenges of community leaders and the systems they administer, we believe partnerships could be more successful in achieving high participation if they are initiated and convened by one of the following: (a) County District Attorney; (b) County Sheriff; or (c) City Police Chief. Given their local influence (as well as their practical interest in reducing the numbers of individuals with mental illness who come into contact with the criminal justice system), these local officials are likely to inspire invited stakeholders to actively participate, prioritize partnership meetings, and follow through on initiatives the partnership group identifies. Other conveners likely to inspire active participation include: County Superior Court Judges, City Mayors, and County Executive Officers.

COMIO recommends including, at a minimum, the participants listed below. It is critical that agencies listed below be represented in meetings by the chief executive or his or her designee. As described in the Consensus Project report, this ensures that individuals with decision making authority are at the table, and signals to their subordinates and stakeholders that the organization is committed to the initiative:

- County Sheriff
- County District Attorney
- County Public Defender
- County Probation Chief
- County Superior Court Judge
- County Behavioral Health Director
- County Board of Supervisors Chair
- Community-based providers and faith leaders
- City Police Chief
- City Fire Chief
- Local Emergency Medical Services Authority (LEMSA) Administrator and Medical Director
- California Highway Patrol – local office leadership
- California Department of Corrections & Rehabilitation – local regional parole leadership
- Consumers and family members
- Community-based service providers and faith leaders
- Public and private hospital emergency department directors

How do you get stakeholders to the table? Communities should use and/or expand upon existing partnerships that already bring many of these individuals and groups together, including but not limited to:

- Community Corrections Partnerships (AB 109)
- Planning groups for local jail construction and jail rehabilitation projects
- Planning groups for the Mentally Ill Offender Crime Reduction (MIOCR) grant program
- Mental Health Services Act (Proposition 63) stakeholder planning bodies
- Crisis Intervention Teams
- Local Reentry Teams
- Criminal Justice Cabinets
- Multidisciplinary Teams
- Mental Health Court Teams

Additionally, communities should use strategies included in the Stepping Up Initiative Toolkit to ensure the timing, composition, staff support, and scope are likely to produce desired results. In particular, the report, "Getting It Right: Collaborative Problem Solving for Criminal Justice" provides a variety of concrete suggestions for consideration, and is available online at the toolkit web site: https://stepuptogether.org/toolkit.

What is to be accomplished by the collaborative group? As recommended by the Consensus Project report, once the group has made a commitment to improve the criminal justice and mental health systems' response to individuals with mental illness, it is critical that they begin their work by identifying and focusing their shared objectives. For example, these objectives could identify ways of working together to:

- Secure housing for inmates upon release from jail
- Efficiently share relevant client information and history among law enforcement, local jails, behavioral health service providers, and the judiciary
- Coordinate supervision, treatment, and case management for probationers
- Establish protocols across first responding agencies to clearly identify roles when all arrive at a call for service
- Identify opportunities to share training resources and classes across agencies.

If the local partners are specifically focused on how to reduce the number of people with mental illnesses in the local jail, for example, the Stepping Up Initiative toolkit provides technical assistance modules (webinar, planning guides, other tools) for each of the following steps a community can take together:

- Collect and review data on the prevalence of people with mental illnesses in jails and assess their treatment needs
- Examine treatment and service capacity and identify policy and resource barriers

- Develop a plan with measurable outcomes
- Implement research-based approaches
- Create a process to track and report on progress

2. AT INITIAL CONTACT, FIRST RESPONDERS AND LAW ENFORCEMENT SHOULD PROVIDE ASSISTANCE TO PREVENT INDIVIDUALS FROM BEING ARRESTED & INCARCERATED

COMIO recommends supporting efforts that ensure first responders and law enforcement are trained to identify individuals in mental health crisis and to link them to appropriate, locally available alternatives to jail and hospital emergency departments.

Recent research shows that even *briefly* incarcerating individuals with mental illness prior to diverting them to the community will cause more harm than good and should be avoided whenever possible. Specifically, a recent study of Connecticut's statewide diversion program compared individuals with mental illness who experienced "jail first" before being diverted to the community, with individuals who were diverted straight to the community at arraignment.[viii] While Connecticut's program aims to divert individuals with mental illness directly into treatment at arraignment, some program participants first spend some time in a jail before being diverted.[ix]

Using Medicaid claims data and arrest and incarceration data, the researchers found that the "jail first" diversion group had markedly worse reoffending outcomes (i.e., they were more likely to reoffend and faced incarceration more quickly) and did not motivate higher participation in treatment (i.e., they were no more likely to participate in outpatient services, they were no less likely to use crisis driven care). The researchers concluded that, "a brief incarceration before diversion to the community does not ultimately achieve the goals of the courts—reduced recidivism and improved public safety—whether by motivating participants to 'get with the program,' achieving precommunity-release stabilization, or otherwise."

A number of evidenced-based, cost effective models exist for providing community-based interventions to avoid arresting or incarcerating an individual in mental health crisis (e.g., Mobile Crisis Teams, Crisis Intervention Teams, training law enforcement in techniques to de-escalate a crisis and educating them about the available local alternatives to emergency rooms and jail). Family members should be utilized, when appropriate and available, for gathering relevant historical information about the individual and identifying potential housing options for individuals. Existing models are discussed in more detail in Recommendation 4.

3. INDIVIDUALS ARRESTED AND BOOKED SHOULD BE SCREENED, ASSESSED, AND RECOMMENDED FOR DIVERSION OR ALTERNATIVE COMMUNITY SUPERVISION RELEASE

Since there are likely to be individual instances and local communities in which pre-booking diversion is not feasible, COMIO recommends that individuals who are brought to the jail be screened and assessed to determine their suitability for diversion into treatment and/or community supervision in the

community. In conducting the screening and assessment, information that is readily available should be utilized, including information contained in police officers' initial reports of an incident and any prior mental health history and/or treatment while the individual was previously in jail custody.

The screening and assessment information gathered should be used to develop a pre-trial/pre-arraignment report to be presented to the Judge at the individual's first court appearance (i.e., when a decision is made as to bail or sentencing, when a decision is being made by the District Attorney). This should include information about the individual, and when appropriate, a recommendation for diversion that includes a detailed discharge plan. At each community's discretion, this approach could be applied to felonies, misdemeanors, or both. The approach may also be useful in cases in which individuals Incompetent to Stand Trial for a misdemeanor charge may be restored to competency in a community-based, setting.

An array of valid and reliable screening and assessment tools are available to provide communities with a number of options.[x] Additionally, COMIO strongly recommend providing training to parties in the judiciary system (i.e., judges, public defenders, district attorneys) to enable them to understand, interpret, and support the screening and assessment results and accompanying recommendations. The three areas listed below should be considered in an assessment:

(1) Mental Health Care Needs;

(2) Central 8 Criminogenic Risk Factors[xi]
- *History of antisocial behavior*
- *Antisocial personality pattern*
- *Antisocial attitudes/thinking*
- *Antisocial associates*
- *Family/marital problems*
- *Lower levels of education/poor employment history/prospects*
- *Lack of prosocial leisure activities*
- *Substance use*

(3) Physical Health Care Needs

Based on the results of assessments, a clear and specific discharge plan should be developed for the court to divert individuals with mental illness out of jail to community-based assistance and supervision. Additionally, courts are encouraged to use this option for individuals with mental illness who are in custody pre-trial simply due to an inability to make bail.

4. DIVERT TO WHERE? CALIFORNIA MUST EXPAND PSYCHIATRIC CRISIS CAPACITY AND AFFORDABLE HOUSING

In order to divert individuals away from jail, our local law enforcement agencies, courts, mental health consumers and their families, and treatment providers need viable options for evaluating, stabilizing, and linking people experiencing a psychiatric crisis to further assistance. Police-friendly drop-off locations for people in crisis are greatly needed in communities throughout California. While recent legislative and budget initiatives (e.g., Mentally Ill Offender Crime Reduction grant and Investment in

Mental Health Wellness grants) have provided opportunities for expanded psychiatric crisis capacity, it is clear that additional capacity is needed to provide the criminal justice system with viable alternatives to jail.[xii]

COMIO is currently aware of the following existing options for conducting an initial screening and stabilizing an individual experiencing a mental health crisis. This is not an exhaustive list. We strongly recommend an analysis be conducted to establish the degree to which the supply and variety of these options is sufficient to meet the substantial demand in California.

- *Mental Health Urgent Care Centers* (An example can be found in Los Angeles County, where individuals may be assisted with a crisis at any day or time for up to 24 hours. There are currently 4 operating in Los Angeles County, with 3 additional Centers being planned)
- *Private Psychiatric Hospitals*
- *Psychiatric Units in General Hospitals*
- *Emergency Departments in General Hospitals*
- *Crisis Intervention/Psychiatric Emergency Response Teams*
- *Peer-Run Respite Houses* (An example can be found in Santa Cruz County)

Given the high degree of co-occurring substance use disorders, and the extent to which substance use is a key criminogenic risk factor, crisis evaluation and stabilization services are needed which can also address detoxification and substance use disorder screening and treatment referrals as well.

Once a crisis is stabilized and an individual has been assessed and diverted away from jail, Californians need a safe and affordable place to live while receiving community-based treatment and support. While housing is not typically regarded as a high criminogenic risk factor, a recent study of Connecticut's Supervised Diversionary Program for individuals with mental illness found it to be a critical factor in the program's success.[xiii] Specifically, clients without stable housing were less likely to complete the program and more likely to recidivate. Since housing is a dynamic risk factor that is possible to change for the better, the study authors recommend that Connecticut target housing problems early in the course of clients' participation. Additionally, one of the largest multi-site studies of jail diversion to date evaluated 14 jail diversion programs for persons with serious mental illness (grantees of the SAMHSA Targeted Capacity Expansion for Jail Diversion Program initiative).[xiv] The study found stable housing to be strongly related to reductions in recidivism among program participants.

COMIO is currently aware of the following existing housing and residential options. This is not an exhaustive list. We strongly recommend an analysis be conducted to establish the degree to which the supply and variety of these residential options is sufficient to meet the substantial demand in California. In addition to the options below, family members can be an excellent source of information, as well may be willing and able to provide temporary or permanent housing to individuals.

- *Mental Health Services Act Full Service Partnerships (FSP)*, which include housing supports. Statewide, there were 35,110 individuals being served in FSP programs statewide in FY 2011-12.
- *Mental Health Rehabilitation Centers (MHRCs)*, which provide 24-hour program services designed to assist clients to develop skills to achieve self-sufficiency and independent living in the community. Statewide, there are 22 MHRCs with total beds of 1,369.

- *Psychiatric Health Facilities (PHFs)*, which provide 24-hour acute inpatient care designed to be a lower-cost alternative to acute psychiatric hospitals. (Note: PHFs are prohibited by state regulations from admitting or treating individuals with primary diagnoses of chemical dependency disorders). Statewide, there are 28 PHFs with total beds of 504.
- *Skilled Nursing Facilities (SNFs)/Special Treatment Programs (STPs)*, which are 24-hour programs that serve clients with a chronic psychiatric impairment whose adaptive functioning is moderately impaired. Therapeutic services assist individuals with self-help skills, behavioral adjustment, interpersonal relationships, and pre-vocational preparation. Statewide, there are 26 SNF/STPs with total beds of 2,338.
- *Community Residential Treatment Services (CRTS)*, which provide 24-hour treatment in a home-like setting to individuals with mental illness who are unable to care for themselves in independent living. There are three categories of CRTS, including 1) Short-Term Crisis Residential (an alternative to acute hospitalization that may last up to 3 months); Transitional Residential (an activity program that encourages utilization of community resources for up to 18 months); and Long-Term Residential (provides rehabilitative services for up to three years to help individuals develop independent living skills). Statewide, there are 100 CRTS with total beds of 1,227.
- *Permanent Supportive Housing*, which is affordable housing combined with voluntary supportive services in which service providers proactively engage tenants and offer treatment plans. Statewide, there are 50,057 permanent supportive housing beds in California.[xv]
- *Board and Care/Adult Residential Facilities,* provide care for adults age 18-59, who are unable to provide for their own daily needs. Statewide, there are 5,078 Adult Residential Facilities with 38,862 total beds in California.

5. DIVERSION SERVICES MUST TARGET CRIMINOGENIC RISKS AND NEEDS, NOT JUST TREAT MENTAL ILLNESS

A recent study of offenders with mental illness has challenged a long held assumption that the psychiatric symptoms (e.g., hallucinations, delusions, impulsivity, anger) of people with a serious mental illness are to blame for the crimes they commit. To the contrary, researchers are finding that crimes committed by *most* offenders with a serious mental illness are completely independent of mental illness symptoms.[xvi] Researchers are now acknowledging that diversion programs that focus primarily on controlling mental illness symptoms have little impact on recidivism. Instead, most offenders with mental illness may benefit from interventions that target the risk factors shown to reduce recidivism for other offenders without a mental illness.

Connecticut's statewide Supervised Diversion Program for individuals with mental illness has found that addressing offenders' mental health problems is only part of the solution to reducing recidivism and keeping clients engaged in the program. Specifically, individuals with more extensive criminal histories and higher criminal risk factors (Criminal Companions, Alcohol/Drug, and Attitude/Orientation) were found to have lower program completion rates and be more likely to be rearrested. Therefore, the program evaluation authors recommend that supervision officers aggressively target criminal risk factors after ensuring clients are connected with mental health providers: "One way of thinking about the connection between mental health treatment, criminal risk, and recidivism is that improving mental health symptoms is important so that the probationer can work on reducing their criminal risks, but alleviating distress does not replace the importance for intervention around criminogenic needs."[xvii]

One of the largest multi-site studies of jail diversion to date evaluated fourteen jail diversion programs for persons with serious mental illness (grantees of the SAMHSA Targeted Capacity Expansion for Jail Diversion Program initiative).[xviii] The study found that participants in jail diversion programs experience fewer arrests and less jail time in the one year following enrollment than in the prior year. However, the strongest predictor recidivism among participants with serious mental illness is the same as for people without mental illness – prior criminal involvement. Therefore, this study suggests that diversion programs must specifically target changeable, criminogenic risk factors, not just improved mental health and service connectedness.

Next Steps

Areas COMIO may further explore in the following year on diversion could include:

- Identify effective practices for information sharing across agencies for purposes of coordination and diversion away from the criminal justice system;
- Identify best practices for collecting and analyzing data for agencies to assess the effectiveness of their strategies;
- Identify regulatory or legislative barriers to California expanding diversion strategies; and
- Identify a diverse array of both large and small county examples being used in California today.

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First Responder Training for Encountering Persons in Mental Health Crisis

The COMIO Committee on First Responder Training, which was chaired by Council Member Charlie Walters, sought to develop an understanding of the training is that currently delivered to the variety of professionals in California who serve as "first responders" to individuals in mental health crisis. These first responders in California communities include:

- Police Officers;
- Sheriff's Deputies;
- California Highway Patrol Officers;
- Paramedics and Emergency Medical Technicians;
- Emergency Dispatchers;
- Fire Fighters; and
- Hospital Emergency Department Personnel.

Additionally, the Committee on First Responder Training recognized that the following criminal justice and public safety personnel are also frequently in contact with individuals experiencing a mental health crisis:

- County Probation Officers;
- State Parole Agents; and
- State, County, and City Correctional Officers.

In order learn about the array of training mechanisms used to address all of the above first responder professionals, the COMIO Committee on First Responder Training benefitted from information provided by an array of subject matter experts, to which we are indebted for their assistance. These included, but are not limited to:

- Shawn Ahern, Captain, Sunnyvale Department of Public Safety, Bureau of Fire Services
- Jan Bullard, Assistant Executive Director, Standards and Development Division; Ralph E. Brown, Senior Consultant, Basic Training Bureau; and Janna Munk, Senior Consultant, California Law Enforcement Officers Killed and Assaulted in the Line of Duty (LEOKA); California Commission on Peace Officer Standards and Training (POST)
- Pat Frost, Administrator, Contra Costa County EMS Authority
- Evonne Gardner, Deputy Director, Standards and Training for Corrections Division, California Board of State and Community Corrections (BSCC)
- Lisa L. Heintz, Chief Clinical Program Administrator, Division of Adult Parole Operations, California Department of Corrections and Rehabilitation (CDCR)
- Sheree Kruckenberg, Vice President, Behavioral Health, California Hospital Association
- Captain Danny Lamm, California Highway Patrol (CHP)
- Elena Lopez-Gusman, Executive Director, American College of Emergency Physicians – California
- Michael J. Richwine, Assistant State Fire Marshall, California Department of Forestry and Fire Protection (CAL FIRE), Office of the State Fire Marshall

- Pricilla Rivera, Manager, Personnel Standards Unit; Sean Trask, Chief, Emergency Medical Services (EMS) Personnel Division; and Jennifer Lim, Deputy Director, EMS Policy, Legislative & External Affairs; California Emergency Medical Services Authority (EMSA)
- Dr. Gregory H. Sancier, San Jose Police Department (Retired Crisis Intervention Team Trainer), Crisis and Mental Health Consultant

Additionally, COMIO staff participation in the following events over the past year substantially helped inform our understanding of issues concerning first responder training:

- California Statewide Crisis Intervention Team Conference, Monterey
- NAMI National Convention, San Francisco
- NAMI California Annual Conference, Orange County
- POST Workshops to update the curriculum for peace officer training academy on "People with Disabilities" (Learning Domain 37)

FINDINGS

1. A COMPREHENSIVE OVERVIEW OF CURRENT MENTAL HEALTH TRAINING FOR FIRST RESPONDERS IS LACKING

Once embarking on our efforts to better understand existing first responder training, it became quickly apparent to COMIO that a comprehensive description of the current training on mental health and the systems through which training is delivered is currently not available in California. The variety of first responder and public safety professionals described on the previous page each have different employers and different levels of authority when encountering an individual in need of assistance. Additionally, their federal and state regulatory agencies vary, as do their statutory requirements to obtain initial and ongoing training.

First responder and public safety personnel training on mental health vary greatly in content, frequency, quantity, and method of delivery. The role of the California Commission on Peace Officer Standards and Training (POST) has some overlapping oversight for training across different types of personnel since some personnel must meet POST statewide standards as a "peace officer" as well as any additional training standards their employer may require. In some cases, we learned that training in mental health is quite lacking.

Based on the research and outreach we conducted, COMIO developed the list that follows on the next page, which describes which agencies are involved in the training of the array of first responders and correctional staff in California.

First Responder Type	Employer	Agency that Regulates Training Standards
State prison correctional officers	CA Department of Corrections and Rehabilitation (CDCR)	POST and CDCR
State hospital police	CA Department of State Hospitals (DSH)	POST and DSH
Parole agents	CDCR	POST CDCR
County jail deputies	County Sheriff's Departments	POST and BSCC
City jail officers	City Police Departments	POST and BSCC
County juvenile detention facility probation officers	County Probation Departments	POST and BSCC
Highway patrol officers	California Highway Patrol (CHP)	POST and CHP
City and special district police officers	Cities and Special Districts	POST
County sheriff's deputies	County Sheriff's Departments	POST
County probation officers	County Probation Departments	POST
Paramedics, EMTs, Dispatchers	State, Counties, Cities, and Special Districts	California Emergency Medical Services Authority (EMSA)
Firefighters	State, Counties, Cities, and Special Districts	Cal Fire - Office of the State Fire Marshall

2. The Goals of Providing Mental Health Training Vary, But Can Still Be Complimentary

The COMIO First Responder Training Committee learned that while the objectives of providing first responders with mental health training may vary, it can nevertheless improve officer and consumer safety, and reduce public agency costs. Specifically, first responder training might be designed to achieve one -- or all -- of the following goals:

- Divert individual away from criminal justice system to other crisis services
- Minimize emotional trauma for individual and officer
- Improve peace officer safety
- Reduce injury and use of force of consumers
- Deescalate a crisis situation and/or prevent suicide

3. First Responders in California Desire Additional Training in Mental Health

Personnel from nearly every sector with whom we spoke indicated "more" training in mental health would be welcome, given the frequency with which they come into contact with individuals in crisis. However, despite their interest, many first responder agencies appear to be limited by competing priorities for other important training topics, as well unable to cover the cost of compensating employees covering the duties of their coworkers while they attend training. In spite of these resource challenges, some agencies do find a way to go beyond (in some cases, far beyond) statutory minimums for mental health training.

4. First Responders in California Want Much More Access to Jail & Emergency Room Alternatives

The first responders with whom we spoke expressed a great need for access to additional mental health crisis resources that are alternatives to jail and hospital emergency rooms. Many of these individuals had a strong desire to take people in crisis to some place other than jail or the emergency room, but felt those options are extremely limited in their communities.

Priorities for 2016

An area for potential focus in a subsequent year is the mental well-being of first responders themselves. It is critical for California to support the mental health and resilience of its first responders and public safety personnel, given the stressful nature of the job and the accumulated trauma experienced by many of these professionals. However, given time constraints, the Committee was unable to delve deeply into this area and to identify specific recommendations in this report.

Additionally, the Committee is interested in continuing to learn more about the training delivered to correctional staff, probation staff, and parole staff. The Committee would like to develop specific recommendations aimed at improving the impact of mental health training in California.

The Committee may also examine high priority First Responder Mental Health Training:

- Identify the need to broaden the scope and definition of training, and work towards policy change, for first responders;
- Identify the need to provide additional mental health training for fire, EMT, EMS and hospital emergency room medical professionals;
- Identify best practices for collecting and analyzing data for agencies to assess the effectiveness of their Mental Health first responder training strategies.

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Effective Programs for Preventing Juvenile Delinquency

The COMIO Committee on Preventing Juvenile Delinquency, which was chaired by Council Member Dave Lehman, focused on identifying programs and strategies that take a *primary* prevention approach to keeping children and youth out of the criminal justice system. To begin, we conducted literature reviews and online research to develop an understanding on what factors place youth at risk of juvenile delinquency, and what factors help protect them.

Risk factors can include individual level issues (e.g., early antisocial behavior, hyperactivity), family issues (e.g., poverty, maltreatment, home discord), peer issues (e.g., peers who engage in delinquent behavior), and school/community issues (e.g., high crime neighborhood, unsafe and unsupportive school environments). Additionally, protective factors can be supported in all of these areas as well. In order to take an early intervention, primary prevention approach, the Committee decided to focus on identifying strategies at the school/community and family levels.

The Committee and staff reviewed a number of online resources to identify evidence-based practices for achieving early prevention of youth from coming into contact with the criminal justice system. These sources included:

- National Institute of Justice's Crime Solutions
- SAMHSA's National Registry of Evidence Based Practices and Programs (NREPP
- California Department of Social Services' California Evidence-Based Clearinghouse for Child Welfare (CEBC)
- University of Colorado Boulder's Blueprints for Health Youth Development
- Promising Practices Network's Programs that Work
- California Mental Health Services Authority - Student Mental Health Initiative

Findings

Based upon our research, we feel reasonably confident that the following programs briefly described below show substantial promise -- if brought to scale -- in California at reducing criminal justice contact for youth with trauma and other mental health needs.

1. Nurse-Family Partnership

Nurse-Family Partnership (NFP) serves low-income, first-time mothers who are at risk for adverse childhood experiences. Home visits are provided by a public health nurse, and services begin prenatally or immediately following the birth of a baby, and are offered voluntarily over two years. Home visitors build relationships as they provide services tailored to each family's needs, such as: Teaching parenting skills and modeling parenting techniques; Providing information and guidance on safe sleeping position and nutrition; Providing referrals to address substance abuse, family violence, and maternal depression; and Promoting early learning in the home that emphasizes positive parenting and building a language-

rich environment. Research has shown that home visiting programs produce positive outcomes by reducing child abuse and neglect, poor health, and academic failure.

2. Cognitive Behavioral Intervention for Trauma in Schools (CBITS)

CBITS is a school-based, group and individual intervention designed to reduce symptoms of posttraumatic stress disorder (PTSD), depression, and behavioral problems among students exposed to traumatic life events, such as exposure to community and school violence, accidents, physical abuse, and domestic violence. It is designed for students, who have experienced a traumatic event and have current distress related to that event. The goals of the intervention are to reduce symptoms and behavior problems and improve functioning, improve peer and parent support, and enhance coping skills. The program includes 10 student group sessions, 1-3 student individual sessions, 2 parent sessions, and a teacher educational session. Developed for the school setting in close collaboration with school personnel, the program is well suited to the school environment.

3. The Incredible Years

The Incredible Years is a series of three separate, multifaceted, and developmentally based curricula for parents, teachers, and children. This series is designed to promote emotional and social competence; and to prevent, reduce, and treat behavior and emotional problems in young children. The parent, teacher, and child programs can be used separately or in combination. There are treatment versions of the parent and child programs as well as prevention versions for high-risk populations.

4. Triple P - Positive Parenting Program

As a prevention program, System Triple P helps parents learn strategies that promote social competence and self-regulation in children. Parents become better equipped to handle the stress of everyday child rearing and children become better able to respond positively to their individual developmental challenges. As an early intervention, System Triple P can assist families in greater distress by working with parents of children who are experiencing moderate to severe behavior problems. Throughout the program, parents are encouraged to develop a parenting plan that makes use of a variety of System Triple P strategies and tools. System Triple P practitioners are trained, therefore, to work with parents' strengths and to provide a supportive, non-judgmental environment where a parent can continually improve their parenting skills.

5. Positive Behavior Intervention and Supports (PBIS)

PBIS is a framework or approach for assisting school personnel in adopting and organizing evidence-based behavioral interventions into an integrated continuum that enhances academic and social behavior outcomes for all students. PBIS is a prevention-oriented way for school personnel to (a) organize evidence-based practices, (b) improve their implementation of those practices, and (c) maximize academic and social behavior outcomes for students. PBIS supports the success of all students.

Next Steps

COMIO recommends undertaking additional research to ascertain the status of their implementation in California, as well as opportunities for expansion. Additionally, we recognize the great racial and ethnic disproportion of youth of color in the juvenile justice system and were very pleased to have recently learned from staff at the Board of State and Community Corrections of resources available to help mitigate potential bias in youth serving systems, and would like to further explore the utility of these tools in the future.[xix]

Additionally, COMIO recommends compiling information on these effective practices and creating a "tool kit" for local communities who wish to work toward preventing youth from becoming involved in the criminal justice system. Audiences for this tool kit could include, but would not be limited to: County school superintendents, K-8 school principals, special education local planning areas, parent-teacher associations, school council advisory boards, behavioral health service providers, and county probation departments.

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END NOTES

[i] Case, BA, Steadman, H, Dupuis, SA, et al (2009). Who Succeeds in Jail Diversion Programs for Persons with Mental Illness? A Multi-Site Study. *Behavioral Sciences and the Law (27)*, 661-674.

[ii] Steadman, HJ, Naples, M (2005). Assessing the Effectiveness of Jail Diversion Programs for Persons with Serious Mental Illness and Co-Occurring Substance Use Disorders. *Behavioral Sciences and the Law (23), 163-170.*

[iii] Cox, SM, Mitchell, DM (2013). Evaluation of the Supervised Diversionary Program. Conducted by faculty of the Institute for the Study of Crime and Justice, Department of Criminology and Criminal Justice at Central Connecticut State University.

[iv] Testing the Cost Savings of Judicial Diversion: Final Report Submitted to the New York State Unified Court System (March 2013). NPC Research and Center for Court Innovation.

[v] These savings calculations would be even higher if the savings to the health care and child welfare systems were included. The criminal justice agency to experience the largest savings due to reduced recidivism for diversion participants was the state prison system, which saved over $8,700 per participant over five years), followed by county jails, district attorneys, and defense attorneys. When computing the difference between the net investment costs required by judicial diversion ($5,186) and the outcome savings that judicial diversion produces over five years ($10,330), the net benefit of judicial diversion is $5,144 per offender. When victimization costs are included, the net benefit is $13,284 per offender. The largest cost (77%) per participant was for treatment, followed by judicial status hearings (10%) and case management (8%).

[vi] The Criminal Justice/Mental Health Consensus Project, coordinated by the Council of State Governments Justice Center, was a bipartisan national effort to help local, state, and federal policymakers and criminal justice and mental health professionals improve the response to people with mental illnesses who come into contact with the criminal justice system. The Consensus Project Report, published in 2002, provides 47 policy statements that can serve as a guide or prompt an initiative to improve the criminal justice system's response to people with mental illness. Online at: http://csgjusticecenter.org/mental-health-projects/report-of-the-consensus-project/

[vii] The Stepping Up Initiative was launched earlier this year by leaders of the Council of State Governments Justice Center, the National Association of Counties, and the American Psychiatric Foundation. This nationwide initiative is providing coordinated support to counties to help people living with mental illnesses stay out of jail and on a path to recovery. The Stepping Up Initiative toolkit provides resources for communities to create plans to reduce the number of people with mental illnesses in their jails. Included are five technical assistance modules. Available online at: https://stepuptogether.org/toolkit

[viii] Robertson, AG, Lin, H, Frisman, LK, et al. (2014). Mental Health and Reoffending Outcomes of Jail Diversion Participants With a Brief Incarceration After Arraignment, *Psychiatric Services, 65(9)*.

[ix] Using interviews with court and jail diversion personnel, researchers found that reasons for prediversion incarceration varied, but included themes such as acute intoxication at the time of arrest or arraignment, a record of several past failures to appear for court dates, a history of passing through the court repeatedly; and a lack of immediately available community service slots. Anecdotal reports from diversion clinicians also suggested that judges may also opt to let some individuals stay in jail for a short time before presenting them with the diversion opportunity in an effort to enhance their motivation for entering treatment and improve their chances of avoiding a conviction and possible jail sentence.

[x] See Module 2 at https://stepuptogether.org/key-resources

[xi] Andrew, DA, Bonta, J, Wormith, JS (2006). The Recent Past and Near Future of Risk and/or Need Assessment. *Crime & Delinquency, 52(1)*, 7-27.

[xii] As of May 2015, the California Health Facility Financing Authority authorized 26 Investment in Mental Health Wellness (SB 82) grant awards for the benefit of 31 counties to add 43 mobile crisis vehicles with 58.25 mobile crisis staff, and 866 crisis stabilization and crisis residential treatment beds. These awards exceed $81 million in capital funding and nearly $4 million in personnel funding. As of June 2015, the Board of State and Community Corrections has awarded over $16 million in grants targeting juvenile and adult mentally ill offenders to support prevention, intervention, supervision, services and strategies aimed at reducing recidivism in California's mentally ill offender population while continuing to protect public safety.

[xiii] Cox et al.

[xiv] Case, BA, Steadman, H, Dupuis, SA, et al (2009). Who Succeeds in Jail Diversion Programs for Persons with Mental Illness? A Multi-Site Study. *Behavioral Sciences and the Law (27)*, 661-674.

[xv] Source: http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/PDF%20R/PDF%20RightPlaceSupportiveHousingInfographic.pdf

[xvi] Peterson, JK, Skeem, J, Kennealy, P, et al (2014). How Often and How Consistently do Symptoms Directly Precede Criminal Behavioral Among Offenders With Mental Illness? *Law and Human Behavior, 38(5)*, 439-449.

[xvii] Cox et al.

[xviii] Case et al.

[xix] For example, Racial Impact Assessments/Statement (RIA/RIS) and a judicial bench card by Courts Catalyzing Change have been developed to mitigate the potential for bias in youth serving systems.

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