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Robert Wood Johnson Foundation

Communities in Crisis:
Local Responses to Behavioral Health Challenges

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I. Introduction

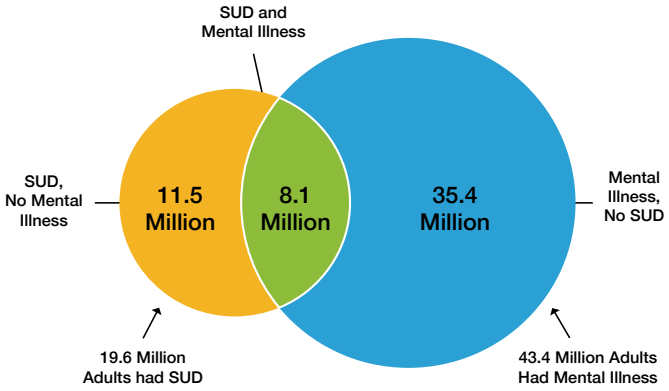
Hardly a day goes by without a report on the impact of the opioid epidemic or the tragedies that befall individuals with mental illness. Serious mental illness (SMI) and substance use disorders (SUD) are having a devastating and far reaching impact on individuals, families, and communities in the United States, with nearly 10 million adults suffering from SMI[1] and 20 million from SUD.[2] Policymakers in Washington, DC and the states are taking action, enacting legislation, and funding new programs, while the President intends to declare the opioid crisis a national emergency.[4,5]

National and state initiatives are vital, but it is local communities that experience firsthand the human and economic costs of untreated SMI and SUD. Individuals with untreated SMI and SUD are more likely to experience homelessness and behavioral health crises, putting demands on emergency responders and hospital emergency departments (EDs). They cycle in and out of jails and EDs, and return to the streets. Crime rates increase and quality of life and public health deteriorate.

City and county officials are responding, designing, and securing funding for local solutions to local challenges. Over 2,600 communities use the Crisis Intervention Team (CIT) community policing model, which trains law enforcement officers in safe de-escalation tactics for use during encounters with individuals experiencing behavioral health crises, and supports strategies to connect those individuals with behavioral health treatment and services. Some communities, such as San Antonio and surrounding Bexar County, Texas, have implemented a comprehensive set of initiatives that build on CIT by engaging individuals with SMI and SUD in the jails, courts, and hospitals, and connecting them to treatment programs.

There are a multitude of examples of local initiatives intended to address the community fallout of untreated SMI and SUD, few have been thoroughly evaluated, making it nearly impossible to build nationally on those that are most successful. This report is intended to begin to fill the knowledge gap. At the outset, we did a literature review of local initiatives, we then interviewed the leadership of 13 city- or county-led initiatives and made two site visits. The work is further informed by an advisory committee of local experts. Based on this work we prepared both a taxonomy of program features (*see Figure 2*) and this report which provides additional information on: the impact of untreated serious mental illness and substance use disorders on local resources and quality of life, how cities and counties are responding, and opportunities to assess program impact and spread promising programs to other communities.

Figure 1: Past Year Substance Use Disorder and Mental Illness Among Adults Aged 18 or Older: 2015[3]



II. Community Impact of Untreated SMI and SUD

Federal and state governments play significant roles in addressing the needs of those with SMI and SUD, through regulation, funding, coverage, and care. Medicaid, CHIP, Medicare, and the Veterans Administration underwrite the cost of coverage and care of millions of Americans. In fact, Medicaid is the nation's single largest payer of behavioral health services. Enacted in 2010, the Affordable Care Act expanded coverage – including for behavioral health – to millions more while also extending the reach of the 2008 Mental Health Parity and Addiction Equity Act. And, just last year, confronted with the opioid epidemic, Congress invested billions more in expanding access to SUD services through the 21st Century Cures Act and

Figure 2: Taxonomy of Local Initiatives

Element	Description
Initiative Objective and Target Population	Purpose of treatment and recovery initiatives targeting individuals with SMI and/or SUD that consume a disproportionate share of community resources.
Points of Engagement ("Intercept Points")[6]	Places and interactions in which initiatives engage individuals, including: (1) homeless shelters and places on the street where individuals experiencing homelessness may be living; (2) law enforcement and the criminal justice system; (3) other emergency first responders; and (4) schools.
Intervention Model	Models for engaging individuals and providing a therapeutic setting to deliver mental health and substance use disorder treatment and recovery services.
Sponsoring and Participating Agencies & Organizations	Lead agencies or organizations and partner entities involved in the initiative.
Type of Locality	Small: fewer than 100,000 inhabitants Large: 100,000 or more inhabitants
Funding Sources	City, county, and state general funds, earmarked fees and levies, Medicaid, and philanthropy.
Evidence of Success	Evaluations or other findings of return on investment, improvements in health outcomes and/or reductions in ED utilization, incarceration rates, recidivism, and homelessness.

the Comprehensive Addiction and Recovery Act. States are the funders of last resort supporting state psychiatric hospitals and community facilities, and underwriting the cost of services for the uninsured.

The federal and state commitment is broad and deep. Nonetheless, in 2015 more than 88 percent of adults with SUD and nearly 35 percent with SMI received no treatment for their conditions.[7] This is a staggering statistic and notably it is local officials and community leaders that must pick up when federal and state policies and programs are inadequate to address the problem. Gaps in treatment for those with SMI and SUD plays out in the community in homelessness, crime, transmittable disease, and demands on emergency responders, hospitals, and the criminal justice system.

Homelessness

One in five homeless individuals has serious mental illness or a chronic substance use disorder.[8] A survey of the homeless population in Roanoke, Virginia, found that nearly 70 percent of homeless people were receiving or had recently received mental health treatment.[9] Homeless individuals with untreated SMI and SUD also have a high incidence of arrest and incarceration; 17 percent of individuals with mental illness in jail were homeless in the year before their arrest.[10] They also are more likely to consume local emergency housing resources, which are more costly than providing transitional or supportive housing.[11,12] And homeless individuals with co-occurring mental illness and SUD more frequently use hospital EDs.[13]

> *"Homelessness, behavioral health issues, and criminal justice involvement go hand-in-hand."*
>
> Jesse Benet
>
> King County Behavioral Health & Recovery Division

Frequent Users of First Responder and Hospital Emergency Department Resources

First responders, including firefighters, emergency medical services (EMS) personnel, and police, are on the front lines responding to the inevitable crises and tragedies that afflict community members with untreated SMI and SUD. In Baltimore, 40 to 60 percent of 911 calls are related to drugs and alcohol, representing more than 150,000 calls each year.[14] One EMS provider in Atlanta found that six percent of calls were related to psychiatric issues and suicide attempts, but the majority of those calls were from a small number of people who utilized the EMS service at least five times per month.[15]

When first responders are called on to intervene in the chaos or worse yet danger created by individuals in crisis, it is time-consuming, costly, difficult to resolve, and sometimes deadly. Nearly half of all fatal shootings by law enforcement nationwide involve a person with a mental illness.[16] An internal review by the Los Angeles Police Department found that 37 percent of police shootings in 2015 involved suspects with documented signs of mental illness.[17]

Hospital EDs are increasingly the default options for managing acute episodes of care involving individuals with SMI and SUD. Nationwide, an estimated one in eight ED visits involve mental health and substance use disorders. Between 2006 and 2013, ED visits involving depression, anxiety, and stress reactions increased by more than half, while visits involving SUD increased by more than a third.[18] A 2004 Washington State study found that 94 percent of the 125 individuals who visited the ED 21 times or more in King County had a diagnosis of mental illness and/or chemical dependency, resulting in more than $3.2 million in health care costs.[19]

> *"Hospitals are overwhelmed by these [SMI/SUD] populations and often there are not sufficient community resources nearby to refer patients for ongoing treatment."*
>
> Ron Manderscheid
>
> National Association of County Behavioral Health & Developmental Disability Directors

Criminal Justice

Criminal justice settings, like hospital EDs, have increasingly become the site of care for individuals with mental health and substance use challenges. Many individuals with untreated SMI and SUD end up in municipal courts after arrest, which handle thousands of cases each year.[20] These individuals are less likely to make bail and experience more frequent delays in case processing.[21] More than 1,500 adult drug courts and 300 mental health courts have been established across the country to divert these individuals from criminal justice settings.[22,23] Yet these court programs often have limited capacity and long wait lists, resulting in the incarceration of many individuals with untreated SMI and SUD.[24] Nationally, nearly two-thirds of jail detainees have a SUD and the rate of SMI in jails is four to six times higher than the general population.[25,26] Indeed, the nation's three largest mental health care providers are correctional facilities in Los Angeles County, New York City, and Cook County, Illinois.[27]

From an economic perspective, it is far costlier to jail people with behavioral health conditions than to treat them in the community.[28] It is also costlier to treat and manage these individuals relative to inmates who do not suffer from SMI or SUD.[29] Additional costs during incarceration are associated with extra staff needed to observe and keep safe individuals who are at-risk for suicide, as well as the added costs for psychiatric services and medications.[30,31,32]

While jails have become a default option for housing and treating individuals with SMI and SUD, they are ill equipped to play this role. They have neither the economic resources nor an adequate supply of trained staff to treat the volume of incarcerated individuals with SMI and SUD.[33,34] As a result only one in six inmates with mental illness receives treatment during incarceration.[35,36]

Prisons and jails are constitutionally required to provide health care to inmates, but federal law prohibits Medicaid from using funding to pay for incarcerated individuals unless the inmate is admitted to an outside institution for more than 24 hours.[37] Consequently, localities must turn to other local, state, federal, and philanthropic sources to finance jail-based health services. Local funds for jails are drawn from the same sources as public hospitals, schools, social services, roads, and other local government functions, which can be negatively impacted when jail costs consume a greater proportion of a locality's budget.[38]

> *"The responsibility for SMI and SUD populations ultimately falls on the criminal justice system."*
>
> Susan Belinda Christian
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> San Francisco District Attorney's Office

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In sum, local communities are experiencing firsthand the impact of individuals with untreated serious mental illness and substance use disorders. Local criminal justice, law enforcement, and first responder systems weren't designed to either treat individuals with SMI and SUD or handle the volume of cases resulting from the opioid epidemic and serious mental illness. The impact is palpable, straining community resources, and touching almost every corner of the community.

III. Local Responses to the Impact of Untreated SMI and SUD

Cities and counties are responding to the human and economic costs of untreated SMI and SUD with programs to divert these individuals from non-therapeutic settings to treatment and social service programs. Following the taxonomy described in *Figure 2*, below we catalog the salient features of these city- and county-led initiatives as follows: target populations and program objectives; intercept points for engaging individuals; intervention models; type and role of local leadership; challenges facing rural communities; sources of financing; and evidence of success. Detailed descriptions of local programs and the taxonomy are available in *Appendix B*.

Initiative Objective and Target Population

The first element of our taxonomy focuses on program objectives and target populations. We decided at the outset to concentrate

our research on local programs that targeted individuals with untreated SMI and SUD who consume a disproportionate share of local resources. Program objectives however varied, with each rooted in addressing one or more manifestations of the local impact of untreated SMI and SUD. We identified five dominant objectives:

1. Reducing drug-related crimes and overdoses
2. Alleviating calls to first responders
3. Reducing homelessness
4. Reducing volatile confrontations with local law enforcement
5. Reducing overcrowded courts and jails

Below we briefly describe programs exemplifying each of these objectives.

Reducing Drug-Related Crimes and Overdoses

In the United States, over 60,000 individuals died from lethal drug overdoses in 2016, exceeding the combined total number of lives lost during the entire Vietnam and Iraq Wars.[39] In West Virginia - the state with the highest rate of drug overdoses in the country – the City of Huntington was a flashpoint in the State's opioid crisis with rising addiction and drug-related crime. In response, Mayor Steve Williams established the Mayor's Office of Drug Control Policy (MODCP) to address drug addiction and related crime in Huntington and surrounding communities with the goal of: preventing drug distribution and initial drug use, and mitigating associated public health risks by diverting people struggling with addiction into treatment and recovery services in coordination with city and county agencies and community partners.[40]

> *"It can be a lonely experience at the local level. You have the sense that you're the only one fighting this (substance use), but we have an obligation to lead."*
>
> Mayor Steve Williams
>
> Huntington, WV

Alleviating Calls to First Responders

Manchester, New Hampshire, a city of 110,000 people, had 721 opiate overdoses and 88 deaths in the first 11 months of 2016. Local fire department and ambulance services became a front line administering nearly 1,000 doses of Naloxone to treat overdose victims in response to 911 calls. The significant increase in the number of drug overdose-related calls was consuming limited first responder resources and jeopardizing their ability to respond to other emergencies. The City lacked a coordinated response to manage individuals suffering from addiction, and connect them with local treatment programs. Consequently, individuals who had previously been treated by firefighters began showing up at local fire stations to seek help. In response, the Manchester Fire Department launched the Safe Stations program, which established coordination programs with local SUD treatment providers to connect individuals engaging with firefighters and other first responders to therapeutic services.

Reducing Homelessness

Like many large localities across the country, San Diego has struggled with a large homeless population, estimated at over 9,000 individuals.[41] In response, the City Attorney's Office and various city and county partners launched the San Diego Misdemeanant At-Risk Track (SMART) program, directing individuals with drug and "quality of life" offenses (offenses that are typically linked to homelessness including vagrancy, disorderly conduct, and loitering) to long-term sustainable housing as a prerequisite to receiving treatment and recovery services.

Reducing Volatile Confrontations with Local Law Enforcement

The fallout of mental illness in communities, including rising rates of behavioral health crises and declines in public safety, has been a major focus of local programs. In San Francisco, between 2005 and 2013, people in the midst of a psychiatric crisis made up a disproportionate number of those shot by police; 58 percent of people killed by law enforcement officials had a mental illness that was a contributing factor in the incident.[42] After a series of fatal shootings involving persons with mental illness, the San Francisco Police Department's citizen advisory board recommended adoption of the CIT model to de-escalate and minimize the use of force in situations involving individuals with behavioral health disorders. The goal of the program is to reduce hospitalizations, injury, and death during encounters between law enforcement and people with SMI and/or SUD. More than 700 law enforcement officials have received training, and crisis intervention specialists – who are licensed mental health professionals – are being deployed with police officers to support non-violent resolution during intense law enforcement interactions.

Reducing Overcrowded Courts and Jails

Many localities have deployed programs designed to divert individuals with untreated SMI and SUD from courts and jails, to community-based recovery programs. In Miami-Dade County, Florida, where 9.1 percent of residents have a serious mental illness, behavioral health crises were driving increased involvement of the justice system. Law enforcement officials were responding to 16,000 crisis calls per year, resulting in arrests and incarcerations costing the County $218,000 per day, or $80 million per year, just to house people with mental illness in its jails.

Recognizing the need to address the root cause of the criminal justice impact, Judge Steven Leifman of the Eleventh Judicial Circuit led the establishment of the Miami-Dade Criminal Mental Health Project, to divert individuals with mental illness from jail to treatment services. People arrested for misdemeanors can be referred to a community-based crisis stabilization unit within

three days of arrest. Court appearances are scheduled for two weeks post-arrest to allow time for stabilization, and individuals completing the three to six-month program can have charges against them dropped. Approximately 300 people per year are referred to the misdemeanor diversion program.

Intercept Points – Opportunities for Engagement and Intervention

The second element of the taxonomy examines the settings or "intercept points" that local programs use to connect with individuals with untreated SMI and SUD and assist them in moving into therapeutic settings. In our taxonomy, we identify intercept points commonly used by local programs including: the criminal justice system (including interactions with law enforcement officials, the court systems, and in jails); homeless shelters and the streets; the emergency response system (including firefighters and EMS personnel); and schools. Cities and counties tend to use intercept points based on the problems they are trying to solve or the setting most impacted by untreated SMI and SUD.

Criminal Justice System

For localities focused on reducing rates of incarceration and recidivism among individuals with SMI and SUD, the criminal justice system offers several intercept points at which contact can be made with the target population. SAMHSA's sequential intercept model (SIM) has been widely used to identify intercept points across the criminal justice continuum – from pre-arrest interactions with law enforcement, to pre- and post-booking intercepts in the courts and jails, and release into the community – with associated steps to divert individuals needing treatment to settings that can more effectively address their underlying behavioral health needs *(see Figure 3)*.[43]

Starting with the SIM model, officials in King County, Washington, mapped different intercept points within the County justice system, documenting opportunities to divert repeat offenders to treatment. Through the mapping exercise, they also identified services that were being used by their target population to address some aspect of their behavioral health conditions. The County found that services were program-centric; they were not being effectively coordinated to address all of their target individuals' underlying behavioral health needs. To create a system of integrated behavioral health care, the County established the Familiar Faces Initiative, a person-centric approach to connect non-violent repeat offenders with a coordinated set of treatment and social services, designed to meet the needs and condition of the individual at each intercept point.[44]

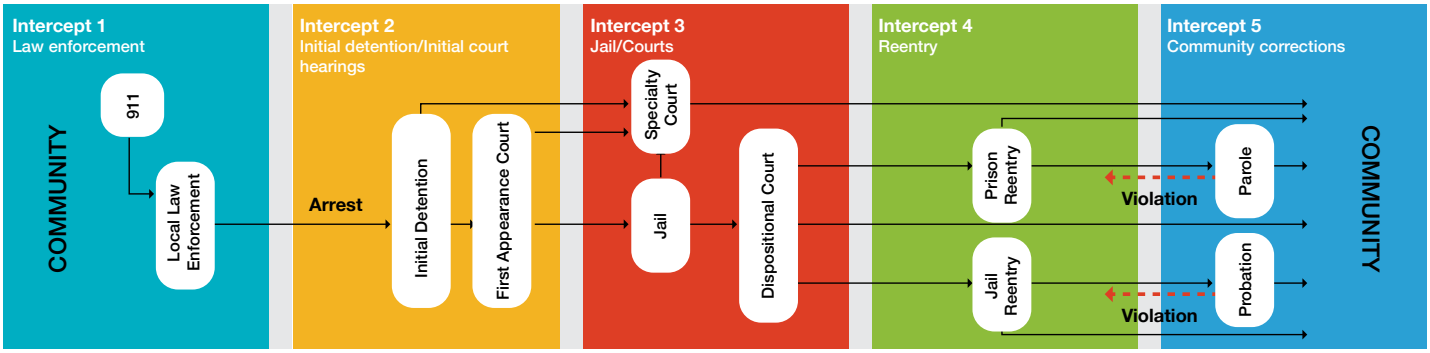
Homeless Shelters and the Streets

In Los Angeles County, 30 percent of the 58,000 homeless individuals in the community have mental illness. In response to the growing homeless population and associated increase in the number of medical and psychiatric ED visits and incarcerations, the County Department of Mental Health created integrated mobile health teams that provide street outreach, field-based mental health, physical health, case management, substance use treatment, and housing services. The County partners with federally qualified health centers (FQHCs), substance treatment providers, and housing agencies to transition those with mental health conditions and co-occurring physical and/or substance use conditions from homelessness into permanent housing, and links them with community-based supportive services, including longer-term mental health services.

First Responder Intercept Points

Cities and counties are seeing significant increases in the number of mental-health related EMS calls. San Diego County received over 31,000 mental health-related EMS calls in 2015, an increase of 84 percent over 2009 while overall call volume increased just 17 percent during the same period.[45] In Wake County, North Carolina, increases in ED utilization and EMS calls related to behavioral health crises led the County to establish the Advance Practice Paramedic (APP) program. The program provides APP training to EMS personnel to screen individuals experiencing behavioral health crises and refer them to community-based crisis and treatment centers. The County also established a robust data sharing infrastructure to track individuals that APPs encounter and facilitate care coordination as they transition across care settings.[46]

Figure 3: Sequential Intercept Model



Schools

Some local leaders are recognizing the need to engage at-risk youth when they are exhibiting early signs of mental illness and substance use and before they experience a crisis. Miami-Dade County's Criminal Mental Health Project partnered with schools to train more than 500 teachers, guidance counselors, and other staff to identify students with potential mental illness and work with their parents to connect them to services to decrease the likelihood of truancy, substance use, and criminal activity.[47] In Manchester, New Hampshire, the city's fire department partnered with local schools to provide education to students on substance use prevention.[48]

Intervention Models

There are a wide range of intervention models used by local officials to address the unmet needs of individuals with SUD and SMI as they are playing out in individual communities. And, of course, approaches are informed by the particular problem the community is trying to address. The CIT model is widely used, but local officials are also incorporating Law Enforcement Assisted Diversion (LEAD) and post-booking jail diversion, harm reduction, housing first, and jail-based treatment models into city and county initiatives. Many communities are adopting multiple models simultaneously.

> *"We started with a jail diversion program, but realized we didn't have community resources in place to divert people to treatment. We needed to take a broader view of how to address the issue."*
>
> Gilbert Gonzales
>
> Bexar County Department of Behavioral and Mental Health

Crisis Intervention Team (CIT)

CIT is a community policing, pre-arrest jail diversion program. The program includes training for law enforcement officers to acquire skills to safely de-escalate behavioral health crises and increase the chances of peaceful resolutions. The model supports collaboration between law enforcement, behavioral health and other physical and social service providers with the goals of reducing the risk of injury to police officers and mentally ill persons, and reducing arrests and recidivism by diverting individuals to mental health treatment instead of jail. Originally developed in Memphis, the model has been used and customized in 2,600 localities nationwide.[49]

LEAD and Post-Booking Diversion

LEAD was first deployed in Seattle over a decade ago in response to lawsuits involving racial disparities in drug arrests. It was developed as a collaboration between community stakeholders and city and county executives, police, social service, prosecutors, and public defenders to train law enforcement officers to identify and divert low-level drug offenders from the criminal justice system to a case manager. The case managers then work with public and community-based organizations to provide drug treatment and other social service programs.

LEAD is a pre-booking model; police are trained and must use their discretion to refer individuals to a case manager instead of arresting them for misdemeanor drug-related offenses. Collaboration between local police, prosecutors, and public health agencies also allows for an arrested individual to be directed to the program, where charges can be suspended while they are referred to case managers and given an option to enter into treatment. Cases can be dropped by prosecutors when enrollees meet program milestones. LEAD programs have been replicated in Santa Fe and in over a dozen other cities and counties.

Post-booking diversion models include jail, court, and mental health or drug court diversion efforts that deploy specialized personnel who screen and assess justice-involved individuals for mental health and substance use disorders and develop diversion and treatment plans with oversight from the courts and consent of judges, prosecutors, and public defense attorneys. The courts typically require community-based behavioral health treatment with the prospect of dismissing charges and avoiding incarceration as incentives to enter into and continue therapy. Post-booking diversion models including those in Miami-Dade, Bexar, and Cook Counties have been in existence for many years.

> *"When it comes to this issue, the traditional battle lines among stakeholders in the criminal justice system don't apply. We have to work together."*
>
> Jennifer Johnson
>
> San Francisco Public Defender's Office

Community Paramedicine and Integrated Mobile Health Teams

Community paramedicine deploys paramedics to operate in an expanded capacity outside of their traditional emergency response and transportation role. The model has been used to redirect individuals experiencing a behavioral health crisis from a hospital emergency department to a detox or treatment facility. Advance practice paramedics (APP) typically receive additional training to help screen individuals and conduct assessments to support appropriate diversions. They can also support outreach, in collaboration with local health providers, to individuals in the community and in their homes. APPs in Wake County respond alongside EMS personnel to mental health or substance use crises in the community. They conduct an individual assessment, after which the APP screens the individual for potential ED

diversion to one of three 24-hour crisis centers. The crisis centers provide stabilization services, and facilitate referrals to longer-term outpatient behavioral health treatment.

Integrated mobile health teams (IMHTs) are typically multi-disciplinary care teams that may include physicians, nurses, social workers, mental health professionals, substance use counselors, case managers, and peer supports that are deployed in communities to proactively identify and engage at-risk individuals to provide treatment and transition them from homelessness to housing. Los Angeles County uses IMHTs to transition homeless clients to housing and provide key services, including individual and group counseling, physical health care, crisis intervention, employment assistance, transportation, benefits establishment, medication support, and family supportive services.

Harm Reduction

Harm reduction models incorporate a spectrum of substance-misuse treatment strategies from safer use, to managed use and abstinence to meet drug users "where they're at." They are designed to minimize the harm individuals might cause to themselves and those around them, rather than requiring sobriety to remain in treatment.[50] Programs based on harm reduction models have become increasingly widespread over the past several decades. These include sterile syringe exchange programs that provide safe environments for drug users and mitigate the spread of transmittable disease, which now operate in 33 states and the District of Columbia.[51]

The Mayor's Office in Huntington expanded upon traditional needle exchange harm reduction programs, adding Naloxone training and kits for friends and family members of drug-addicted individuals to treat overdose episodes, and recovery coaches to connect clients to resources for detox, treatment, family support, and education. Seattle and Santa Fe have also adopted drug treatment programs based on harm reduction models, complementing traditional drug court programs that require sobriety.[52]

Housing First

Housing first models recognize that safe and stable housing is a prerequisite to engage anyone in serious mental illness or substance use disorder treatment. Housing first programs focus on helping individuals access and sustain housing, before delivering voluntary and needed behavioral and other social supportive services instead of requiring people to address their behavioral health problems before they can access housing.

Two common program models follow the housing first approach. Permanent supportive housing targets individuals with mental health or substance use disorders who have experienced long-term or repeated homelessness and provides long-term rental assistance and supportive services. Rapid re-housing, provides short-term rental assistance and services. Interventions in several cities and counties, including San Diego, Los Angeles, and King, incorporate these models in their programs. The SMART program in San Diego is implementing a two-year housing first pilot that provides intensive case management, care coordination, enrollment in drug treatment programs, and placement in supportive housing.

Jail-Based Programs

Jails can serve as an opportunity to stabilize individuals with substance use disorders and serious mental illness and provide short-term treatment services, offering a more controlled environment that many individuals do not have once released into the community – especially for individuals lacking sustainable housing or a social-support network.

Inmates with drug-related charges in Kenton County, Kentucky, can be referred at booking or ordered by judges into the Detention Center's treatment programs. The three to six-month tiered program uses a peer-driven support model that includes cognitive-behavioral therapy, 12-step individual and group counseling, spiritual programming, and medication-assisted treatment to mitigate risk of relapse after release.

These models aren't mutually exclusive; most of the localities we interviewed have adopted and are synchronizing multiple models simultaneously to address their most pressing needs and provide the most appropriate therapeutic settings and resources to target populations. They have recognized that none of the models on their own are sufficient to address the needs and impact of individuals with untreated SMI and SUD.

Localities have also found that program success necessitates significant coordination across city and county agencies and community-based organizations. Bexar County, Texas has integrated multiple programs and established a Restoration Center at the County's Center for Health Care Services to provide residential detoxification, sobering, outpatient substance use treatment, and in-house recovery to individuals struggling with alcohol and drugs. Combined with crisis intervention team training, the program and its associated jail diversion program have diverted over 17,000 people from jails and emergency departments, saving Bexar County taxpayers over $10 million a year.[53]

Local governments can't do it all on their own; they need community partners to meet the full complement of needs. Even with partners, local agencies are struggling with capacity constraints as demand for behavioral health professionals and facilities exceeds supply of local resources.[54] So while local agencies can establish intercept points and programs, many have found that there are not enough local resources available to target populations.

Sponsoring and Participating Agencies & Organizations

This project focused on initiatives led by government agencies and officials, and we found a diverse group of agencies stepping up to the plate, again driven by local imperatives. Champions in high-level local government positions, such as the mayor, city

attorney's office, judges, and police chiefs, can use the power of their office to direct funding and set agency priorities, or use the bully pulpit to rally support among partnering agencies and organizations in the community that share common goals.

> *"It is critical to foster a culture of collaboration when developing these programs."*
>
> Lara Easton
>
> San Diego City Attorney's Office

Regardless of lead agency, every local program representative emphasized the importance of leadership to foster collaboration. Collaboration is necessary to align priorities and coordinate programs across public agencies, community-based organizations, and service providers even across city and county jurisdictions. The Mayor's office in Brockton, Massachusetts, led an effort to create the Champion Plan to reduce rates of drug addiction and overdoses in the community. The Plan brings together the Mayor's Office, police department, Brewster Ambulance Service, Gandara Center, and the Brockton Area Opioid Abuse Prevention Collaborative to establish coordinated referrals to housing and treatment programs.

> *"Local leaders need to take a broad view of their programs to identify opportunities to support individuals before they experience a crisis."*
>
> Judge Steven Leifman
>
> 11th Judicial Circuit of Florida

Type of Locality

In calling out program location as an element of the taxonomy, the primary issue we wanted to highlight is the unique challenges of programs in rural communities and small cities. The opioid epidemic is having a devastating effect on rural communities where the rate of opioid-related overdose deaths is 45 percent higher than in metro counties.[55] Rural communities as well as small cities and counties are hampered by the smaller tax base and resources at their disposal and have fewer behavioral health care providers that limit access to care and their ability to provide treatment for SMI and SUD populations relative to urban centers.[56]

Huntington, West Virginia, a city of 50,000 residents, experienced rates of drug overdose deaths that were three times the state average and more than 10 times the national average,[57] yet it receives allocations of state and federal funds to address their crisis based on the size of their population, not on the magnitude of their local problem. To address the shortfall, the City leveraged a patchwork of local, state, federal, and private funds to develop several initiatives to combat the opioid epidemic, including increased policing of drug traffickers, implementing the LEAD model, providing supportive housing to individuals with SUD, developing a needle exchange program, and distributing Naloxone to treat overdoses.

Funding Sources

Central to the viability of these programs is financing. For the most part, officials rely on city and county general funds both to launch as well as to sustain their initiatives. These funds may be specifically allocated by the local government or a local agency may determine to allocate a portion of its budget to the initiative. Medicaid is critical to assuring access to treatment, including in some communities, social supports such as case management. For administrative costs, officials are relying heavily on agency budget or local general funds. Some officials have been able to supplement local resources with grants from foundations. Finally, in an effort to stabilize funding, some communities have enacted local fees or taxes dedicated to support treatment and recovery programs.

> *"Our program is supported through a patchwork of public and private funds, while long-term sustainability is best achieved through the legislative process."*
>
> Jason Merrick
>
> Kenton County Detention Center

In short, local officials are weaving together a patchwork of funding streams to build and operate programs to address the most pressing unmet needs of community members afflicted with SMI or SUD. The examples below highlight the wide mix of funding that local officials are accessing to underwrite these programs. Notably, the range reflects not widespread support for these types of initiatives, but rather the difficulty in financing these programs and the lengths to which dedicated officials go to identify and secure the funds required to support needed programs.

City, County, and State General Funds and Local Fees

To underwrite the costs of local initiatives, the programs we examined rely heavily on city and county general funds, sometimes in combination with state funds and local problem-specific fees and taxes. The jail and hospital ED diversion program in Lee County, Florida received start-up and annual appropriations from the County's general fund to support its efforts to connect low-level offenders with SMI and SUD to treatment services, including for the development of the

Bob Janes Triage Center.[58] The Santa Fe LEAD program was established with an initial $300,000 allocation from the Santa Fe City Council and $600,000 from the Open Society Foundation for a three-year pilot, and is supported by an annual $250,000 City appropriation. However, obtaining separate appropriations for a program can be challenge for local leaders, as Santa Fe's LEAD program found when it unsuccessfully sought funding from the state legislature.

Some local programs are leveraging allocations from state general funds. The Kenton County Detention Center, which provides jail-based SUD treatment, leverages funding from the state's Department of Corrections to fund medication-assisted treatment (MAT) and program staffing. The Restoration Center in Bexar County is funded through a combination of local and state resources, including the city of San Antonio, Bexar County, the University Health System, and the Texas Department of State Health Services.

Costs associated with implementing local programs are also being absorbed directly by the agencies implementing them. The Safe Stations program in Manchester, New Hampshire, which connects individuals with SUDs to treatment at the City's fire stations, was implemented by the fire department without any additional public funding from the City and County.[59]

In Brockton, Massachusetts, the City requires a local marijuana dispensary to contribute funding to combat SUDs as a condition of its operation through a community host agreement. The Criminal Mental Health Project in Miami-Dade County accesses funding from a local tax established to address homelessness. The County recognized that many homeless individuals have co-occurring SMI and SUD, and in response directed revenues from the tax to programs that provide housing and treatment services.[60] Similarly, King County's Familiar Faces program is partially funded through three local tax levies targeted on mental illness, drug use prevention, and homelessness.[61]

Philanthropy

National and community foundations across the country are likewise providing important support to local initiatives.[62,63,64] For example, Santa Fe's LEAD program received funding from the Open Society Foundation, McCune Foundation, Just Woke Up Fund, and Santa Fe Community Foundation.[65] The Safe Stations program received funding from the Robert Wood Johnson Foundation and Anthem Blue Cross and Blue Shield Foundation to support ongoing operations and expanded drug prevention outreach to youth.[66,67] Health plans, health systems (often as part of hospital community benefit obligations), and corporations are also providing funding and in-kind support.[68] In Indiana, Reid Health's community benefit program provided more than $93,000 in grants to local programs that address mental health and substance use.[69]

Medicaid

Since the passage of the Affordable Care Act, 31 states and the District of Columbia have expanded Medicaid to low-income childless adults, of whom 29 percent have a mental health disorder or SUD.[70] Medicaid is the single largest funder of behavioral health services in the nation and provides the foundation of coverage, access, and care for Medicaid-eligible individuals, including the individuals targeted by the programs discussed here. While Medicaid can cover a range of support services, including case management, housing, and employment supports, local programs we interviewed were generally unfamiliar with these opportunities or were frustrated by limited support from state Medicaid officials in taking advantage of these Medicaid options.

This failure to make maximum use of Medicaid suggests a breakdown in communication between state and local officials as states, most particularly expansion states, are intent on expanding coverage and services to individuals with SMI and SUD, including justice-involved populations and homeless individuals – precisely the target population of these local initiatives.[71] Moreover, states have been exploring and expanding Medicaid's role in covering the costs of social interventions which again are central to addressing the needs of those with SMI or SUDs.[72] Notably, Medicaid expansion has enabled states to redeploy some of the block grant dollars from underwriting the cost of services to uninsured individuals to essential services and supports not covered by Medicaid.[73]

Other Federal Funding

In addition to sharing in the cost of the Medicaid program with states, the federal government provides financial support through various grant-making programs. Two key funding streams include SAMHSA's Substance Abuse Prevention and Treatment, and Community Mental Health Services Block Grant programs. These programs provide funding directly to states on pre-defined formulas that take into account state populations, risk factors for behavioral health, and the local cost of services.[74] While states are the recipients of the block grants, in some cases they pass on funding to cities and counties to support local programs. The Justice Department has also provided funding to foster collaboration among justice and social services agencies to reduce the prevalence of behavioral health conditions in jail.[75] And in 2016, the Department of Housing and Urban Development made almost $2 billion in grants available to support local permanent and transitional housing, and supportive services.[76]

Local programs have also accessed SAMHSA funding opportunities including through: Comprehensive Addiction and Recovery Act grants; grants for the Benefit of Homeless Individuals-Services in Supportive Housing; and Projects for Assistance in Transition from Homelessness (PATH) grants that can extend up to five years to train first responders, provide outreach, intensive case management, mental health and substance use treatment, funding for specialized drug courts, and assistance in obtaining supportive housing benefits services. And the MacArthur Foundation has collaborated with SAMHSA to create funding opportunities focused on behavioral health diversion.[77,78]

In 2016, Congress passed the 21st Century Cures Act which allocated nearly $1 billion in federal grant funding over two years to help states and localities combat the opioid epidemic. The funds are being administered through a third SAMHSA program – the State Targeted Response to Opioid Crisis Grant program – and will be allocated to states based on a formula tied to unmet need for opioid-use disorder treatment and overdose deaths.[79]

Evidence of Success

Virtually all programs we reviewed had some evidence of success and were able to document their impact; only a few had rigorous evaluations. Robust study designs including randomized controlled trials and case-control studies have not been widely deployed to assess program efficacy. Instead, pre- and post-evaluation methods and matched cohorts are more commonly used to track near-term outcomes, such as arrests, recidivism rates, homelessness, and 911 calls. These data often depend on self-evaluations by the agencies and community partners.

> *"We were very purposeful about dedicating resources and funding to evaluation."*
>
> Maria Funk
>
> Los Angeles County Department of Mental Health

CIT

CIT has been associated with a reduction in the rate of arrest for mental health-related disturbance calls from 24 to seven percent.[80] Evidence also strongly suggests that CIT increases the connection of persons with mental illness to psychiatric services or diverts them to services instead of jail.[81] A study of CIT-trained officers in Chicago found that the program not only increased linkages to mental health services, but also improved safety in calls involving persons with mental illness. Officers reported using less force than officers where CIT training was limited, and CIT officers directed a significantly greater proportion (18 percent more) of subjects to mental health services than non-CIT officers.[82] In Memphis, injuries to law enforcement officers dropped by 80 percent after CIT was implemented.[83]

LEAD and Post-Booking Diversion

An evaluation of the Seattle LEAD program found that participants were 58 percent less likely than non-LEAD participants to be arrested, and 87 percent less likely to be incarcerated.[84] Another Seattle LEAD study found an average reduction of $2,100 in legal and criminal justice utilization costs for each LEAD program participant.[85]

The Miami-Dade Criminal Mental Health Project diversion programs have also been found to reduce the number of arrests associated with mental illness in the County and have reduced recidivism rates for individuals booked for misdemeanor crimes to less than 20 percent from approximately 72 percent before the program and to approximately six percent among individuals in the felony diversion program.[86]

Community Paramedicine and Integrated Mobile Health Teams (IMHT)

A study of the Wake County APP community paramedicine diversion program found that more than one-third of patients encountered by APPs met the criteria for ED diversion, of which 61 percent agreed to be diverted to a community-based crisis care center. The study also found that the APP program saved 2,448 ED bed hours and reduced care costs by $500,000.[87] An evaluation of Los Angeles County's IMHT program – which includes housing first and harm reduction components – found significant reductions in illness management and recovery (IMR) scores; a strong signal that clients continued to make progress towards recovery.[88]

Harm Reduction

Some harm reduction models, such as syringe exchange programs, have been shown to be effective at reducing overdoses and recidivism rates, but efficacy in the context of local SMI and SUD interventions in the United States is lacking. Medication-assisted treatment, particularly for opioid addiction has been shown to be effective in the United States and elsewhere, yet this form of therapy has not been widely utilized.[89] Research on the broader application of harm reduction in local efforts to reduce the impact of untreated SMI and SUD is limited.[90]

Housing First

Evidence suggests that housing first approaches significantly reduce drug use compared to models that focus on treatment first, and that housing first participants spend significantly less time homeless and in psychiatric hospitals, and incurred fewer costs than a control group of individuals who were not enrolled in a housing first program.[91,92] An evaluation of King County's housing first pilot used a pre- and post-comparison group design and found that participants experienced significant reductions in emergency department use, hospital admissions, and jail bookings. Reductions in estimated costs for participants and comparison group members were $62,504 and $25,925 per person per year respectively.[93]

Jail-Based Treatment Programs

Findings from several studies indicate the effectiveness of in-jail substance use treatment programs in reducing criminal recidivism.[94] Reductions in re-arrests for treated inmates range from five percent to 25 percent in comparison to untreated inmates, over follow-up periods of six months to five years. Treated inmates also have a longer duration to re-arrest following release from incarceration, relative to untreated inmates.[95] Cost savings associated with jail treatment programs have been reported from $156,000 to $1.4 million per year.[96]

Few localities have established programs that conduct evaluations tracking long-term client outcomes and financial impact to public agencies. Bexar County's Department of Behavioral and Mental Health has three full-time staff dedicated to program evaluation, which support the County's assessment of multiple programs targeted at SMI and SUD populations. Similarly, in Los Angeles County, the Department of Mental Health allocated dedicated funding and staffing to support an evaluation of its Integrated Mobile Health Team program, supported by the University of California, San Diego. That analysis assessed housing first, harm reduction, and motivational interviewing program elements, finding that approximately three-quarters of participants showed significant improvements in overall health and made progress in their recovery, with significant decreases in the use of emergency services.[97]

While CIT, LEAD and post-booking jail diversion programs have been shown to be effective at diverting individuals with SMI and SUD from the justice system to treatment, less is understood about the comparative effectiveness and the costs and benefits of those initiatives relative to jail-based therapeutic treatment programs and services in jail-based settings where individuals can be engaged more consistently.[98,99] Furthermore, while some local programs have been shown to generate savings that accrue to a specific agency, research assessing the impact of these programs across the broad spectrum of public agencies and community stakeholders that serve SMI and SUD populations is limited.

For instance, while pre-trial diversion programs may increase costs for District Attorney's offices and social service agencies that provide treatment to program participants, they also reduce incarceration rates and jail costs. In one study, CIT training and diversion programs increased costs to law enforcement agencies, and required increased funding for treatment of diverted individuals, but were shown to reduce cost to the local criminal justice system.[100] In Memphis, the CIT program was associated with a significant cost savings for the criminal justice system, higher treatment costs however offset these savings.[101] These findings reveal a significant challenge that city and county agencies confront when building support for local programs, namely cost-shifting; where savings that accrue to one set of program participants may be borne at the expense of another set of agencies or stakeholder groups.

IV. Local Program Success Factors

There is a plethora of local initiatives that address the fallout of untreated SMI and SUD on individuals and the communities in which they reside. We have used our taxonomy (*Appendix B*) to describe a sample of those programs and reviewed many others. It is clear from published research that some local program models show levels of success that merit socialization and spread. CIT, LEAD, and post-booking jail diversion programs have been shown to reduce incarcerations and recidivism, jail-based treatment programs can reduce re-arrests, and community paramedicine and integrated mobile health teams can divert more individuals away from hospitals to behavioral health treatment and improve recovery. Here we discuss the elements across programs that appeared most critical to program success; program examples are in the endnotes that follow each factor.

Client-Centric System of Care

Our research suggests that successful programs are systematically aligning law enforcement, criminal justice, public health, health care, and social service resources to coordinate, improve access to, and deliver a broad spectrum of treatment, recovery, health, and social services for people with untreated SMI and SUD. Within that client-centric system of care, we have identified five re-current success factors that can be spread to other community initiatives. These elements include: creating collaborative partnerships between city and county agencies and community-based health and social service providers to support the diversion of clients away from the justice system and homelessness to therapeutic treatment settings; improving access to health and social service benefits; developing discharge and care coordination plans in partnership with public and community-based health and social service providers; creating community support for local behavioral health infrastructure and services; and leveraging multiple funding streams to support program sustainability.

Collaboration

Programs that coordinate city and county agency resources with community-based health and social support organizations are significantly reducing overcrowding and recidivism and improving access to behavioral health treatment and other supportive services. Successful programs require coordination with outreach workers, police officers, jail administrators, public defenders, judges, and others to screen individuals at various intercept points and develop diversion plans with behavioral health, housing, employment, transportation, and other social service providers as an alternative to jail.[102] Some local programs are leveraging partnerships to address shortages in housing and treatment capacity for SUD and SMI populations,[103] while others are breaking down information silos to share data across agencies and community partners to inform decision-making.[104]

Access to Public Benefits and Services

Recovery from behavioral health disorders is built upon access to clinical treatment and social support services.[105] Successful programs recognize that without access to these dimensions of recovery, individuals they serve will be more likely to relapse, ending up in the criminal justice system or in hospital emergency departments. They have incorporated supportive mechanisms to help clients obtain access to social security benefits, health care coverage including Medicaid, and other benefits that can help pay for clinical services and provide a source of income and other benefits that help clients recover.[106]

Care Coordination and Management

Successful local programs are integrating case management, care coordination, and discharge planning into their programs to help clients navigate across public and community-based treatment programs. Case workers and counselors develop individualized care and transition plans with clients and work with partners in the community to place and provide therapeutic treatment, housing, education, employment, and other social services.[107]

Community Engagement

People with SMI and SUD, especially those with criminal histories face significant barriers accessing both affordable housing and health care services. Strong community engagement and advocacy is necessary to overcome the stigma associated with serious mental illness and substance use in order to build support for community-based treatment and expansion of housing capacity. The role that a local champion plays is particularly important to lead and convene advocates, politicians, and community-based organizations to gain support and agreement to provide health and social services instead of jail.[108]

Sustainable Financing

To sustain initiatives, local programs are braiding together various funding streams, leveraging general funds, establishing local fees and taxes, and opportunistically tapping into philanthropy and federal grants. Commercial health insurance and public coverage including Medicaid and the Veterans Administration (VA) are critical to pay for physical and behavioral health treatment. In some states Medicaid is or could be used more to pay for care coordination and management services for eligible beneficiaries.

While most local programs rely heavily on a combination of city, county, and state funds for local program administration, some cities and counties are supplementing general funds by creating "problem"-specific fees and taxes. These include marijuana dispensary fees, levies that earmark revenue for local mental illness, substance use prevention, and housing services. Creating these additional revenue streams requires close collaboration and leadership within mayor's offices and county boards of supervisors to generate political support for new taxes and ballot measures.

SAMHSA state block grant programs and programs targeted specifically to city and county agencies are also being accessed to train first responders, provide outreach, intensive case management, mental health and substance use treatment, funding for specialized drug courts, and assistance in obtaining supportive housing benefits services. The Justice Department and the Department of Housing and Urban Development also provide funding to support justice and social services agency collaboration and housing.[109,110]

Private philanthropic funding is being used to test, launch, and sustain local efforts. Local insurers and health systems provide funding to local programs, often as part of their community benefit programs. Local, state, and national philanthropies are providing grants.[111]

Local leaders are clear as to the importance of health insurance including VA and Medicaid coverage to pay for clinical services. Successful programs go to considerable lengths to improve access to Medicaid coverage; this effort is more limited and less impactful in non-expansion states where few childless adults are eligible for Medicaid. With limited exception, Medicaid does not cover the cost of health care services for inmates, therefore successful programs are linking care plan development and access to coverage with jail release planning – again primarily in expansion states where Medicaid is available to almost all inmates upon release. In Kenton County, Kentucky, a week prior to release from jail, many clients are given a Naltrexone or Vivitrol injection to block the effects of opioids, and re-entry specialists help recovering opioid clients access Medicaid coverage and connect with community-based providers so that clients can continue receiving therapy after release.

Despite the best efforts and these success factors, there remains a pervasive lack of public and community-based behavioral health treatment and housing support service networks. One out of five adults with a mental illness report they are not able to get the treatment they need, while fewer than 12 percent of individuals needing treatment for an illegal drug or alcohol use problem received specialized treatment in the past 12 months.[1,2]

The Medicaid Institutions for Mental Diseases (IMD) exclusion further constrains available treatment by prohibiting Medicaid reimbursement for services provided to non-elderly adults in an institution larger than 16 beds that primarily provides diagnosis, treatment, or care of persons with mental diseases and related services.[3] The April 21, 2016 Medicaid Managed Care Final Rule allows states to receive federal matching funds for capitation payments for adults receiving behavioral health services in an IMD for up to 15 days a month.

1. "Substance Abuse and Mental Health Services Administration," *Behavioral Health Treatments and Services*, September 20, 2017, available at: https://www.samhsa.gov/treatment.
2. "Legal Action Center," *The Medicaid IMD Exclusion: An Overview and Opportunities for Reform*, July 2014, available at: https://lac.org/wp-content/uploads/2014/07/IMD_exclusion_fact_sheet.pdf.
3. Paradise, Julia and MaryBest Musumeci, "CMS's Final Rule on Medicaid Managed Care: A Summary of Major Provisions," *The Henry J. Kaiser Family Foundation*, June 9, 2016, available at: https://www.kff.org/medicaid/issue-brief/cmss-final-rule-on-medicaid-managed-care-a-summary-of-major-provisions/.

Few local programs have made use of case management or targeted case management (TCM), an optional Medicaid benefit whereby Medicaid reimburses for care management services to assist individuals in accessing needed medical, social, educational, housing, and transportation services. Greater use of both TCM and case management may offer an additional financing stream for a critical service need.

V. Opportunities for Evaluation and Spread

With thousands of local programs focusing on different intercept points and intervention models, there are myriad opportunities to evaluate success and support replication. In this section, we highlight local intervention models where there is some evidence that they are successfully addressing one or more community problems related to SUD and SMI and accordingly where replication in additional communities may be warranted. We end the section by suggesting areas where additional research would be helpful to assess the broader potential of such programs.

As noted earlier, there is abundant evidence that local initiatives are successfully addressing – to some greater or lesser extent – specific programmatic objectives. Arrest rates involving mental-health related response calls can be reduced by four times when they are met with trained crisis intervention teams compared with traditionally trained law enforcement officers.[112] Pre-arrest diversion programs including LEAD can reduce recidivism and have been associated with a 39 percent lower odds of being charged with a felony over the longer term.[113] Post-booking diversion programs can reduce time spent in jail and improve linkages to community-based services.[114] Jail-based treatment programs can reduce re-arrests for participating inmates from five to 25 percent when compared to untreated inmates.[115] And models deployed across non-criminal justice intercepts, including community paramedicine and IMHT have demonstrated that they can divert a significant portion of behavioral health patients to mental health crisis centers and away from hospital EDs, and can have a significant impact on recovery and reduction of drug use.[116,117]

We have found less evidence that these local programs are having broader and longer-term impacts on the well-being of individuals and communities; that is, programs that are breaking the cycle of substance use and reducing its prevalence; producing broader return on investment and long-term cost-savings; and initiatives that are improving behavioral and physical health outcomes. Given the number and range of local programs, it is not surprising that many have not been assessed and may in fact be highly effective models that can and should be replicated in additional communities. Areas warranting additional attention include the following:

Breaking the Cycle of Substance Abuse

Reducing the prevalence of the disease requires that programs both demonstrate long-term recovery, and are scalable, with the potential to reach a significant portion of the affected population. Future evaluations should focus on better understanding the proportion of individuals in a community with untreated SMI and SUD that can be reached through local programs, which models have an appreciable impact on long-term recovery, and whether and how successful models can be scaled.

Clinical Outcomes

There is surprisingly little evidence documenting whether and how local programs are leading to improvements in substance use recovery, mental health functioning, and co-occurring physical health outcomes. Los Angeles County's IMHT program did show a significant and clinically meaningful improvement in clients' mental health recovery over the first two years of services. Improvement in physical health outcomes however were not significantly different after program enrollment.[118] Further evaluations should focus on comparative analyses of different local program impacts to both long-term behavioral health recovery and improvements in physical health outcomes.

ROI, Cost Savings, and Sustainability

While many studies have assessed individual reductions in jail, court, first-responder, and other local program costs, few have quantified cost savings and return on investments across city, county, and community-based providers. One notable exception was a 2008 assessment of the Bexar County diversion program by RTI International, which found per client city and county cost savings of $3,149 in the six months following pre-booking diversion and $1,100 in the 18 to 24 months following post-booking diversion. Most of the savings accrued to the criminal justice system, with no significant savings or additional costs related to treatment.[119] Additional analyses focusing on cost reduction and return on investment that account for cost-shifting (from courts to treatment for example) are needed to assess the community-wide return on investment of local programs.

Unique and Untested Models

There are thousands of local programs with their own unique intervention variations that if assessed could potentially identify key success factors to inform the implementation of similar initiatives in other localities. Future evaluations should focus on exploring these issues by addressing these as yet unanswered research questions:

- Are there innovations that are more effective than others at circumventing the jail and criminal justice loop?
- Are there harm reduction approaches that haven't been thoroughly assessed in the United States – such as safe and clinically supervised injection sites – that might have a positive impact? How might they be integrated into local program initiatives?
- Collaboration across city, county, and community organizations is amorphous and fluid, but it is a critical success factor, the "secret sauce of diversion" and not well understood. What are the most effective ways to foster collaboration between law enforcement, prosecutors, care managers, and community providers?

- Are there models that are more effective in rural settings? Community paramedicine programs are emerging as a promising model for providing outreach and diversion in rural communities. Can these and other models be deployed in rural settings to reduce the impact of untreated SMI and SUD?

While the impact that housing can have on recovery and treatment outcomes is well known,[120] the extent to which access to affordable and permanent housing is a critical success factor of these local programs is not. Diverted individuals are not all the same, and have a variety of needs that may be better suited to different housing first variants including independent, permanent, supportive housing, and rapid re-housing. Understanding the impact housing has on these programs, and the difference these various housing first models can have on different populations would inform housing first approaches that communities across the country should adopt.

Finally, it must be acknowledged that the range of settings across which these interventions take place, spanning city, county, and community organizations, makes conducting evaluations with rigorous research designs challenging. Researchers have struggled with devising feasible approaches and securing the necessary resources to do so.[121] Program design factors that have been difficult to control for include: tracking cases that leave the community; securing data from a variety of disparate city, county, and community resource information systems; and isolating the impact of one set of programs and controlling for a variety of other interventions, types of therapies delivered, and other programs in which target populations may participate. While these factors can be overcome, they must be considered and factored into evaluation designs.

VI. Conclusion

Local communities see firsthand the human and economic costs of untreated SMI and SUD, including rising rates of incarceration, homelessness, and use of emergency services. The problems are palpable and cannot be ignored. Cities, counties, and community providers are responding by funding and operating programs that engage individuals in crisis and divert them to treatment and therapeutic settings. The programs are not a complete solution by any means, but they are making a difference. The taxonomy reviewed in this report highlights the key programmatic elements and success factors of 13 local programs, but these represent just a fraction of the initiatives that have been implemented across the country. Many of these programs are not well understood, preventing the spread of successful models in other communities. This report offers recommendations for further areas of research to promote a better understanding of variations in local program design and intervention models, including their efficacy in addressing the prevalence and impact of untreated SMI and SUD in communities. A richer body of evidence on successful, scalable, and sustainable intervention models will empower city and county leaders to invest in programs that improve the well-being of individuals with SMI and SUD and the communities in which they reside.

About the Authors

Jonah Frohlich, *Managing Director*

Jonah Frohlich is a Managing Director at Manatt Health, where he helps health care organizations with strategy, policy, and regulatory advice. He works with health systems and academic medical centers, health plans, state governments, and philanthropic organizations.

To bolster improvements in medical care for individuals and high-risk populations, Jonah leads projects that enable physician-hospital integration, and align IT, clinical, financial, and administrative services.

Jonah also leads and facilitates complex multi-stakeholder engagements, and assists health systems and health plans with the development of accountable care organizations and clinical integration initiatives by creating and advancing strategic and business plans. In addition, Jonah publishes reports describing the impact of state and federal policy on public and private markets.

Before joining Manatt, Jonah was deputy secretary of health information technology at the California Health and Human Services Agency, where he facilitated policy, statutory, and regulatory changes needed to advance health information exchange. As the administration's top executive and advisor on health IT, Jonah was responsible for coordinating the state's $1.5 billion initiative for the development, application, and use of electronic health records and secure information exchange.

As a senior program officer with the California Health Care Foundation, Jonah managed the organization's health IT portfolio, driving efforts to develop electronic health records, disease registries, and state and national data exchange standards.

Previously, Jonah was a manager at Brown & Toland Physicians, where he managed, collected, analyzed, and reported clinical, quality, financial, and utilization data; oversaw clinical integration requirements; and supervised population health and disease management programs.

Deborah Bachrach, *Partner*

Deborah Bachrach is a Partner at Manatt Health, where she uses her significant experience with both public- and private-sector health policy and financing to help states, providers, insurers, and foundations analyze and implement the Affordable Care Act. She also counsels clients on Medicaid coverage, payment policies, delivery systems, and other healthcare reforms.

Before rejoining Manatt, Deborah served as Medicaid director and deputy commissioner of health for the New York State Department of Health's Office of Health Insurance Programs, where she managed coverage, care and payment policies for more than four million children and adults enrolled in the state's Medicaid and Child Health Insurance programs. She led reforms to streamline Medicaid's eligibility and enrollment process, and improve its purchasing strategies.

Deborah has advised the Center for Health Care Strategies, the Medicaid and CHIP Payment and Access Commission, the Robert Wood Johnson Foundation, and the Kaiser Family Foundation.

Before working with the state of New York, as a Manatt partner Deborah provided legislative, regulatory, and strategic counsel to academic medical centers, safety net hospitals, community health centers, health plans, and other healthcare companies.

Deborah has also worked as vice president, external affairs, at St. Luke's–Roosevelt Hospital Center; as New York State chief assistant attorney general; and as chief of the Office of the New York State Attorney General's Civil Rights Bureau.

Deborah was an adjunct professor of law at the New York University School of Law, where she taught a seminar on federal health reform from 2011 to 2013.

Chris Cantrell, *Manager*

Chris Cantrell is a Manager at Manatt Health, where he provides project support and strategic business advice to a broad range of health care organizations, including health systems, academic medical centers, medical groups, foundations, and state and local governments. Chris' work has focused on state and federal health care reform, Medicaid, and health system strategy, with an emphasis on delivery-system transformation and alternative payment models.

Prior to joining Manatt, Chris worked at the California Department of Public Health, where he evaluated sustainability strategies for the California Home Visiting Program. Chris was previously a policy analyst with the National Academy for State Health Policy, where he provided research and technical assistance on a wide array of topics, including children's oral health, workforce issues, Medicaid, CHIP, health information technology, and health reform.

Alixandra Gould, *Consultant*

Alixandra Gould is a Consultant at Manatt Health, where she provides policy analysis, operational, research, and project management support to the full spectrum of health care stakeholders, including health care providers, payers, foundations, life sciences companies, and federal and state governments.

Alixandra joined Manatt from her internship at the Office of Evaluation and Inspections, Office of Inspector General, U.S. Department of Health and Human Services (HHS). In that role, she assisted with national evaluations of HHS programs, and contributed to reports reviewing domestic health policies.

Prior to HHS, Alixandra was an Executive Editor at Oxford University Press, where she led the print and digital content development group for the U.S. reference division. Alixandra also served as a teaching colleague at the Robert F. Wagner Graduate School of Public Service at New York University. In addition, she volunteered at Beth Israel Medical Center.

Appendix A: Stakeholder Interviewees

Local Initiatives

- Michael Bachman, Chief of Medical Affairs, Wake County EMS (Wake County, NC)
- Jesse Benet, Program Manager, Behavioral Health and Recovery Division, King County Department of Community and Human Services (King County, WA)
- Stephanie Bergeron, Executive Director, Serenity Place (Manchester, NH)
- Jose Cabanas, Medical Director, Wake County EMS (Wake County, NC)
- Koren Cappiello, Director of Social Services, City of Brockton (Brockton, MA)
- Lara Easton, Chief Deputy City Attorney (San Diego, CA)
- Travis Erickson, Healthcare Transformation and Implementation Manager, Public Health Department, Seattle and King County (Seattle, WA)
- Maria Funk, District Chief, Los Angeles County Department of Mental Health (Los Angeles County, CA)
- Deanna Gilkerson, Program Manager, Lee County Human and Veteran Services (Lee County, FL)
- Gilbert Gonzales, Director, Bexar County Department of Behavioral and Mental Health (Bexar County, TX)
- Chris Hickey, Chief Emergency Medical Services Officer (Manchester, NH)
- Judge Steve Leifman, 11th Circuit Court of Florida (Miami-Dade County, FL)
- Jason Lidyard, Deputy District Attorney (Santa Fe, NM)
- Jason Merrick, Director of Inmate Addiction Services, Kenton County Detention Center (Kenton County, KY)
- Lieutenant Mario Molina, Crisis Intervention Team Coordinator, San Francisco Police Department (San Francisco, CA)
- Joel Navarro, City Council Member (Tempe, AZ)
- Mayor Steve Williams (Huntington, WV)

National Experts

- Jim Brooks, City Solutions Director, National League of Cities
- Melinda Campopiano, Medical Officer, Substance Abuse and Mental Health Services Administration
- Maeghan Gilmore, Program Director, National Association of Counties
- Ron Manderscheid, Executive Director, National Association of County Behavioral Health and Developmental Disability Directors

Endnotes

1. SAMHSA, *Key Substance Use and Mental Health Indicators in the United States: Results from the 2015 National Survey on Drug Use and Health*, September 2016, available at: https://www.samhsa.gov/data/sites/default/files/NSDUH-FFR1-2015/NSDUH-FFR1-2015/NSDUH-FFR1-2015.pdf.

2. Ibid.

3. Ibid.

4. The 2008 Mental Health Parity Act requires insurers to cover behavioral health services on par with physical health services; the Affordable Care Act's essential health benefits provision, applicable in both the individual commercial market and Medicaid expansion, requires insurers to cover mental health and SUD services. Many states, including New Hampshire and Montana, extended these benefits to all Medicaid beneficiaries. Other states, including Kentucky and West Virginia, are using Medicaid expansion funding to offer enhanced SUD treatment services, such as medication-assisted treatment. At the same time, virtually every state Medicaid agency is adopting strategies to integrate physical and behavioral health services to more effectively care for individuals with co-morbid conditions. And less than a year ago, Congress passed the 21st Century Cures Act allocating $1 billion in grant funding for states to address the opioid epidemic.

5. The White House, Office of the Press Secretary, "President Donald J. Trump Directs Administration to Use All Appropriate Authority to Respond to Opioid Emergency." *Press Release*, August 10, 2017, available at: https://www.whitehouse.gov/the-press-office/2017/08/10/president-donald-j-trump-directs-administration-use-all-appropriate.

6. While not the focus of this report, public hospitals, community health centers and other physical health settings are also critical intercept points for identifying and engaging SMI and SUD populations.

7. SAMHSA, *Key Substance Use and Mental Health Indicators in the United States: Results from the 2015 National Survey on Drug Use and Health*, September 2016, available at: https://www.samhsa.gov/data/sites/default/files/NSDUH-FFR1-2015Rev1/NSDUH-FFR1-2015Rev1/NSDUH-FFR1-2015Rev1/NSDUH-National%20Findings-REVISED-2015.htm.

8. SAMHSA, *Homelessness and Housing*, September 15, 2017, available at: https://www.samhsa.gov/homelessness-housing.

9. Hammack, L., & Adams, M., "Roanoke turns its focus on homeless," *Roanoke Times*, December 15, 2007, available at http://www.roanoke.com/webmin/news/roanoke-turns-its-focus-on-homeless/article_0449a5e8-f769-50cb-ba4f-cebbf4db6c49.html.

10. James, Doris J. and Lauren E. Glaze, "Mental Health Problems of Prison and Jail Inmates," Bureau of Justice Statistics Special Report, December 14, 2006, available at: https://www.bjs.gov/content/pub/pdf/mhppji.pdf.

11. "National Alliance to End Homelessness." *Homelessness Statistics*, available at http://www.endhomelessness.org/pages/cost_of_homelessness.

12. U.S. Department of Housing and Urban Development Office of Policy Development and Research, *Costs Associated with First-Time Homelessness for Families and Individuals*, March 2010, available at: https://www.huduser.gov/publications/pdf/Costs_Homeless.pdf.

13. NCBI, *Frequent Emergency Department Visits and Hospitalizations Among Homeless People With Medicaid: Implications for Medicaid Expansion*, November 2015, available at: https://www.ncbi.nlm.nih.gov/pubmed/26447915.

14. Rienzi, Greg, "Johns Hopkins pilots study on EMS treatment of substance abusers." *Johns Hopkins University Gazette*, Sept-Oct 2014, available at: https://hub.jhu.edu/gazette/2014/september-october/focus-baltimore-city-ems/.

15. Stanaway, Nathan, "Community paramedic program cuts mental health patient call volume." *EMS1.com*, May 23, 2016, available at: https://www.ems1.com/community-paramedicine/articles/93357048-Community-paramedic-program-cuts-mental-health-patient-call-volume/.

16. Ad Hoc Police Practices Review Commission Mental Health and CIT Subcommittee, *Final Report and Recommendations*, August 2014, available at: http://www.fairfaxcounty.gov/policecommission/materials/mhcit-draft-report-august14.pdf.

17. Los Angeles Police Department, *Use of Force Year-End Review Executive Summary 2015*, available at: http://assets.lapdonline.org/assets/pdf/UOF%20Executive%20Summary.pdf.

18. Weiss, Audrey J., Marguerite L. Barrett, Kevin C. Heslin and Carol Stocks, "Trends in Emergency Department Visits Involving Mental and Substance Use Disorders, 2006-2013," HCUP, December 2016, available at: https://www.hcup-us.ahrq.gov/reports/statbriefs/sb216-Mental-Substance-Use-Disorder-ED-Visit-Trends.jsp?utm_source=AHRQ&utm_medium=EN-1&utm_term=&utm_content=1&utm_campaign=AHRQ_EN1_10_2017.

19. Tacoma-Pierce County Health Department, Office of Assessment, Planning, and Improvement, *A Community Mental Health and Chemical Dependency Assessment, City of Tacoma*, December 2012, available at: http://cms.cityoftacoma.org/hrhs/mentalhealth/CityofTacomaMHCDAssessmentfinal.pdf.

20. SAMHSA, *Municipal Courts: An Effective Tool for Diverting People with Mental and Substance Use Disorders from the Criminal Justice System*, 2015, available at: http://store.samhsa.gov/shin/content/SMA15-4929/SMA15-4929.pdf.

21. Justice Center, The Council of State Governments, *Improving Outcomes for People with Mental Illnesses Involved with New York City's Criminal Court and Correction Systems*, December 2012, available at: https://csgjusticecenter.org/wp-content/uploads/2013/05/CTBNYC-Court-Jail_7-cc.pdf.

22. National Institute of Justice, *Drug Courts*, available at: https://www.nij.gov/topics/courts/drug-courts/Pages/welcome.aspx.

23. Justice Center, The Council of State Governments, *Mental Health Courts*, available at: https://csgjusticecenter.org/mental-health-court-project/.

24. Vidaurre, Oskar, "Breaking the Cycle of Recidivism: Alternative Sentencing for Criminal Defendants with Psychiatric Illnesses," People with Disabilities Foundation, Winter 2008, available at: https://www.pwdf.org/enews/Winter08_Vol_6_Community_Currents.html.

25. Peters, Roger H., Harry K. Wexler and Arthur J. Lurigio, "Co-Occurring Substance Use and Mental Disorders in the Criminal Justice System: A New Frontier of Clinical Practice and Research," *Psychiatric Rehabilitation Journal*, 2015, available at: https://www.apa.org/pubs/journals/features/prj-0000135.pdf.

26. Nearly 20 percent of the 17,000 individuals in Los Angeles County jails suffer from SMI and 80 percent have a SUD. Many of these individuals have a high rate of recidivism. A study of jail inmates in Philadelphia found that recidivism rates were 54 percent for individuals with SMI, 66 percent for individuals with SUD, and 68 percent for those with co-occurring SMI and SUD. County of Los Angeles, Chief Executive Office, *Response to the Los Angeles County Board of Supervisors Regarding Possible Creation of a Health Agency*, June 30, 2015, available at: http://priorities.lacounty.gov/wp-content/uploads/2015/07/Response-to-the-Los-Angeles-County-Board-of-Supervisors-Regarding-Possible-Creation-of-a-Health-Agency-Final-Report_FINAL.pdf.

27. Sheffield, Wesley, "The Community Mental Health Act of 1963, Still Pursuing the Promise of Reform Fifty Years Later," *Young Minds Advocacy*, October 31, 2013, available at: https://www.ymadvocacy.org/the-community-mental-health-act-of-1963/.

28. Kinsella, Chad, "Corrections Health Care Costs," The Council of State Governments, January 2004, available at: https://www.prisonpolicy.org/scans/csg/Corrections+Health+Care+Costs+1-21-04.pdf.

29. "The Treatment Advocacy Center," *How Many Individuals with Serious Mental Illness are in Jails and Prisons?*, updated November 2014, available at: http://www.treatmentadvocacycenter.org/storage/documents/backgrounders/how%20many%20individuals%20with%20serious%20mental%20illness%20are%20in%20jails%20and%20prisons%20final.pdf.

30. Tacoma-Pierce County Health Department, Office of Assessment, Planning, and Improvement, *A Community Mental Health and Chemical Dependency Assessment, City of Tacoma*, December 2012, available at: http://cms.cityoftacoma.org/ncs/mhcd/CityofTacomaMHCDAssessmentfinal.pdf.

31. In Miami-Dade County, inmates with mental illness remain incarcerated four to eight times longer and cost seven times more than inmates without such conditions. The Sheriff's Department in Wayne County, Michigan found that 70 percent of individuals in its jails had a mental health condition, each of whom can cost the county up to $31,000 per year compared to $10,000 for providing community-based treatment. Chang, Daniel. "Criminal mental health program in Miami-Dade seen as a model for nation." *Miami Herald*, May 21, 2016, available at: http://www.miamiherald.com/news/health-care/article79004057.html.

32. Green, Jay. "Mental health cuts in Detroit have increased law enforcement problems, flooded ERs and created general misery," *Crain's Detroit Business*, May 6, 2011, available at: http://www.crainsdetroit.com/article/20110506/BLOG010/110509920/mental-health-cuts-in-detroit-have-increased-law-enforcement-problems.#sthash.ZEGeabBJ.dpuf.

33. AbuDagga, Azza, Sidney Wolfe, Michael Carome, Amanda Phatdouang and E. Fuller Torrey, "Individuals with Serious Mental Illnesses in County Jails: A Surey of Jail Staff's Perspectives," Public Citizen's Health Research Group and The Treatment Advocacy Center, July 14, 2016, available at: https://www.citizen.org/sites/default/files/2330.pdf.

34. Ibid.

35. Kim, KiDeuk, Miriam Becker-Cohen and Maria Serakos, "The Processing and Treatment of Mentally Ill Persons in the Criminal Justice System, A Scan of Practice and Background Analysis," The Urban Institute, March 2015, available at: http://www.urban.org/sites/default/files/publication/48981/2000173-The-Processing-and-Treatment-of-Mentally-Ill-Persons-in-the-Criminal-Justice-System.pdf.

36. In San Francisco's Behavioral Health Court, individuals requiring mental health or addiction treatment wait in jail an average of 120 days for an open mental health bed. San Francisco District Attorney's Office, *Justice that Heals: Promoting Behavioral Health, Safeguarding the Public, and Ending our Overreliance on Jails*, June 2016, available at: http://sfdistrictattorney.org/sites/default/files/Document/BHJC%20Concept%20Paper_Final_0.pdf.

37. "The Pew Charitable Trusts," *How and When Medicaid Covers People Under Correctional Supervision*, August 2, 2016, available at: http://www.pewtrusts.org/en/research-and-analysis/issue-briefs/2016/08/how-and-when-medicaid-covers-people-under-correctional-supervision.

38. Vera Institute of Justice, *The Price of Jails: Measuring the Taxpayer Cost of Local Incarceration*, May 2015, available at: https://storage.googleapis.com/vera-web-assets/downloads/Publications/the-price-of-jails-measuring-the-taxpayer-cost-of-local-incarceration/legacy_downloads/price-of-jails.pdf.

39. Lopez, German. "In 2016, drug overdoses likely killed more Americans than the entire wars in Vietnam and Iraq." *Vox Media*, July 7, 2017, available at: https://www.vox.com/policy-and-politics/2017/7/7/15925488/opioid-epidemic-deaths-2016.

40. Centers for Disease Control and Prevention, *Drug Overdose Death Data*, December 2016, available at: https://www.cdc.gov/drugoverdose/data/statedeaths.html.

41. Warth, Gary. "Homeless up 5 percent in the county, skyrockets downtown." *The San Diego Union-Tribune*, April 20, 2017, available at: http://www.sandiegouniontribune.com/news/homelessness/sd-me-homeless-count-20170419-story.html.

42. Emslie, Alex and Rachael Bale, *More Than Half of Those Killed by San Francisco Police Are Mentally Ill*. September 30, 2014: KQED News, available at: http://ww2.kqed.org/news/2014/09/30/half-of-those-killed-by-san-francisco-police-are-mentally-ill/.

43. SAMHSA, *Sequential Intercepts for Developing CJ-BH Partnerships*, April 2016, available at: https://www.prainc.com/wp-content/uploads/2016/04/SIMBrochure.pdf.

44. "King County Executive," *Familiar Faces Initiative*, May 27, 2015, available at: http://www.kingcounty.gov/elected/executive/health-human-services-transformation/familiar-faces.aspx.

45. Steele, Jeanette. "Mental health calls to local authorities up 84%." *San Diego Union Tribune*, June 6, 2016, available at: http://www.sandiegouniontribune.com/sdut-rise-police-calls-mental-health-2016jun06-story.html.

46. Walston, Stephen R., "Advanced Practice Paramedics," *Wake County EMS*, June 9, 2016, available at: http://www.wakegov.com/ems/about/staff/Pages/advancedpracticeparamedics.aspx.

47. "Eleventh Judicial Circuit, Miami Dade County, Florida," *Eleventh Judicial Criminal Mental Health Project Program Summary*, available at: http://fmhac.net/Assets/Documents/2015/Handouts/Leifman%20CMHP%20Program%20Description%20102714.pdf.

48. Hickey, Chris. Interview with Manchester Fire Department conducted by Manatt Health. Phone interview. March 9, 2017.

49. "University of Memphis," *CIT Center*, available at: http://cit.memphis.edu/.

50. "Harm Reduction Coalition," *Principles of Harm Reduction*, available at: http://harmreduction.org/about-us/principles-of-harm-reduction/.

51. "Kaiser Family Foundation," *Sterile Syringe Exchange Programs*, 2014, available at: http://kff.org/hivaids/state-indicator/syringe-exchange-programs/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

52. Benet, Jesse. Interview with King County Behavioral Health & Recovery Division conducted by Manatt Health. In-person site visit. May 8, 2017.

53. Heiss, Christian, MPH, Stephen A. Somers, PhD, and Mark Larson, "Coordinating Access to Services for Justice-Involved Populations," Millbank Memorial Fund, August 2016, available at: http://www.chcs.org/media/MMF_CoordinatingAccess-FINAL.pdf.

54. U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Workforce, National Center for Health Workforce Analysis, *National Projections of Supply and Demand for Selected Behavioral Health Practitioners: 2013-2025*, November 2016, available at: https://bhw.hrsa.gov/sites/default/files/bhw/health-workforce-analysis/research/projections/behavioral-health2013-2025.pdf.

55. Centers for Disease Control and Prevention, National Center for Health Statistics, *Multiple Causes of Death*, 1999-2013.

56. Olfson, Mark. "Building The Mental Health Workforce Capacity Needed To Treat Adults With Serious Mental Illnesses." *Health Affairs*, June 2016, available at: http://content.healthaffairs.org/content/35/6/983.full.pdf+html.

57. City of Huntington, *2015 Strategic Plan, Mayor's Office of Drug Control Policy*, August 24, 2015, available at: http://www.cityofhuntington.com/assets/pdf/document-center/STRATEGIC_PLAN_FINAL.pdf.

58. Gilkerson, Deanna. Interview with Lee County Human Services conducted by Manatt Health. Phone Interview. March 6, 2017.

59. Hickey, Chris. Interview with Manchester Fire Department conducted by Manatt Health. Phone interview. March 9, 2017.

60. Leifman, Steven. Interview with Miami-Dade County Eleventh Judicial Circuit. Phone interview. March 20, 2017.

61. Benet, Jesse. Interview with King County Behavioral Health & Recovery Division conducted by Manatt Health. In-person site visit. May 8, 2017.

62. The Bristol-Myer Squibb Foundation awarded Miami-Dade County $1.2 million to support the development of a coordinated system of care for justice-involved individuals with mental illness. Eleventh Judicial Circuit, *Eleventh Judicial Criminal Mental Health Project Program Summary*, Miami Dade County, Florida, 2015, available at: http://fmhac.net/Assets/Documents/2015/Handouts/Leifman%20CMHP%20Program%20Description%20102714.pdf.

63. Interact for Health, a Cincinnati-based foundation that serves 20 counties in Ohio, Kentucky and Indiana, provided $162,000 in funding to support the planning and implementation of the Northern Kentucky Regional Mental Health Court to divert individuals with mental illness from jail to treatment. "Interact for Health," *Northern Kentucky court saves money by treating mentally ill*, available at: https://www.interactforhealth.org/northern-kentucky-regional-mental-health-court-spotlight.

64. The Open Society Foundation provided funding to support the launch of Seattle's LEAD program and in 2015 distributed more than $1.4 million in grants to replicate the model in other localities. *Open Society Foundations, "*Open Society Foundations Announce New Investments in Innovative Drug Policy," December 1, 2015, available at: https://www.opensocietyfoundations.org/press-releases/open-society-foundations-announce-new-investments-innovative-drug-policy.

65. See Appendix B: Law Enforcement Assisted Diversion (LEAD) Program, Santa Fe, NM.

66. "Robert Wood Johnson Foundation." *Manchester, New Hampshire, 2016 RWJF Culture of Health Prize Winner*, available at: https://www.rwjf.org/en/library/features/culture-of-health-prize/2016-winner-manchester-nh.html.

67. "Anthem Blue Cross and Blue Shield Foundation Tackled Complex Health Needs in NH in 2016." *Business Wire*, January 31, 2017, available at: http://www.businesswire.com/news/home/20170131005850/en/Anthem-Blue-Cross-Blue-Shield-Foundation-Tackled.

68. Concord Hospital's Community Benefits Program in New Hampshire invested $1.8 million to provide substance use services including Program for Addictive Disorders, Fresh Start and support for Neonatal Abstinence Syndrome babies. *Concord Hospital*, "Concord Hospital Provides $46 Million in Community Benefit Programs and Services," 2017, available at: http://www.concordhospital.org/news/news-2017/concord-hospital-provides-46-million-in-community-benefit-progra/.

69. "Reid Health," *2017 Grants*, available at: https://www.reidhealth.org/reid-gives-grants/2017-grants/.

70. The CBHQS Report, *SAMHSA National Survey on Drug Use and Health*, November 18, 2015.

71. State Health Reform Assistance Network, *Medicaid: States' Most Powerful Tool to Combat the Opioid Crisis*, July 2016, available at: http://www.statenetwork.org/wp-content/uploads/2016/07/State-Network-Manatt-Medicaid-States-Most-Powerful-Tool-to-Combat-the-Opioid-Crisis-July-2016.pdf.

72. Bachrach, Deborah, Jocelyn Guyer and Ariel Levin, "Medicaid Coverage of Social Interventions: A Road Map for States," Millbank Memorial Fund, July 25, 2016, available at: https://www.milbank.org/publications/medicaid-coverage-social-interventions-road-map-states/.

73. Grady, April, Deborah Bachrach and Patricia Boozang, "Medicaid's Growing Role for SUD Services in Montana," *Manatt on Medicaid*, March 29, 2017 available at: https://www.manatt.com/Insights/Newsletters/Medicaid-Update/Medicaids-Growing-Role-for-SUD-Services-in-Montana.

74. SAMHSA, *Substance Abuse and Mental Health Block Grants*, available at: https://www.samhsa.gov/grants/block-grants.

75. Non-block grant SAMHSA programs include: (1) Comprehensive Addiction and Recovery Act Cooperative Agreement, (2) Grants to Expand Substance Abuse Treatment Capacity in Adult Treatment Drug, (3) Grants for the Benefit of Homeless Individuals-Services in Supportive Housing, (4) Projects for Assistance in Transition from Homelessness. Congress authorized $50 million in grants administered by The Justice Department through the Justice and Mental Health Collaboration Program (JMHCP) through the Mentally Ill Offender Treatment and Crime Reduction Act (MIOTCRA).

76. U.S. Department of Housing and Urban Development, *HUD's 2016 Continuum of Care Program Funding Awards*, April 19, 2017, available at: https://www.hudexchange.info/resource/reportmanagement/published/CoC_AwardComp_NatlTerrDC_2016.pdf.

77. MacArthur Foundation, *SAMHSA, MacArthur Renew Commitment to Justice-Involved Youth with Behavioral Health Needs*, January 13, 2014, available at: https://www.macfound.org/press/press-releases/samsa-macarthur-renew-commitment-justice-involved-youth-behavioral-health-needs/.

78. Miami-Dade County used SAMHSA grant funding to support training for its CIT program, while drug courts in Huntington, West Virginia used grant funds to address drug addiction among former prostitutes.

79. "SAMHSA to Award Nearly $1 Billion in New Grants to Address the Nation's Opioid Crisis." *News Release*, December 14, 2016, available at: https://www.samhsa.gov/newsroom/press-announcements/201612141015.

80. Steadman, Henry J., Martha Williams Deane, Randy Borum and Joseph P. Morrissey, "Comparing Outcomes of Major Models of Police Responses to Mental Health Emergencies," *Psychiatry Services*, May 2000, available at: http://ps.psychiatryonline.org/doi/10.1176/appi.ps.51.5.645.

81. Compton, Michael T., Masuma Bahora, Amy C. Watson, and Janet R. Oliva, "A Comprehensive Review of Extant Research on Crisis Intervention Team (CIT) Programs," *The Journal of the American Academic of Psychiatry and the Law*, March 2008, available at: http://jaapl.org/content/36/1/47.

82. Watson, Amy C., "Research in the Real World: Studying Chicago Police Department's Crisis Intervention Team (CIT) Program," *Research on Social Work Practice*, 2010; 20:536–543.

83. Dupont, R., Cochran, S., & Bush, A. (1999) "Reducing criminalization among individuals with mental illness." Presented at the US Department of Justice and Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA) Conference on Forensics and Mental Illness, Washington, DC, July 1999, available at: https://www.nami.org/Law-Enforcement-and-Mental-Health/What-Is-CIT#_edn1.

84. Seattle and King County LEAD Program, "*Innovative Law Enforcement Assisted Diversion (LEAD) Program Is Showing Success*," April 8, 2015, available at: http://static1.1.sqspcdn.com/static/f/1185392/26121915/1428514214557/2015-04-08+LEAD+Press+Release+and+Evaluation+Summary.pdf?token=k2XYATm6uE%2BNjbMFWCyolazpUEo%3D.

85. Collins, Susan E., Heather S. Lonczak and Seema L. Clifasefi, "LEAD Program Evaluation: Criminal Justice and Legal System Utilization and Associated Costs," Presented at the Harm Reduction and Treatment Lab, University of Washington, Harborview Medical Center, June 24, 2015, available at: https://media.wix.com/ugd/6f124f_2f66ef4935c04d37a11b04d1998f61e2.pdf.

86. Buntin, John, "Miami's Model for Decriminalizing Mental Illness in America," *Governing the States and Localities*. August 2015, available at: http://www.governing.com/topics/public-justice-safety/gov-miami-mental-health-jail.html.

87. Glickman, S., et al, "An Advanced Practice Paramedic Program Can Safely and Effectively Divert Acute Mental Health Patients from the ED to a Community Mental Health Center," University of North Carolina, Chapel Hill, NC; Wake County Department of Emergency Medical Services, Raleigh, NC.

88. Los Angeles County MHSA Innovation Program, *Annual Report*, December 2014, available at: http://file.lacounty.gov/SDSInter/dmh/226026_Innovation1AnnualReport.pdf.

89. Volkow, Nora, Thomas Frieden, Pamela Hyde, and Stephen Cha, "Medication-Assisted Therapies — Tackling the Opioid-Overdose Epidemic," *The New England Journal of Medicine*, May 29, 2014, available at: http://www.nejm.org/doi/full/10.1056/NEJMp1402780.

90. Hunt, Neil, "A Review of the Evidence-Base for Harm Reduction Approaches to Drug Use," *Forward Thinking on Drugs*, available at: https://www.hri.global/files/2010/05/31/HIVTop50Documents11.pdf.

91. Padgett, D.K., V. Stanhope, B.F. Henwood, and A Stefancic, "Substance use outcomes among homeless clients with serious mental illness: comparing Housing First with Treatment First programs," *NCBI*, April 2011, available at: https://www.ncbi.nlm.nih.gov/pubmed/20063061.

92. Gulcur, Leyla, Ana Stefancic, Marybeth Shinn, Sam Tsemberis and Sean N. Fischer, "Housing, Hospitalization, and Cost Outcomes for Homeless Individuals with Psychiatric Disabilities Participating in Continuum of Care and Housing First Programmes," *Journal of Community and Applied Social Psychology*, Volume 13, Issue 2, March/April 2003, Pp 171–186.

93. Srebnik, Debra, PhD, Tara Connor, PhD, and Laurie Sylla, MHSA, BSW, "A Pilot Study of the Impact of Housing First–Supported Housing for Intensive Users of Medical Hospitalization and Sobering Services," *American Journal of Public Health*, February 2013, Vol 103, No. 2, pp316-321.

94. Leukefeld, Carl G., Frank M. Tims and David Farabee, *Treatment of Drug Offenders: Policies and Issues*, New York: Springer Publishing Company," 2002. pp. 186–203.

95. Tucker, T.C., "Outcome Evaluation of the Detroit Target Cities Jail Based Substance Abuse Treatment Program," Wayne County Department of Community Justice, 1998.

96. Hughey, Ray and Lloyd W. Klemke, "Evaluation of a Jail-Based Substance Abuse Treatment Program," *Federal Probation*, 1996, available at: http://www.heinonline.org/HOL/Page?handle=hein.journals/fedpro60&div=66&id=&page=&collection=journals.

97. Los Angeles County MHSA Innovation Program, *Annual Report*, December 2014, available at: http://file.lacounty.gov/SDSInter/dmh/226026_Innovation1AnnualReport.pdf.

98. "NAMI," *What is CIT*, available at: https://www.nami.org/Law-Enforcement-and-Mental-Health/What-Is-CIT#_edn1.

99. Collins, Susan E., Heather S. Lonczak and Seema L. Clifasefi, "LEAD Program Evaluation: Criminal Justice and Legal System Utilization and Associated Costs," Presented at the Harm Reduction and Treatment Lab, University of Washington,Harborview Medical Center, June 24, 2015, available at: https://media.wix.com/ugd/6f124f_2f66ef4935c04d37a11b04d1998f61e2.pdf.

100. Steadman, Henry J. and Michelle Naples, "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.

101. Cowell Alexander J., Nahama Broner and Randolph Dupont, "The Cost-Effectiveness of Criminal Justice Diversion Programs for People with Serious Mental Illness Co-Occurring with Substance Abuse: Four Case Studies," *Journal of Contemporary Criminal Justice*, 20:292–325, 2004.

102. The Cook County Sheriff's Department forged strong relationships with local non-profits, low-income housing providers, local employers, and other partnerships to support transition out of jail and recovery back in the community. Mentally ill inmates participating in their programs recidivate far less often, which has resulted in a reduction in Cook County's overall jail population by 20 percent and millions of dollars in saving, including the shutdown of several large Cook County jail facilities. Cook County Sheriff Thomas J. Dart, *A Mental Health Template for American Jails*, July 2016, available at: http://www.cookcountysheriff.org/MentalHealthTemplate.html.

103. Bexar County built the Restoration Center where law enforcement, hospitals, courts, and community-based organizations can refer individuals to a medical detox unit and intensive outpatient substance use and counseling services. The coordinated efforts of the County and its partners enable approximately 1,800 to 2,100 individuals per month to receive treatment and have saved the County more than $10 million per year in jail and emergency room costs. See Taxonomy: Bexar County Jail and Hospital ED Diversion program.

104. King County is developing a comprehensive, integrated client-level health and human services data system that would support care coordination, help identify high risk groups, and support population health analysis, program evaluation, and costs analysis. See Taxonomy: King County Familiar Faces program.

105. SAMHSA, *Recovery and Recovery Support*, 2012, available at: https://www.samhsa.gov/recovery.

106. In Miami-Dade, the Court collaborates with the local Social Security Administration Office and health providers to facilitate and expedite program clients' access to benefits using the SSI/SSDI, Outreach, Access and Recovery (SOAR) model. SOAR was developed as a federal technical assistance initiative to expedite access to benefits for people with mental illnesses who are homeless. See: https://soarworks.prainc.com/.

107. King County's Familiar Faces program has adopted this approach and established an intensive care management team and case workers to provide and coordinate behavioral health and social services.

108. In Miami-Dade County, Judge Steven Leifman worked with the County Commission and the Mayor, to support issuance of City bonds to fund the transformation of a closed County facility into a 181,000-square foot mental health diversion facility with over 200 beds, where individuals can stay for up to 90 days to receive treatment and stabilization services.

109. "Bureau of Justice Assistance, U.S. Department of Justice," *Justice and Mental Health Collaboration Program*, accessed October 2017, available at: https://www.bja.gov/ProgramDetails.aspx?Program_ID=66#horizontalTab1.

110. U.S. Department of Housing and Urban Development, *HUD Awards $1.6 Billion for Local Homeless Programs*, March 8, 2016, available at: https://portal.hud.gov/hudportal/HUD?src=/press/press_releases_media_advisories/2016/HUDNo_16-030.

111. See the earlier Funding Sources section for examples of philanthropic funding.

112. Skeem, Jennifer and Lynne Bibeau, "How Does Violence Potential Related to Crisis Intervention Team Responses to Emergencies?" *Psychiatric Services*, available at: http://ps.psychiatryonline.org/doi/10.1176/ps.2008.59.2.201.

113. Collins, Susan E., Heather S. Lonczak and Seema L. Clifasefi, "Seattle's Law Enforcement Assisted Diversion (LEAD): Program Effects on Recidivism Outcomes," *Evaluation and Program Planning*, May 2017.

114. Steadman, Henry J. and Michelle Naples, "Assessing the Effectiveness of Jail Diversion Programs for Persons with Serious Mental Illness and Co-Occurring Substance Use Disorder," *Behavioral Sciences and the Law*, 23: 163–170. doi:10.1002/bsl.640 (2005).

115. Tucker, T.C.," Outcome Evaluation of the Detroit Target Cities Jail Based Substance Abuse Treatment Program," Wayne County Department of Community Justice, 1998.

116. Coffman, Janet M., Cynthia Wides, Matthew Niedzwiecki, and Igor Geyn, "Evaluation of California's Community Paramedicine Pilot Project," Presented at the 2017 Healthforce Center at UCSF, January 23, 2017, available at: http://www.emsa.ca.gov/Media/Default/PDF/Evaluation%20of%20California's%20CP%20Pilot%20Program_final.pdf.

117. Los Angeles County MHSA Innovation Program, *Annual Report*, December 2014, available at: http://file.lacounty.gov/SDSInter/dmh/226026_Innovation1AnnualReport.pdf.

118. Ibid.

119. Cowell, Alexander J., Arnie Aldridge, Nahama Broner and Jesse M. Hinde, "A Cost Analysis of the Bexar County, Texas, Jail Diversion Program," May 2008, available at: https://www.americanbar.org/content/dam/aba/administrative/criminal_justice/texascommunitycorrections.authcheckdam.pdf.

120. Padgett, Deborah K., Victoria, Stanhope, Ben F. Henwood and Ana Stefancic, "Substance Use Outcomes Among Homeless Clients with Serious Mental Illness: Comparing Housing First with Treatment First Programs," *Community Mental Health Journal*, January 9, 2010, available at: http://doi.org/10.1007/s10597-009-9283-7.

121. Watson, Amy, "Research in the Real World: Studying Chicago Police Department's Crisis Intervention Team (CIT) Program," *Research on Social Work Practice*. 2010; 20

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