Prearrest Diversion -- A Review of Programs and Implications for Program Design

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I. Introduction

There is growing recognition that diverting people before they reach the criminal justice system can have a significant impact on reducing prison populations and stabilizing the lives of those who would otherwise cycle in and out of the prison and legal system. Such efforts can keep individuals with behavioral health issues, or who are involved in low-level crimes, out of the justice system machinery, with resulting cost savings and improved individual outcomes. Given that even short stays in prison increase risk of future justice involvement and destabilize the lives of individuals and families, such programs have the potential to shut down a portion of the pipeline that moves people toward recurring criminal justice involvement.

A wide variety of approaches have been adopted or are being explored in various locales. These programs vary in their primary goal. Some programs are designed primarily to reduce future crimes, others are designed to provide appropriate treatment for behavioral health issues, and still others are designed to improve police response to those with mental health issues or cognitive impairments. These variations in focus influence which individuals are targeted for intervention, which institutions serve as an entry point to programs, and the approach to providing services to involved individuals. At the same time, there are often commonalities among these programs, reflecting a response to similar issues in similar populations.

This paper briefly reviews some promising pre-booking diversion approaches that vary along a number of dimensions. This survey of a small number of programs is by no means exhaustive, but there are enough design differences among the programs to illustrate a range of possible designs. A brief review of research on the effectiveness of additional pre-booking programs is brought in for perspective when applicable. The paper notes program similarities and differences and identifies features that could be useful in a local program. The review briefly looks at the following programs:

- Law Enforcement Assisted Diversion (LEAD) programs
- Chronic Utilizer Alternative Response Team (CHART) - Everett
- Behavioral Health Unit - Portland
- Response Planning De-escalation and Referral (RADAR) - Shoreline
- Hot Spotter Program - Spokane
- Bexar County, TX, diversion programs

As the review shows, all of these programs have a behavioral health component and most have a crime diversion aspect. These programs vary on a continuum from those focused on diverting people from certain low-level crimes, to those that emphasize proactive response to social and behavioral issues. Although program entry criteria may vary, most have established specific pathways to treatment and services for program participants. Because the problems these programs attempt to solve are at least somewhat similar, elements from more than one program could be drawn upon to create a program tailored to goals and conditions in Whatcom County.

II. A brief description of programs

Law Enforcement Assisted Diversion (LEAD). The nation's first LEAD program was developed in Seattle in 2011. This pre-booking diversion program creates a pathway for police officers to refer low-level drug users and sex crime suspects to treatment and community services in lieu of criminal charges. The program focuses on low-level offenders and excludes those who commit violent crimes, deal drugs, or promote prostitution. Officers transport a person to case managers, who do intake assessment and evaluate participant situations and personal issues, and connect people with services including housing, food, clothing, health care, and legal advice. Case assessment entails "…items evaluating participants' substance-use frequency and treatment, time spent in housing, quality of life, psychological symptoms, interpersonal relationships, and health status."[1] Program staff work with local courts to help resolve outstanding criminal or civil charges. A workgroup consisting of police officers, case managers, and service providers meets every two weeks to review client status and make adjustments to treatment programs or services.[2]

Although the program focuses on diverting people who would otherwise be charged with crime, it also allows officers to refer a person to the program in the absence of a present offense if they have similar characteristics and risks to other program participants. These "social contacts" inject a proactive element into the program. The primary aim of the program is to reduce repeat crimes. Secondary aims are to reduce criminal justice system costs, and improve life outcomes for participants.[3] The program began in the Belltown area just north of downtown, and has been expanded to include the rest of the Seattle downtown core and the Capitol Hill area east of downtown.

Initial evaluations indicate that the LEAD program is effective in reducing repeat crimes and in reducing criminal justice costs. These results have prompted additional cities to add their own version of LEAD. Santa Fe was the second City to implement a LEAD program beginning in April 2014. This program is substantially similar to the Seattle model but focuses specifically on drug users, especially those using opiates. Services are based on a harm reduction model, and include housing, employment assistance, health care, and substance abuse treatment. Exclusion factors are similar to Seattle's. Similarly, once an officer determines that someone is eligible they are connected to a case manager. Officers and case managers meet twice a month to discuss each client's progress and the effectiveness of services they are getting. As in Seattle, the program allows "social contact referrals" whereby an officer does not have to see a crime being committed to refer a particular person to the program. Santa Fe plans to conduct an evaluation of the effectiveness of its program.[4]

Additional cities have implemented, or are starting to implement, a LEAD model in their communities. Albany, NY, the third city to implement LEAD, started its program in March 2016 with full implementation expected later in the year. The Albany program focuses on low-level crimes such as shoplifting and marijuana possession.[5] According to a news release at the outset of the program, "Historically, a relatively small number of individuals in Albany with high needs demand a great deal of police time and resources. They cycle in and out of jail or prisons without treatment of their underlying issues, such as mental illness and substance use problems, homelessness, unemployment, and inadequate medical care. This population also tends to be high utilizers of the hospital emergency room, which is costly and is not designed to provide preventative or regular health care."[6] While initially focused on the City of Albany, elements of the program may be extended countywide as the program develops.[7] A project manager oversees and coordinates the program. Services to be provided to participants include health care, housing, and mental health and drug treatment. Case management in the program is supported in part by Medicaid funds made available from a Medicaid waiver received by the State of New York.[8] The

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program includes training of police officers on harm reduction approaches to addiction, and on ways to reduce implicit bias in policing and improve interactions between citizens and the police.[9]

Additional cities are creating LEAD programs. For example, Fayetteville, NC, will launch a LEAD program in late 2016. The program focuses on drug crimes, low-level prostitution crimes, and larceny. Services will include housing, food assistance, and job placement assistance.[10] Ithaca, NY will start its LEAD program in 2017.[11]

Behavioral Health Team Model. Some cities have adopted diversion models that are focused on managing behavioral health issues proactively while also improving police-citizen interactions. These programs include enhanced training of officers to ensure appropriate response to individuals in mental health crisis or who are under the influence of alcohol or narcotics. Some programs go further by creating special response teams that include mental health or social work professionals, increasing the level of expertise available for interactions with individuals with chronic or acute behavioral health issues. For example, one version of this co-responder model embeds mental health professionals into special police units that are deployed in response to individuals manifesting behavioral health problems.

Goals of this approach include ensuring an appropriate response to mental illness and reducing the cycling of those with mental health and substance abuse issues through the legal and prison system. Another goal is to divert such individuals into more appropriate care. The City of Portland has adopted one version of this approach, establishing an array of programs since 2013 that support proper response to, and treatment of, individuals who have substance abuse or mental health problems. Components of the Portland program, called the Behavioral Health Unit (BHU), include:

- A minimum of 40 hours of Crisis Intervention Training (CIT) for all officers;
- An Enhanced Crisis Intervention Team (ECIT) made up of volunteer officers who receive an additional 40 hours of training and who are designated first responders to mental health crisis calls;[12]
- Proactive Behavioral Health Response Teams (BHRT) consisting of a patrol officer and a licensed mental health professional that work proactively with those with multiple prior police contacts;
- A Service Coordination Team to coordinate services and treatment.[13]

An officer who is part of the Enhanced Crisis Intervention Team is dispatched by 911 when there is an incident indicating mental health or other behavioral issues. In addition to providing crisis response expertise, this team may also make referrals to community services when indicated. Behavioral Health Response Teams (BHRT) include an officer and a licensed mental health professional. There are three of these teams, one for each precinct. These teams work proactively with individuals with mental illnesses and who have high risk of additional contact with police, making referrals to local services. Each BHRT works with about 12 to 15 people at any time. The program has also developed an Electronic Referral System that allows any officer to refer an individual with behavioral issues to the BHU. Also, using the system, officers can notify the BHU when they interact with anyone currently on the BHU case list.[14]

The Service Coordination Team arranges treatment for drug and property crime offenders to address substance abuse, mental health, and criminal risk factors. Services may include stay in a six-bed treatment center (the Supportive Transitions and Stabilization Program) for mental health and co-occurring disorders.[15] According to one description of Portland's program, "This multilayered approach allows for

both a reactive and proactive model, with the goals of resolving behavioral crises, connecting people to resources, and reducing the frequency of police contact."[16] Early findings indicate that the Service Coordination Team has reduced recidivism by 91 percent among its graduates.[17]

Chronic Utilizer Alternative Response Team (CHART). Another, broader approach to diversion is to identify those who are repeat users of health care, emergency services, and other resources and shifting those individuals into more appropriate systems of care. This approach is designed to improve response to and treatment of behavioral health issues and to also save resources expended with overuse of certain services. Everett's CHART program is an example of such a program, targeting chronic users of public systems including jail, hospital ER, and 911. The program includes a coordinated response across many institutions (e.g. the Court, EMS, jail, hospital systems) to divert individuals from jail or the ER and into appropriate services. The program was an outgrowth of Everett's Safe Streets program, resulting from a 2014 initiative to address a broad array of behavioral and crime issues particularly visible in the downtown core.[18] This program resulted in a number of recommendations, many of which have been implemented. A sample of recommendations from the 2014 report that seek to enhance appropriate response to behavioral issues or reduce incarceration include:

- Embed a social worker in EMS and Police teams;
- Create a multi-agency team to develop a response plan for frequent utilizers of the ER and those who cycle through the legal system;
- Support Snohomish County's creation of a Jail Transition Services facility to act as a focal point for services for those leaving the jail;
- Expand therapeutic courts;
- Create a resource (e.g. map) showing all available services for housing and supportive services for use of individuals and agencies;
- Improve housing access, to include creation of low-barrier housing and putting a housing levy on the ballot.[19]

The Community Streets report noted that "Traditional criminal justice and law enforcement responses, while appropriate for many, are often ineffective, inappropriate, and too expensive to deal with street level social issues…." The CHART program is a response to this issue. CHART participants are identified by one or more staff of project partners the Everett Police Department, Everett Fire Department, Snohomish County Department of Human Services, Snohomish County Jail, the Everett City Attorney's Office, and Providence Regional Medical Center Everett. The main selection criteria for participants is frequent use of one or more services: in the prior 6 months, individuals must have had six or more contacts with the EMS and one contact with three of the following agencies or service: fire, police, jail, court, or emergency room.

A CHART social service team includes members of the above agencies as well as housing and behavioral health organizations. Individuals must sign a privacy release so that their case can be discussed every two weeks by the service team. Services may include resolution of outstanding legal issues such as standing warrants.[20] Project partners work together to create an individualized plan for each participant. The program has developed a data system to identify chronic users and track service use and progress in the program. There are no specific requirements to remain a participant in the program although individuals are encouraged to actively engage in improving their situation.

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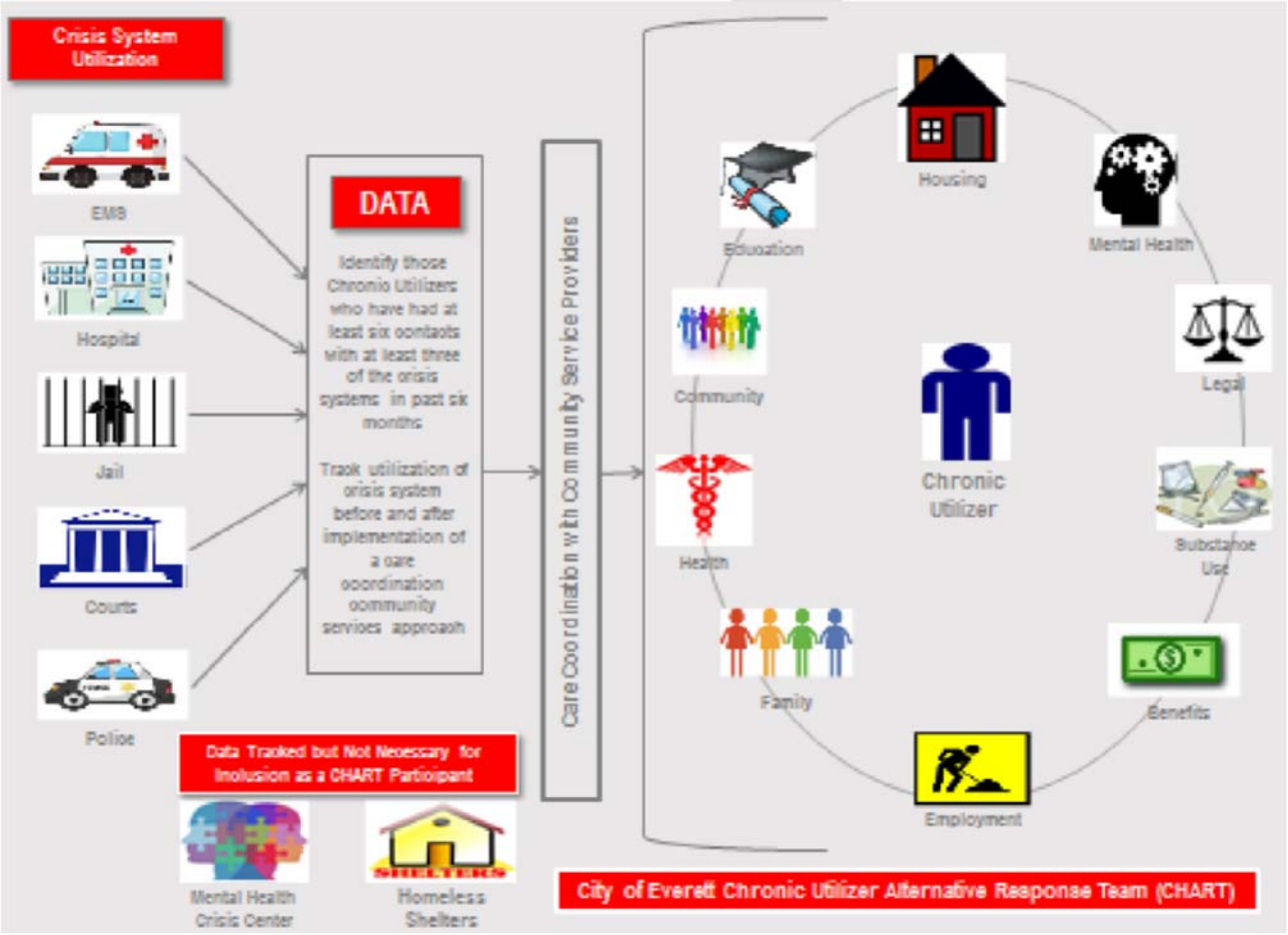
While the CHART program employs a proactive, behavioral health approach, police may also use possible jail for unresolved misdemeanors as an incentive to enter the program and be connected with services and treatment.[21] In this way, it has some affinities with a LEAD approach. In addition, the police department has added an embedded social worker to start the process of connecting individuals to services.

The program is tracking activities of participants to determine it is reducing inappropriate use of services and resulting in better outcomes. Very early results with just a few participants indicate that the program appears to be helping to reduce EMS contacts as well as arrests and incarceration of participants.[22]

CHART Program Diagram



Source: Chronic Utilizer Alternative Response Team (CHART) Initial Evaluation, April 2016

Response Awareness, De-escalation and Referral (RADAR). This program, being developed in Shoreline, is centered on de-escalation training and information sharing to improve police interactions with those who have mental health and cognitive disorders. Goals of the program include reducing risk of use of excessive force against individuals with behavioral health issues, and also reducing the arrest and jailing of individuals who would be better treated in other facilities. The program is creating a database to be populated with information about specific individuals with mental health issues. In order for an individual to get into the database, a family member of a

person with mental illness must contact the King County Sheriff's Office (which staffs the Shoreline Police Department under contract) with permission to enter the person into the database.[23] An individualized profile will be created to assist officers to respond appropriately, reflecting the specific issues and vulnerabilities of each person. The information will be immediately available to officers as they respond to calls, allowing them to tailor their response to the person's issues and behavioral "triggers."

Officers also attempt to establish a cooperative relationship with individuals who are at-risk of criminal behavior. In addition, the program works to involve "circles of support" - friends or family members who can assist with a person's recovery.[24] Police receive training in de-escalation techniques. Officers involved in the program will work to connect individuals to health care and mental health services. Program managers expect to implement the program starting early 2017.[25] As a condition of receipt of a Bureau of Justice Assistance grant to help establish the program, the program will be evaluated by researchers at George Mason University.[26]

"Hot Spotter" Program (Spokane). Similarly to the Everett CHART program, Spokane's Hot Spotter program is designed to reduce inappropriate overuse of services and direct individuals with behavioral health issues into treatment and other services. Program partners include the Spokane Medical Society, Spokane Fire Department, Providence Sacred Heart Medical Center, Spokane Police Department, Spokane Housing and Human Services Department, other health care providers, and community social service agencies. The program is also designed to reduce system costs, especially overuse of the ER.[27] For example, one individual helped by the program had 40 ER visits during one two-month period in 2012. Program development has helped catalyze a more coordinated network of services. The program provides intensive case management delivered by a multi-organizational team. Services include housing, medical care, financial counseling, behavioral health management, and other services.[28] For individuals with standing legal issues, treatment may include sentencing through Community Court to help offenders resolve misdemeanor offenses in lieu of a jail stay. (The newly-developed Spokane Community Court modeled its care coordination strategy on that developed by the Hot Spotters program.)[29]

Other related programs in Spokane include a Chronic Offenders Unit that attempts to manage activities of chronic low-level offenders committing crimes such as burglary, vehicle theft, and identity theft. Many of these people have addictions that drive their criminal behavior, and Spokane Police attempt to connect chronic offenders with mental health services, job services, housing, medical insurance, etc. Similar to the Shoreline program, the Chronic Offenders unit attempts to build relationships with family members and associates to assist in stabilization and treatment.[30]

Bexar County Diversion Programs. One of the oldest and most evaluated diversion programs began in Bexar County, TX in 2003, with numerous additional elements added in subsequent years. People eligible for diversion in this program have committed low level misdemeanors and must also have been diagnosed with one or more of the following: "major depression, schizophrenia (including schizoaffective disorder) or bipolar disorder."[31] The program employs CIT training for most deputies and also provides a Deputy Mobile Outreach Team composed of officers who have received additional crisis intervention and mental health training. The Bexar County Sherriff credits de-escalation training with reducing use of force against those with mental illness from about 50 times per year to less than once a year.[32] The program provides housing and employment assistance, and

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is oriented toward community rehabilitation. Local efforts also include training attorneys involved in the criminal justice system on mental health issues.

In 2005, the program created a 24/7 dropoff center called the Restoration Center with a no refusal policy. The serves as a triage center for people with mental health or substance abuse issues. Local studies indicate that the Center saves $10 million a year in costs that would otherwise be incurred in other parts of the health or criminal justice systems.[33] Individuals are accompanied by police to the center and are given a psychiatric assessment to determine if they are eligible for pre-booking diversion. There is also a medical clinic on site. The crisis clinic allows police to quickly drop off detained individuals instead of being held up for up to 12 hours at the emergency room.[34]

The Bexar County diversion program also has a substantial post-arrest component. A mental health court was established in 2009 and there are numerous other specialty courts. Those with pending charges are often released on a commercial "mental health bond" and are supervised by a pre-trial services team that assigns a case manager and mental health professional. Those who do not qualify for this form of release may be diverted through the mental health court. The County continues to add additional programs elements to improve response to mental health issues. For example, in 2016, all law enforcement agencies countywide implemented a four question mental health screening tool to be used whenever a person is arrested. If mental health issues appear to be present the person may be more fully screened by a licensed mental health professional.[35]

Table 1 describes some of the featured of the programs discussed above. The next section discusses similarities and differences among these programs.

Table 1. Comparison of Prearrest Diversion and Behavioral Health Programs

	LEAD (Law Enforcement Assisted Diversion) - Seattle	CHART (Chronic Utilizer Alternative Response Team) - Everett	Behavioral Health Unit - Portland	RADAR (Response Awareness, De-escalation and Referral) - Shoreline	Hot Spotter - Spokane	Bexar County, TX Prearrest Diversion
Year Started	2011	2015	2013	2017	2012	2003
Program Goal(s)	Reduce recidivism, system costs, and improve living conditions for participants.	Reduce avoidable repeat use of services; improve lives of participants; reduce costs	Manage behavioral health issues and reduce repeat low level offenses	Reduce inappropriate police response to encounters with people with behavioral health issues	Reduce avoidable repeat use of services; improve lives of participants; reduce costs	Reduce low level crimes related to mental illness; divert people to appropriate systems of care
Participants or target population	Individuals committing low level drug crimes and prostitution crimes	Individuals who are chronic users of court, EMS, jail, hospital systems.	Individuals with substance abuse, property crime, and behavioral health issues	Individuals with mental health and cognitive issues	Individuals with mental health and cognitive issues	Individuals with mental illness diagnoses who commit lower level misdemeanors
Partners	Police Dept., County Prosecutor, City Att'y., Sheriff, City/County execs., advocacy orgs	Police; Fire (EMS); human service agencies; Jail; City Atty.; Providence Hospital	Police, mental health treatment orgs., housing and advocacy groups	Fire and EMS, Mental health professionals, Police	County Medical Society, Providence Medical Center, Fire Department, service and advocacy groups	Police Dept., District Att'y., Hospitals; social services agencies etc.

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Contact agency for entry into program	Police	Police, Fire, EMS	Police	Police	Police, EMS	Police (other local diversion programs have other entry points)
Service Team Approach	Case management; social services contractor identifies service needs and coordinates referrals. Case reviewed every 2 wks.	Leadership/ Identification team IDs who enters; social svc. team discusses case, finds services, etc.	Crisis intervention training for all police; Enhanced Crisis Intervention Team; 3 BH response units (officer + MH); service delivery team	Develop specific response plan for particular individuals, working with fam. members and caregivers.	Provide coordinated care, placement into housing and rehab, etc.	Case manage-ment, housing, legal services, etc.
Services provided	housing, food, clothing, health care, legal advice, resolution of warrants, etc.	Housing, substance abuse, MH treatment; resolution of warrants, etc.	substance abuse, mental health, criminal risk factors; treatment ctr. For mental health and co-occurring disorders; supportive housing		CM services; legal; health care connections; MH/sub. abuse treatment; housing; financial planning; Community Court	Crisis care center, services, healthcare, resolution of legal issues, etc.
Evidence of effectiveness	Reduced odds of arrest; reduced felonies; fewer jail days and bookings; reduced cost	Early eval. shows reduction in service use	Reported 91% reduction in recidivism among program graduates; PSU study says program cost-effective ($9 saved for every 1$ spent)	Program will be evaluated		Cost reductions across different involved systems have been documented
Other features/ misc.		Operational goal to avoid cost shifting btwn. providers		Program partially funded by DoJ Smart Policing initiative		Program has both pre-arrest and post-arrest diversion services
Link for Info.	http://leadkingcounty.org/	https://everettwa.gov/1403/CHART-Program	https://www.portlandoregon.gov/police/62135	http://www.smartpolicinginitiative.com/SPIsites/shoreline-washington		http://www.fairfaxcounty.gov/policecommission/subcommittees/materials/jail-diversion-toolkit.pdf

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III. Comparing Program Elements

The programs examined above have many similarities as well as some differences derived from differences in the goals they are designed to achieve. These programs all work with relatively similar populations: non-violent offenders and/or those with persistent behavioral issues that manifest in the public realm. Consistent with public safety, such programs seek to solve behavioral health issues, reduce overuse of system resources, or divert or otherwise address certain low-level crimes. If the intent of such programs are met, individuals should be shifted from jail, emergency services, and the justice system and toward services such as housing, mental health and drug treatment. Over time, such programs should also reduce incarceration and the need to treat mental health issues in jail, freeing up resources for other services. Similarly, they should allow the justice system to shift its focus toward processing more serious crimes. Similarities and differences of the different program models are summarized briefly below.

Pathway of entry. Program entry pathways vary. Some are police-centric as their focus is to provide an alternative pathway for those who would otherwise be charged with low level crimes. Portland's Behavioral Health Unit also uses the Police Department as the primary program entry point. Conversely, the Everett CHART program provides for multiple entry points, ranging from EMS to Police. The Hot Spotter program also has multiple points of entry. While Shoreline's program is designed to change citizen interactions with police, family members must advocate for someone to be entered into the program's database. This program is less comprehensive than the others and is designed to solve specific police-citizen interaction issues.

Inclusion or exclusion factors. As a result of differences in intent, programs may differ somewhat on entry criteria. Because of an explicit intent to divert certain offenders to services and treatment, LEAD programs exclude those who commit more serious and/or violent crimes from participating, instead targeting low-level felonies or misdemeanors. Seattle focusses on low-level drug and prostitution charges. Albany's LEAD program includes drug crimes but also responds to nuisance crimes stemming from homelessness. Eligibility is further broadened in LEAD programs by allowing participants who have not committed a recent crime, but who are known to officers to have a history of behavioral health issues or of committing low level crimes, to participate.

Because of its focus on diverting frequent system users, the CHART program sets a numerical threshold for prior contacts before a person may enter the program. This program also requires participants to sign a release so that their case can be discussed and data shared. The RADAR program requires consent from a family member to get an individual into the program database. Bexar County requires a formal evaluation for specific mental health conditions before someone can enter the program.

Delivery of services. Most of the programs provide some mechanism for case management and the coordination of care. Partners also vary, although most programs assemble a service delivery team that includes making referrals to other organizations for treatment or other services. Programs identify an array of essential services, most commonly housing and behavioral health treatment. One common feature is regularly-scheduled team meetings to discuss participant progress and adjust treatment and services. Some locales have established triage centers for crisis stabilization and to serve as a portal to program entry.

Evidence of effectiveness. Most of the programs reviewed here are relatively new. As a result, evaluations, if available, are preliminary. Studies that do exist indicate that these programs are

having positive effect on the targeted outcomes. Evaluations of more long-lived programs have also demonstrated effectiveness. Bexar County's program has been in place longer (since 2003) and evaluation to date indicates that the program is successful in meetings its goals. For example, evaluation of the pre-booking component indicated lower system costs for managing persons with mental health issues compared with traditional methods of charging and jailing individuals.[36]

Factors in program success. While these programs are designed to achieve somewhat different ends, commonalities reflect essential elements in creating successful diversion programs. Most importantly, diversion programs need to divert people into something, not just away from something, to be effective. By enhancing program cooperation and identifying additional resources, successful programs create a more integrated system capable of responding to specific individual needs and conditions. According to literature reviews and surveys of numerous programs, commonalities of successful programs include:

- Integration of staff from mental health, substance abuse and criminal justice agencies, including regular meetings of personnel from the relevant agencies;
- A liaison person with a mandate for strong leadership to coordinate various activities;
- An emergency drop-off center with a no-refusal policy;[37]
- For programs that use the 911 system as a screening portal, proper training for dispatch personnel;[38]
- Additional factors in success include "… boundary spanners, strong leadership, early identification, and appropriately qualified case management."[39]

Another key element is improving law enforcement response to behavioral health crises. In this regard, some version of Crisis Intervention Training (CIT) is becoming a baseline practice in communities seeking to reduce the impact of mental health issues on the justice system. CIT training programs are designed to improve police awareness of mental health issues, with a 40 hour course the minimum standard. A full co-responder model pairs up trained officers with mental health or social work professionals to provide an appropriate response and make referrals to treatment or services.

Most programs reviewed above employ service delivery teams to provide the majority of needed treatment, housing, and other support services. Programs can improve the delivery of existing services by bringing together organizations that may have had limited or disjointed contact with one another. Improved coordination and delivery of services along a continuum of care also requires identifying and filling critical gaps in service delivery.

Lastly, it is useful to note that some programs are less comprehensive than others but may have features that could be integrated into a broader approach. For example, Shoreline's RADAR program focusses on one facet of a set of issues, but is employing an innovative approach that could be combined with other features to create a more complete response system. The following section identifies a set of general program functions or components that may serve as building blocks for a local program.

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IV. Implications for Local Program Design.

The review above reveals some common design elements across programs as well as some differences resulting from differences in local issues and program intent. Pulling from this review, and from broader research findings about prearrest diversion programs, we can identify program elements that could serve as building blocks of a local diversion program. Each component would need to be adapted to fit with local goals and existing programs. Additional analysis of best practices of other programs, and adaptation to local realities, is warranted as a local program proceeds through various design phases. Program components are as follows.

1. **Crisis Intervention Training (CIT).** Involving police and sheriff's deputies in 40 hours of response and de-escalation training is becoming a baseline standard for law enforcement in the United States. Among other things, CIT emphasizes responses short of lethal use of force and imparts techniques to de-escalate agitation and conflict during encounters with citizens. CIT also improves understanding of behavioral health issues that officers may encounter in police-citizen interactions. Periodic re-training may also be necessary to sustain the skill level of officers.
2. **Crisis Prevention Intervention Team (CPIT).** Some jurisdictions have augmented basic training in crisis intervention skills by adding special teams to respond to people in behavioral health crises. With CPIT, special teams receive additional training in mental health and crisis de-escalation. Often, such specially trained officers may be paired with mental health professionals who can provide additional expertise during crisis situations, preliminary assessments of individual needs, and referral or transfer to additional services. This co-responder model provides additional assurance of appropriate response and timely management of mental health issues. In some cases, such teams also work proactively to manage issues affecting certain individuals before crises occur.
3. **Triage Center with a no refusal policy.** Creation of a specialized center with diagnostic capabilities and mental and behavioral health treatment provides a safe and professionally staffed place for officers or other first responders to take individuals in crisis situations. After stabilization and initial treatment, individuals may be transferred to other providers for additional treatment, and may be linked to needed services such as housing or a medical care provider. A triage center provides the critical function of an alternative to jail and allows first responders to quickly redeploy to the field after drop-off. If a triage center employs medical staff able to handle emergent medical conditions, such programs may also take additional pressure off hospital ER's while providing immediate access to assessment and initial treatment.
4. **Multiple pathways to referral.** Individuals who get caught up in the justice system for low level crimes are often beset by a series of issues that destabilize their lives and are risk factors to future encounters with police. These include homelessness, untreated mental health and substance use issues, or chronic health issues that make it difficult to work and otherwise maintain a stable household. These problems may manifest in certain ways and impact an array of organizations. For example, individuals with chronic health issues may have frequent contact with EMS and the ER, whereas individuals with an alcohol addition, coupled with homelessness, may have frequent encounters with police as well as EMS or detox centers. Given this intertwining of issues, a program with a behavioral health component is made more coherent by providing multiple pathways to program entry.

5. **Formal entry of individuals into a program.** Once program entry pathways are identified, it is important to establish clear criteria for who is in a program and who is not. Formal entry initiates a process by which program partners work together to provide individualized and appropriate treatment and services, and triggers the start of case management. In addition, clear program entry delineation allows tracking, problem-solving, and evaluation to occur. Once a person enters a program, their use of various services can be monitored, and a before- and after profile of system use provides a measure of program impact. Clear definitions of entry also help prevent people from "falling through the cracks" after they have been referred to a particular set of services.
6. **Referral to treatment and services.** In order to meet the needs of various individuals it is likely that individuals will be referred to an array of outside services. With the exception of any needed centralized case management, services and treatment may occur at various partner organizations.
7. **Regular meetings of a treatment coordination team.** A number of programs establish regular (e.g. every two weeks) meetings to review the progress of particular individuals and fine-tune services. This allows sharing of information between case management and service providers and adjustment of services to optimize outcomes. This also helps resolve coordination issues between programs as they arise.
8. **A database to track treatment/services and outcomes.** A database is needed to track client characteristics, treatment and services, and to monitor use of system resources post-program entry. This requires the identification of software that could capture information from multiple organizations, or some other method of creating a centralized repository of data. Such a system may also be useful in case management if it is configured to allow access by end users in the cooperating organizations.
9. **Mechanisms to resolve legal issues.** Many individuals involved in a program will have legal issues such as outstanding warrants, some of which may have origin in multiple jurisdictions. Even in behaviorally-oriented programs, an offer to clear outstanding warrants or other charges may act as leverage to program participation and is needed to resolve issues that could result in jail time or other outcomes that disrupt people's lives. A program may also help resolve outstanding fines and other obligations, and provide related assistance such as driver's license reinstatement. (In cases where existing charges are more serious or more complex, charges may need to be resolved through a post-booking process such as a mental health or drug court).

Adapting these program components to local needs requires identifying program goals and outcomes and completing a series of design activities. These steps include the following:

1. **Identify system goals.** An initial task is identifying program goals or principles that will help determine program structure and activities. These could include, for example, the following: reducing inappropriate use of force; diverting people to the most appropriate location for care; reducing criminal justice, 911, and ER costs; and/or reducing incarceration resulting from behavioral health and related misdemeanor issues.
2. **Identify program operational guidelines.** This entails identifying operating principles to help determine the design of a program. These could include, as example, focusing first on high frequency system users, or designing a program with an eye for program sustainability.

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3. **Create a portrait of system use by heavy utilizers.** This involves assembling data on high utilizers of each system, including frequency and characteristics of use, and trends over time. Also, to the extent it is available, any data describing patterns of use across multiple systems is also desirable.
4. **Inventory the local system.** Given specified goals and design elements, existing local components can be identified that can be integrated into a program delivery system.
5. **Identify capacity constraints or missing coordination elements.** Another critical activity is identifying capacity constraints or missing coordination elements. These include, most notably, substantial gaps in mental health and drug treatment capacity as well as critical shortages of housing and housing-related services. New case management capacity is also needed. A program may also work to improve coordination among component organizations to ensure efficiency, best use of available dollars, and to reduce chances that participants will get lost in the system.
6. **Identify funding needed to strengthen the system.** New programming will mostly come from existing programs and budgets. Grant funding may be available for planning or program development. New funding for behavioral health services, particularly for housing-related services or to reduce inappropriate use of systems, may be available from Accountable Communities of Health dollars funded by the state's recently-approved Medicaid waiver program. In addition, Medicaid reform under the ACA will meld behavioral health with healthcare dollars and will be a source of mental health reimbursement for services.
7. **Identify data and case management system needs.** A method to collect and analyze data on program participants and outcomes is needed to manage a program and evaluate its effectiveness. Elements needed include software, protocols for collecting information, and identification of ways to resolve or work around privacy concerns. An organization to oversee this data collection and analysis is also necessary.

In Whatcom County, many of these program elements are in place or are being created. For example, planning is underway to create an expanded Triage Center with additional beds for mental health and substance use disorder treatment. Crisis intervention training is close to universal in some local agencies, and a CPIT team is being constructed within the Bellingham Police Department. Whatcom County has also increased its crisis intervention training and is seeking to add specialized deputies with additional training in mental health response. The Homeless Outreach Team (HOT) of the Opportunity Council adds another facet of behavioral response. The Bellingham Fire Department has created a Community Paramedic position to reduce unneeded calls to 911and reduce ER use. Personnel from these programs are starting to meet or otherwise work to coordinate response and care. Possible models for case management are being discussed. Additional organizations will be brought in as partners as program development proceeds.

Continuing work to develop a prearrest diversion program, building off existing capacity, can be an essential piece in reducing incarceration and overuse of emergency response systems. It may also serve as a catalyst for the creation of a management and referral system that will provide performance spillovers to help solve other issues, such as homelessness. Creating more capacity and developing a more cohesive approach should improve the operations of different programs, therefore increasing treatment efficiency and improving individual outcomes.

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2017 TASK FORCE & COMMITTEE SCHEDULE

TASK FORCE **4th Monday** **9-11 a.m.** **Courthouse** **513/514**	**LEGAL & JUSTICE SYS.** **2nd Monday** **9:15-11:15 a.m.** **B'ham Muni. Court** **Fireplace Room**	**STEERING** **As needed** **10:30-noon** **Health Dept.** **Lower Level** **Conference Room**
January 23 February 27 March 27 April 24 May 22 June 26 July 24 August 28 September 25 October 23 November 27 December 18*	January 9 February 13 March 13 April 10 May 8 June 12 July 10 August 14 September 11 October 9 November 13 December 11	January (new year) May (annual report) September (check-in)
MEMBERS Angela Anderson Jill Bernstein Jeff Brubaker Anne Deacon Bill Elfo Nick Lewis Stephen Gockley Susan Gribbin Dan Hammill Fred Heydrich Jack Hovenier Mike Knapp Betsy Kruse Kelli Linville Byron Manering Ken Mann Dave McEachran Moonwater Irene Morgan Darlene Peterson Chris Phillips Randy Polidan Tyler Schroeder Greg Winter	**MEMBERS**	**MEMBERS** Task Force Chair(s) Committee Chairs Ken Mann Tyler Schroeder

* = Alternate meeting day due to holiday/vacation