STAFF REPORT

MEETING
DATE: January 31, 2017

TO: City Council

FROM: Regan M. Candelario, City Manager

SUBJECT: CONSIDERATION OF TAKING A POSITION IN SUPPORT OF THE MARIN COUNTY BOARD OF SUPERVISORS TO AUTHORIZE THE APPLICATION OF LAURA’S LAW IN MARIN COUNTY

REQUEST

Consider reviewing background reports and providing direction to staff regarding a support letter to the Marin County Board of Supervisors to authorize the application of Laura’s Law (AB 1421) in Marin County.

RECOMMENDATION

Approve the draft support letter and direct staff to transmit the letter to the Marin County Board of Supervisors.

DISCUSSION

At the City Council’s quarterly agenda setting work session held on July 12, 2016, Councilmember Drew requested and received majority support to add an item to a future agenda to consider taking a position urging the Marin County Board of Supervisors to authorize the application of Laura’s Law in Marin County.

Laura’s Law AB 1421 (also known as Assisted Outpatient Treatment/AOT) is aimed at providing care for individuals with a history of hospitalization, incarceration, or violence, who are resisting receiving mental health care. Once approved at the county level, family members, health care providers or law enforcement officers can ask the court to order patients into outpatient treatment. Laura’s Law is only operative in those counties in which the county board of supervisors authorizes its application. Marin County Supervisors have opted to forego implementation but will revisit the topic in February or March 2017 (Attachment B).

The law is named for Laura Wilcox, a 19-year-old county mental health clinician killed in 2001 by a man who refused treatment and stormed the clinic she was working at while on winter break from college. The State of California afforded Counties the right to decide whether or not to implement the measure. Current law in Marin County states that to qualify for mandated treatment in a hospital or other inpatient facility, the person must be dangerous to self/others or unable to
provide for basic personal needs for food, clothing, or shelter. Under Laura’s Law, to qualify for mandated treatment as an outpatient living in the community, the person must live in a County where Laura’s Law has been authorized and:

- Have a condition likely to deteriorate;
- Be unlikely to survive safely in the community without supervision;
- Have a history of noncompliance that includes two hospitalizations within the past 36 months’ or;
- Act/threaten/attempt violence to self or others in 48 months immediately preceding petition filing;
- Be likely to need treatment to prevent meeting inpatient standard; and
- Be likely to benefit from assisted treatment.

The law was passed in California in 2002 with Nevada County as an early adopter. Implementation was slow until about 2014 when several other counties began to implement the law. The City and County of San Francisco is one of the newest Counties to adopt Laura’s Law after being approved by the San Francisco Board of Supervisors in a 9-2 vote to adopt in July 2014. San Francisco began implementing the law in November of 2016 and expects that 100 San Francisco residents each year will meet the program’s eligibility requirements.

Another point that may be delaying Statewide County implementation are the estimated costs per person. In San Francisco, the estimated cost for Laura’s Law is $40,000 per person annually.

Those in support of the law say it should be viewed as a bridge to recovery, and a way to stop the revolving door of repeated hospitalizations, homelessness and jailing and a mechanism to address the needs of those with mental illness who fall through the proverbial cracks. Other mental health officials have expressed concerns over Laura’s Law, claiming the law could violate civil rights by coercing those with psychiatric disorders to enter treatment programs against their will.

**FISCAL IMPACT**

None. Administrative impacts as functional facets of Laura’s Law would be carried out by the County of Marin.

**ALTERNATIVES**

1. Approve the draft support letter and direct staff to transit the letter to Marin County Board of Supervisors.
2. Delay taking a position on AB 1421 at this time.

**ATTACHMENTS**

1. Attachment A: Draft support letter
February 1, 2017

Marin County Board of Supervisors
C/O Judy Arnold, Board President
3501 Civic Center Drive, Room 239
San Rafael, CA 94903

Re: Laura’s Law Implementation in Marin County

Dear Supervisor Arnold:

Novato City staff has conducted research and acknowledges that intervention efforts for our most vulnerable populations is certainly a priority, including those who would be eligible for compulsory mental health services rendered via Laura’s Law. However, intervention to this population comes at an additional expense to our public safety efforts in Novato.

In February 2016, the Marin County Health & Human Services staff issued a staff report stating that they did not recommend implementing AB 1421, Laura’s Law. While we respect the County’s decision to delay implementation and revisit the issue in February/March 2017, we encourage the County to continue to consider implementing Laura’s Law in Marin County.

Thank you for your consideration.

Sincerely,

Denise Athas
Mayor, City of Novato

Cc Dr. Grant Colfax, Director of Marin County Health and Human Services
    Matthew Hymel, County Administrator
Marin Health & Human Services: Report on the AB 1421 Workgroup Findings

Prepared by:

Resource Development Associates

January 26, 2016
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Introduction

Mental Health and Substance Use Services (MHSUS), a division of the Marin County Health and Human Services (Marin HHS), provides a complete range of mental health services for children, adults, and older adults with serious to severe mental health needs. The mission of Marin HHS is to promote and protect the health, well-being, self-sufficiency, and safety of all people in Marin County. Like many counties across California, Marin County is facing the challenge of how to interrupt the cycle of repetitive hospitalization and incarceration of people with serious mental illness who are not engaging in services and best meet their needs to promote safety and recovery.

In 2002, the California State Assembly passed the Assisted Outpatient Treatment Demonstration Project Act (AB 1421). AB 1421, also known as “Laura’s Law,” was developed in response to the 2001 Nevada County shooting of a mental health worker by a man who was not receiving treatment.

AB 1421 provides counties with the discretion to opt-in to AB 1421 through a Board of Supervisors’ resolution to adopt AB 1421. The legislation authorizes assisted outpatient treatment (AOT), which are court-ordered intensive outpatient services for individuals with serious mental illness who are unable and/or unwilling to engage in voluntary treatment and are experiencing repetitive crisis events, including hospitalization and/or incarceration. AB 1421 outlines the target population and eligibility criteria per Welfare and Institutions Code (WIC) Section 5346, and the service goals and requirements of AB 1421 programs.

AOT Workgroup Overview

Marin County created an AOT workgroup representative of the county departments involved in serving people with serious mental illness, either through the provision of treatment or participation in the criminal justice and legal systems, and who would be affected if the county decided to move forward with adopting AB 1421. Led by the county’s Health and Human Services Department, AOT workgroup participants included representatives from the Mental Health Substance Use Services, County Counsel, County Administrator’s Office, Courts, Public Defender, District Attorney, Probation, and the Sheriff departments. Specific representatives who participated are listed in Table 1. Community perspectives were gathered through a community forum.

This report is reflective of the workgroup discussions and project activities that took place between June-September 2015 as well as subsequent activities completed by Marin Health and Human Services (HHS), Mental Health and Substance Use Services (MHSUS), and other County departments.
The purpose of the workgroup was to: 1) bring together representatives from public agencies with the County government, 2) build a shared understanding of AB 1421 and AOT, and 3) develop a prioritized list of the pros and cons of AB 1421 implementation. The workgroup was charged with considering and integrating multiple perspectives on AB 1421 to inform Marin HHS’ consideration and recommendation and Board of Supervisor’s decision-making about AB 1421 adoption. The workgroup and associated activities considered:

- AB 1421 legislation and the literature about Assisted Outpatient Treatment,
- Data from Marin County and their adult system of care to identify gaps in service and who may be “falling through the cracks” to estimate how many Marin County residents may be eligible based on the criteria from the legislation,
- Information about the resources AOT implementation would require in Marin County as well as areas of possible alternatives and potential cost savings,
- Information from other counties who have adopted or are currently implementing AOT and an AOT service provider, and

<table>
<thead>
<tr>
<th>AB 1421 Defined Group Affiliation</th>
<th>Position and Agency</th>
<th>AOT Workgroup Participant</th>
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<tr>
<td>Marin County Health and Human Services</td>
<td>Director of Health and Human Services</td>
<td>Grant Colfax, MD</td>
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<td>Mental Health and Substance Use Services:</td>
<td>Director of Mental Health and Substance Use Services</td>
<td>Suzanne Tavano, PhD</td>
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<td></td>
<td>Division Director</td>
<td>Dawn Kaiser, LCSW</td>
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<td></td>
<td>Adult/ Older Adult Program Chief</td>
<td>Chris Kughn, MFT</td>
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<td></td>
<td>Ethnic Services Manager</td>
<td>Cesar Lagleva, LCSW</td>
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<td>County Counsel:</td>
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<td>Stephen Raab, JD</td>
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<td></td>
<td>Deputy County Counsel</td>
<td>Jessica Sutherland, JD</td>
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<td>Marin Superior Court</td>
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<td>Janet Minkiewicz</td>
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<td>Lt. Cheryl Fisher</td>
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<td>Deputy, Office of the Sheriff</td>
<td>Josh Todt</td>
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<td>Public Defender:</td>
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<td>Colleen Sonneborn, JD</td>
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<td>Deputy Public Defender</td>
<td>Beth Wissing-Healy, JD</td>
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<td>Michael Daly</td>
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<td>Alisha Krupinsky</td>
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<td>District Attorney’s Office:</td>
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<td>AJ Brady, JD</td>
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<td>Chief Deputy District Attorney</td>
<td>Dori Ahana, JD</td>
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<td>County Administrator’s Office:</td>
<td>Administrative Analyst</td>
<td>Ralph P. Hernandez</td>
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<tr>
<td></td>
<td>Administrative Analyst</td>
<td>Jacalyn Mah</td>
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Community perspectives about AOT.

The meetings provided education about the AB 1421 legislation and the efficacy of AOT, considerations of the needs of adult consumers who experience frequent crisis events in Marin County, and explored the risks and benefits of AOT implementation in Marin County.

Summary of AOT Workgroup Meetings

Meeting 1: AOT Educational and Information Session

The purpose of Meeting 1 was to bring together workgroup members and help set the groundwork for the planning process and workgroup goals. RDA sought to establish a baseline understanding of the AB 1421 legislation and AOT as well as utilize the initial workgroup meeting to build rapport amongst AOT workgroup participants.

During the first meeting of the AOT workgroup, facilitators established introductions and asked the group to reflect on what they were hoping the workgroup group accomplishes. Participants shared that they were committed to exploring how to best serve Marin County residents with serious mental illness and were hoping to receive clarity about the AB 1421 legislation and AOT. Additionally, participants noted that they were interested enhancing collaboration across the departments regardless of the outcome of this effort.

AOT workgroup members were provided with information on AOT nationally and the landscape of AOT in California, including California counties who have implemented AOT and counties who have adopted AB 1421 legislation but not yet implemented AOT. RDA presented a brief review of the literature as it related to AOT and AB 1421, including the challenges and results. Peer reviewed articles and information from Drs. Swartz and Swanson from Duke University were included in the discussion. HHS staff also completed an additional review of the literature in the last quarter of 2015. Findings from this discussion and additional literature review included:

1. There are challenges with applying the body of AOT literature to California because AOT is an “umbrella term” that describes similar but different types of services and legal processes which vary by state.\(^1\) Additionally, the mental health systems in which AOT operates differs by jurisdiction, at the state and local levels, and this appears to influence AOT efficacy.\(^2\) There are not yet any studies from California, although a number of counties in the early stages of implementation are planning to evaluate their programs.


2. The literature about AOT, as compared to other types of programs, is inconclusive, and there is evidence that mandatory programs do not provide additional benefit in reducing hospitalizations, homelessness, or arrests.\(^3\) There are two randomized control trials of AOT, one from North Carolina\(^4\) and one from New York\(^5\). Both are older studies with some methodological challenges, including issues related to consistency of the intervention and analysis.

3. There is a strong evidence base that suggests that people who engage in the types of services provided as a part of AOT are effective, but the additional benefit of AOT is unknown.\(^6\)\(^7\) Assertive Community Treatment and intensive case management services have a strong evidence base dating back to the 1970s and consistently find that participation in ACT and ICM services reliably reduce hospitalization and improve psychosocial outcomes. While vast research has demonstrated positive outcomes associated with ACT, research based in the UK and US has not found consistently better outcomes the services provided under AOT, such as ACT and ICM as compared to usual community care in areas with established and robust mental health service infrastructures in place. In these areas, established quality mental health care are already achieving the positive outcomes one would expect from an ACT or ICM program.\(^8\)

Unfortunately, the literature about compulsory versus voluntary treatment, service efficacy, and AOT specifically do not definitively lead to a clear course of action about AOT implementation.

RDA facilitators then reviewed AB 1421 legislation with workgroup participants, which included an analysis of AB 1421 eligibility criteria, service requirements, and goals. Workgroup participants received the actual AB 1421 legislation and an AOT flowchart detailing the successive steps in an AOT procedure. Throughout the presentation, RDA facilitators discussed the viewpoints from both advocates and opponents of AOT. The PPT presentation from this meeting is available in Appendix 1.

The eligibility criteria set forth in AB 1421 describes a population of adults with serious mental illness who are experiencing repetitive crisis events and are not engaging in mental health services on a voluntary basis. During this planning process, the workgroup discussed the reasons why someone in such a high level of distress may not voluntarily engage in mental health services. There were three main considerations discussed by the AOT workgroup, all of which are present in the literature about mental illness.

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\(^7\) Marshall M, Lockwood A. Assertive community treatment for people with severe mental disorders. Cochrane Database Syst Rev. 2000.

1. A percentage of people with serious mental illness don’t have an awareness that they are ill and don’t recognize the need for mental health treatment. This is more common in those with schizophrenia, bipolar, and other psychotic disorders.

2. Some adults with mental illness, specifically those with repeated crisis and hospital events, may have experienced trauma and/or stigma related to seeking or receiving mental health services and therefore may avoid engaging in mental health treatment.

3. Some adults may experience difficulty accessing or navigating the mental health system as a result of barriers to access, limited resources or capacity issues, or “falling through the cracks” when moving between levels of care.

After reviewing the AB 1421 legislation and associated literature, the workgroup discussed the AB 1421 target population of Marin County. All participants agreed that Marin County has challenges in working with individuals who are unwilling and/or unable to engage in services that are experiencing repetitive crises. In order to estimate the number of Marin County residents who may be eligible for AOT to inform subsequent discussion, RDA presented a methodology, adapted from Contra Costa County, to the workgroup and available in Appendix 2. Dr. Chambers explained that this type of analysis would provide a range or data-informed estimate of how many Marin county residents may be eligible for AB 1421, their demographics, and service utilization patterns. AOT workgroup participants discussed that many individuals with mental illness in Marin County were incarcerated and receiving treatment in the jails. The group asked if the methodology could be adapted to include individuals with mental illness who receive treatment while in-custody instead of in the hospital. RDA facilitators said they would follow up with workgroup members from the District Attorney’s office and MHSUS to interpret the legislation and discuss data that may be available for the analysis; the methodology was adapted to include those individuals receiving mental health treatment in the jail.

It is important to note that this methodology has limitations and should not be construed as a precise number of potentially eligible individuals but is intended to provide a data-informed estimate for planning purposes. Additionally, this methodology over and under estimates certain elements in the data, which is further discussed in the “Marin County’s AOT Eligible Estimate Methodology and Results” section.

The group noted the following questions during the discussion:

- How, if any, would be the potential legal risks of adopting AB 1421? Dr. Chambers discussed that there are risks. For example, Disability Rights California stated that they will sue Orange County, 9 Pia, L., and Tamietto, T. (2006). Unawareness in schizophrenia. Psychiatry and Neurosciences. 60:531-537.
12 News and Notes, “MHA Survey Shows Progress in Public Knowledge About Mental Disorders, but Stigma Remains a Problem,” Psychiatric Services, vol. 58 (July 2007)
the first large County to implement AOT, for a violation of civil rights once the first AOT petition is filed, although no litigation has yet been filed in any California County implementing AOT.

- Do visits to Psychiatric Emergency Services (PES) or Crisis Stabilization Unit (CSU) visits count as hospitalizations in the legislation? Dr. Chambers suggested that PES or CSU visits are not specifically named in the legislation when referencing hospitalization or other qualifying events that support one set of eligibility criteria and are unlikely to meet the hospitalization specific eligibility criteria.

- Would AOT help Marin County’s homeless population? Dr. Chambers suggested that given the size of Marin County and the homeless population, some people experiencing homelessness may be AOT eligible but that it was likely to be a much smaller number than the total number potentially eligible for AOT and only a small fraction of homeless individuals in the County. This was further discussed in meeting #2.

- Would AOT be available for otherwise eligible individuals who have private insurance? Dr. Chambers shared that this has been an ongoing debate across the state and that there is not yet a definitive answer. She also shared that she had sought opinions at the state level and the guidance she received was that the legislation doesn’t rule out people with private insurance.

The workgroup also asked questions about the financial resources required for AOT implementation, which is planned for meeting #3.

Inclusion of the Board and Community

The workgroup discussed having an opportunity for the Board of Supervisors to receive educational information on AOT, and for consumers, family members, and the Mental Health Advisory Board to have an opportunity to share their insight to the workgroup. However, participants acknowledged that because of the Brown Act, having more than two Board of Supervisors in a closed meeting without proper notice and a public agenda was prohibited. The group grappled with how to be inclusive of community stakeholders and Board of Supervisors. Ultimately, the group decided to invite two Board of Supervisors to attend an educational session on AOT, and hold a separate Community Forum event to provide community members with education on AOT and solicit their feedback for the workgroup’s consideration.

Meeting 2: Exploring the Data

The purpose of Meeting 2 was to: 1) review the AB 1421 legislation and interpret Marin County data on the population that may meet AB 1421 criteria, and 2) place AOT in context of the current adult system of care.

AOT workgroup members received a presentation from the Chief of Adult and Older Adult Services in MHSUS on the adult system of care and how consumers move through the system before, during, and after a psychiatric emergency. While there is a robust system of care for individuals, particular attention was paid to the crisis components of the system because the nature of the AB 1421 population is that they are not able/willing to engage in ongoing care. Primarily, individuals who experience crisis are routed to Marin General Hospital Emergency Department or Psychiatric Emergency Services (PES), co-located at
Marin General Hospital. Following a PES encounter, individuals are either hospitalized or discharged to the community, which may include admission to a crisis residential treatment facility or follow-up outpatient treatment. Workgroup members asked questions about those individuals who are seen at PES but not subsequently hospitalized and expressed concern that this is one potential gap where some may fall through the cracks. The map of the adult system of care is provided in Appendix 2.

MHSUS also described three new programs targeted specifically toward individuals experiencing psychiatric crisis: 1) Mobile Crisis Team, 2) Outreach and Engagement Team, and 3) Transitions Team.

- **Mobile Crisis Team:** The mobile crisis team provides acute mental health crisis intervention in the community and partners with law enforcement and the Crisis Intervention Team (CIT). This team is intended to support people during a crisis to get to the appropriate location to ensure safety, promote healing, and reduce the likelihood that the person is hospitalized and/or incarcerated.

- **Transitions Team:** The transitions team provides short term case management, education, and linkage to services following a mental health crisis for people who are willing to accept voluntarily services and require additional support to engage in services. The transitions team may stay involved with a person until they become connected to ongoing, regular mental health services. This team is intended to address the gap for those who may fall out of care following a crisis because they experience difficulty engaging in service or navigating the service system but are otherwise willing.

- **Outreach and Engagement Team:** The outreach and engagement team provides outreach and engagement following a psychiatric crisis for individuals who are not willing to engage in regular, ongoing services. This team is able to meet with individuals where they are for as long as it takes to help them engage in services and accepts referrals from family members, service providers, law enforcement, and other emergency and crisis personnel. This team is intended to address the gap for those who may fall out of care following a crisis because they are not willing to engage in service or do not recognize the need for mental health services.

By intervening early in crises situations and providing necessary supports and services, these teams reduce clients’ risk of hospitalization and involvement in the criminal justice system while increasing the likelihood that individuals are connected to and accept regular, ongoing mental health services.

The workgroup identified some of the challenges facing the Adult System of Care, including:

- Lack of affordable housing in the county as a result of low vacancy rates and high rents.
- Inadequate number of outpatient or residential placement options for individuals evaluated in PES but not meeting criteria for hospitalization.

AOT workgroup participants also discussed MHSUS data describing who may be AOT eligible in Marin County. Through their discussion of the data, AOT workgroup participants developed more questions that required further investigation by MHSUS and RDA, including the number of individuals included in the target population who are conserved under the Lanterman-Petris-Short Act (LPS). The full methodology and results are located in the subsequent section entitled “Marin County’s AOT Eligible Estimate Methodology and Results” beginning on page 17.
After the discussion, AOT workgroup participants requested:

1. Additional data on the individuals identified who may be AB 1421 eligible
2. Information on the costs of AOT for each department, planned for meeting #3
3. Information from other counties regarding housing provision and costs

Meeting 3: Financial Considerations

The purpose of Meeting 3 was to: 1) provide an overview of AOT financial considerations from the literature and Nevada and Yolo County’s experience; 2) discuss the costs and implementation considerations from each department involved in AOT; and 3) engage in a discussion to consider the financial resources that would be required for Marin County.

AOT workgroup members were provided with information on the potential costs and savings associated with AOT implementation, as well as general assumptions. The facilitators presented information from the literature and Nevada and Yolo County experiences that suggests that implementing AOT increases costs associated with mental health and legal services and reduces costs associated with interrupting the cycle of hospitalization and incarceration, as detailed in the proceeding table.

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<tr>
<th>Potential AOT Cost Increases</th>
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<td>➢ Jail</td>
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<td>➢ Court</td>
<td>➢ Law Enforcement</td>
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RDA worked closely with representatives from County Counsel, Public Defender, Courts, and MHSUS to understand the costs driving an AOT program. The following are some of the considerations shared by departments:

Mental Health Considerations

MHSUS is currently working on a number of initiatives that improve the accessibility and delivery of care to large numbers of clients without the additional administrative functions and costs of AOT and by using treatment interventions with demonstrated effectiveness, such as:

- Implementing multiple initiatives for culturally appropriate community outreach and education expected to result in increased awareness of available services and requests for mental health care.
- Engaging in ongoing work to increase the capacity to receive referrals from the community of persons in presumed need of services but not seeking care as well as the availability of field-based intervention teams to increase voluntary engagement in services and more timely intervention when involuntary acute care is needed.
Re-evaluating services provided at PES and implementing structural changes to enhance client care while on the unit and to promote more coordinated client care upon discharge.

Reviewing the current organizational structure of MHSUS with the intent to implement structural changes to promote efficiency and service capacity, including in the three Full Service Partnerships (STAR, HOPE, Odyssey), Adult Case Management and Medication Support Services.

Developing additional housing assistance options.

Court Considerations

- Limited resources are available for large collaborative court; the court would have difficulty accommodating more than 20 person capacity at any given time.
- Court estimates assume a collaborative court model where AOT is largely uncontested. If an AOT petition were contested, court costs could increase up to $2,850 per person per day.

County Counsel Considerations

- Estimates include staffing to advise the County on program design and implementation as well as to file and represent petitions.
- Staff time estimates assume that there would be more petitions filed than people enrolled in AOT.

AOT workgroup participants discussed the estimates and expressed concern about a potentially substantial investment in time and resources. However, the workgroup acknowledged that these are people for whom the County might already be incurring high costs, primarily through emergency and crisis services, and that any resources invested in serving these individuals may not represent new costs but “shifting” costs from other systems already serving these individuals.

The workgroup also discussed:

- **The impact on the larger mental health system:** Would adopting AOT increase the number of individuals seeking voluntary services? Does MHSUS have the current capacity to manage a larger demand for service?
- **How an AOT program could be funded:** What funds would be available? Are there unspent MHSUS funds that could be used? Would the board allocate general funds?
- **Coordination with Law Enforcement Agencies:** How would transport occur if a person was ordered for an evaluation but wasn’t willing and didn’t meet 5150 criteria? Which law enforcement agencies would provide transport and under what authority?

The workgroup discussion about financial resources raised more questions than conclusions and highlighted the challenges in estimating resources that would be required in advance of a program design or decision. Workgroup members wondered if learning from the experience of other counties would be useful to help guide this workgroup’s discussion.
Meeting 4: AOT County Comparisons & Data Part II

The purpose of Meeting 4 was to: 1) provide AOT cost and implementation comparisons from counties that had either implemented AB 1421 or were in the planning stages; 2) present additional information about individuals who may be AB 1421 eligible; and 3) prepare workgroup members to brainstorm pros/cons of AOT implementation.

RDA presented additional research about other county AOT experiences, including a review of available cost estimates and program information as well as interviews with Turning Point, the AOT service provider for Nevada and Yolo Counties, and the Yolo County mental health director. Please note that there are differences in program design at the county level that impact AOT funding.

MHSUS presented additional data from a manual chart review and found 2 distinct populations who may be eligible for AOT: 1) a small group of adults (1-2 individuals) receiving crisis-driven mental health services and 2) a larger group of adults (5-12 individuals) receiving mental health services in jail. RDA explained the range was due to the way in which the data was captured, the resulting analytic challenges, and the predictive nature of different variables in the eligibility criteria that limit the precision of these estimated. The group considered the high representation of potential AOT enrollees from the jail data and discussed how to best serve those receiving mental health services while in_custody. The full methodology and results are located in the subsequent section entitled “Marin County’s AOT Eligible Estimate.”

Workgroup members were concerned about the over incarceration of mentally ill individuals in Marin County, and wondered if AOT would be a duplicate effort from the County’s Support and Treatment After Release (STAR) Court. STAR court is a court-supervised program for defendants with serious mental illness that provides connections to employment, housing, and treatment, and support services. Workgroup members inquired on the differences between the enforcement mechanisms of STAR Court and AOT.

Meeting 5: Pros and Cons of AOT Implementation

The purpose of Meeting 5 was to: 1) further discuss county data on who may be AB 1421 eligible, 2) provide a comparison of AOT, STAR, and LPS conservatorship, and 3) consider the pros and cons of AOT implementation. RDA worked with representatives from the District Attorney’s Office, Sheriff’s Department, and County Counsel to develop a chart comparing STAR Court, AOT, and LPS conservatorship. The comparison chart provided an analysis of the different target population, eligibility criteria, services available, referral process, voluntary/involuntary status, enforcement mechanisms, length and level of engagement, and department involvement.

Overall, workgroup members saw the main differences between STAR Court, AOT, and LPS conservatorship were related to eligibility and the level of enforcement mechanisms. Specifically, the STAR court program requires that someone have committed a crime that would be assigned to post-release supervision (e.g. probation) while AOT and LPS conservatorship do not require involvement with the criminal justice system. LPS conservatorship has a much higher threshold for level of illness and
burden of proof (e.g. grave disability) while AOT does not have the same eligibility requirement. However, workgroup members also discussed the differences in enforcement mechanisms. While the STAR court program offers a similar set of services as AOT and the person must initially agree to voluntarily participate, the service plan is then included in the terms and conditions of their probation. For example, a judge can apply consequences for drug and/or alcohol use as well as medication non-compliance or non-compliance with other service agreements. LPS conservatorship also includes the authority to make treatment decisions, including medication, housing, and other related services. AOT, however, relies on the “black robe” effect and a collaborative court model and treatment team to persuade the individual to comply; the only AOT enforcement mechanism for non-compliance with an AOT order is a mental health evaluation.

Workgroup members also did an exercise in which they shared their personal opinions on the possible pros and cons of adopting 1421 and the pros and cons of not adopting 1421. The following are the results from the brainstorming exercise.

Table 5: Potential Pros and Cons of Adopting AB 1421

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<thead>
<tr>
<th>Potential Pros of Adopting AB 1421</th>
<th>Potential Cons of Adopting AB 1421</th>
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</thead>
<tbody>
<tr>
<td>Might help targeted population</td>
<td>No conclusive evidence that it is more effective than baseline interventions</td>
</tr>
<tr>
<td>Additional assistance for housing</td>
<td>Few number of people potentially eligible for AOT</td>
</tr>
<tr>
<td>May stabilize people in treatment</td>
<td>Uses funding for AOT rather than to expand/strengthen/build current services</td>
</tr>
<tr>
<td>Avoid or get people off conservatorship</td>
<td>Will do little to reduce homelessness</td>
</tr>
<tr>
<td>Avoid incarceration and hospitalization and subsequent costs</td>
<td></td>
</tr>
<tr>
<td>Expands engagement</td>
<td></td>
</tr>
<tr>
<td>Increases FSP availability</td>
<td></td>
</tr>
</tbody>
</table>

Table 6: Pros and Cons of Not Adopting AB 1421

<table>
<thead>
<tr>
<th>Potential Pros of Not Adopting AB 1421</th>
<th>Potential Cons of Not Adopting AB 1421</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allows investment in other programs with more support of effectiveness (intensive case management)</td>
<td>Someone people might not get necessary services/some people might fall through the cracks</td>
</tr>
<tr>
<td>Avoid additional upfront costs for a program with insufficient evidence of efficacy</td>
<td>Less potential for housing expansion</td>
</tr>
<tr>
<td>Ability to learn from other counties’ experiences prior to re-considering adoption</td>
<td></td>
</tr>
</tbody>
</table>

Community Forum:

RDA held a Community Forum for Marin County residents to: 1) provide information about AB 1421 and the associated literature; 2) give background information on the purpose of the AB 1421 workgroup; and 3) solicit stakeholder feedback for the workgroup’s consideration. RDA asked for stakeholders to share

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14 Please note that AB 1421 requires “housing assistance” but does not explicitly require that an AOT program pay for or directly provide housing.
Marin Health and Human Services
Assisted Outpatient Treatment Workgroup

January 28, 2016 | 15

their experiences and perspective for the workgroup. Marin County stakeholders shared their experiences and identified gaps in the system. Some stakeholders said:

- Navigating the mental health system as a consumer or family member is difficult, and information on how to get services should be more accessible.
- During a mental health crisis, engaging law enforcement is the primary mechanism for accessing mental health treatment and families don’t want to “criminalize” their loved ones.
- Limited options exist for urgent mental health treatment outside of a locked psychiatric hospital setting.
- Many consumers need urgent mental health services, but don’t meet the 5150 criteria threshold and end up, “falling through the cracks.”
- The STAR program is instrumental in providing structure and support for consumers, but the eligibility requirements require committing a crime.
- Consumers experiencing homelessness face difficulty engaging in services.

Community stakeholders shared the possible benefits of adopting AOT.

- Stakeholders believed that AOT would provide a mechanism to engage consumers who aren’t otherwise engaging in voluntary services and desperately need it.
- Stakeholders expressed that AOT could increase referrals into all types of mental health services and help those in need regardless of their AOT eligibility criteria.
- Stakeholders felt that AOT would provide oversight and accountability for mental health staff.
- Stakeholders said AOT would provide mental health professionals with an additional tool.
- Stakeholders emphasized that AOT would decrease the involvement of law enforcement and provide an alternative to the STAR program before a crime is committed.

Community Stakeholders shared the possible risks of adopting AOT.

- Stakeholders highlighted ethical concerns about the coercive nature of AOT.
- Stakeholders remarked that AOT “has no teeth,” and the county should first expand and enhance voluntary services like the Mobile Crisis Team and the Outreach and Engagement Team.
- Stakeholders insisted that AOT might create a barrier for consumers to disclose their mental illness.
- Consumer stakeholders insisted that AOT conversation cannot be led by people who are not mentally ill and including consumer input was imperative.

**Meeting 6:**

The purpose of Meeting 6 was to: 1) relay the information from the community forum presentation, 2) review potential recommendations for the Board, and 3) discuss risks and benefits of implementing AOT or a pilot, or not implementing AOT or delaying AOT implementing.
Information Presented

AOT workgroup members received the stakeholder feedback from the Community Forum. Many workgroup members were present and also shared their experiences community forum.

After debriefing the stakeholder conversation from the Community Forum, the AOT workgroup participated in a facilitated discussion about the perceived benefits and challenges of implementing AOT in Marin County. Below is a summary of the AOT workgroup’s reflections on the benefits and challenges that were taken directly from the meeting notes:

Perceived Benefits of Implementing AOT:

- Expanded and continuous outreach and engagement for a hard to reach target population.
- Create a mechanism to increase housing assistance.
- Consumer engagement could provide stabilization of mental health issues.
- Provide step down/step up alternative for LPS conservatorships.
- Reduction in hospitalizations and incarcerations.

Perceived Challenges of Implementing AOT:

- Potential diversion of the funding stream from strengthening and building current services with solid evidence of effectiveness.
- Investment of resources in a program without demonstrated efficacy.
- Incurring additional costs, especially around housing assistance.
- Limited availability of housing to achieve all of the program objectives outlined by the AB 1421 legislation.
- Lack of information regarding the cost savings and cost avoidance associated with implementing AOT.
- Potential lack of access for those with private health insurance or coverage.
- Not addressing the community expectations to address the homeless population.
- Dependence on the “Black Robe Effect” for compliance to a treatment plan, but no real enforcement mechanism outside of ordering a mental health evaluation.

Marin County’s AOT Eligible Estimate Methodology and Results

AB 1421 Eligibility Criteria

AB 1421 sets forth the following eligibility criteria that must be met for enrollment in an assisted outpatient treatment program:

- The person is 18 years of age or older.
- The person is suffering from a mental illness.
- There has been a clinical determination that the person is unlikely to survive safely in the community without supervision.
The person has a history of lack of compliance with treatment for his or her mental illness, in that at least one of the following is true:

- The person’s mental illness has, at least twice within the last 36 months, been a substantial factor in necessitating hospitalization, or receipt of services in a forensic or other mental health unit of a state correctional facility or local correctional facility, not including any period during which the person was hospitalized or incarcerated immediately preceding the filing of the petition.
- The person’s mental illness has resulted in one or more acts of serious and violent behavior toward himself or herself or another, or threats, or attempts to cause serious physical harm to himself or herself or another within the last 48 months, not including any period in which the person was hospitalized or incarcerated immediately preceding the filing of the petition.

The person has been offered an opportunity to participate in a treatment plan by the director of the local mental health department, or his or her designee, provided the treatment plan includes all of the services described in Section 5348, and the person continues to fail to engage in treatment.

- The person’s condition is substantially deteriorating.
- Participation in the assisted outpatient treatment program would be the least restrictive placement necessary to ensure the person’s recovery and stability.
- In view of the person’s treatment history and current behavior, the person is in need of assisted outpatient treatment in order to prevent a relapse or deterioration that would be likely to result in grave disability or serious harm to himself or herself, or to others, as defined in Section 5150.
- It is likely that the person will benefit from assisted outpatient treatment.

Identifying Marin County’s AB 1421 Target Population

Projecting the number of people who may be qualify for an assisted outpatient treatment program requires estimating the number of individuals who are likely to meet the above criteria. Two approaches were applied to determine the number of potentially eligible. The first is a population based estimate used in New York State as well as in other California Counties that assumes that 1 of every 25,000 may be AOT eligible. The second approach uses data from MHSUS to determine the number of individuals who are known to the mental health system through hospitalization and/or contact with jail mental health who may be AOT eligible. It is important to note that the experience of other California counties is that the number of individuals who are referred and may be eligible for AOT is a larger group than those who end up requiring court involvement to engage in mental health services. For example, Orange County’s first year of AOT implementation resulted in approximately 100 eligible individuals referred, more than 90% voluntarily engaging in full service partnership, and less than 10% requiring court involvement to accept services.
Population Based Estimate

The population of Marin County is 258,365. When applying the assumption that 1/25,000 may be AOT eligible, Marin County would have **approximately 10 AOT eligible individuals**.

MHSUS Informed Estimate

In the following section, we present data from MHSUS, the methodology and assumptions for estimating the target population, and the projected number of individuals likely to meet the eligibility criteria set forth in the legislation. While some of the criteria are clear (e.g. the person is 18 years of age or older), some of the criteria are predictive and less easily estimated (e.g. the person is unlikely to survive safely in the community without supervision). Please note that this data was extracted from the MHSUS data systems and represents utilization of people without insurance or with Medi-Cal; claims paid by Medicare or other private insurance are not represented in this data. A table summarizing this approach and results immediately proceeds this section.

First, we looked at how many adults had at least two hospitalizations or receipt of mental health services in a forensic environment within the past 36 months. The legislation also includes “one or more acts of serious and violent behavior toward himself or herself or another, or threats, or attempts to cause serious physical harm to himself or herself or another within the last 48 months.” However, this type of data are not available and we therefore assumed that someone who met the criteria of one or more acts, threats, or attempts at violence towards self or other in the past 48 months would also likely have at least 2 hospitalization or forensic mental health encounters within the past 36 months. Hospitalization was defined as admission to a psychiatric hospital and does not include crisis stabilization services at Psychiatric Emergency Services (PES). Receipt of mental health services in a forensic environment was defined as a mental health evaluation that resulted in a psychiatry service. Two hundred and eighty six (286) adults had at least two hospitalizations or jail psychiatry services within the past 36 months in Marin County, 78 of whom met this criteria through hospitalization, 204 through jail psychiatry encounters, and 4 with a combination.

We then looked at the predictive criteria of:

- There has been a clinical determination that the person is unlikely to survive safely in the community without supervision, and
- The person's condition is substantially deteriorating.

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15 US Census Bureau
16 Correctional officers request mental health evaluations for a variety of inmates who may or may not experience mental illness. Receipt of jail psychiatry implies that the mental health evaluation resulted in identification of a need for psychiatry and implies the presence of mental illness. This approach may overestimate the number of people who may be eligible for AOT in that a person who does not have a serious mental illness but may take an anti-depressant or other psychiatric medication would fall into this category. This approach may underestimate the number of people who may be eligible because there may be inmates housed at the jail with serious mental illness who do not receive a mental health evaluation and/or subsequent psychiatry service.
Adults with serious mental illness who are “unlikely to survive in the community without supervision” and who are “substantially deteriorating” have likely experienced hospitalization or jail mental health more recently than 36 months. The most precise method for determining if someone is “unlikely to survive safely in the community without supervision” or if the “condition is substantially deteriorating” is through a face-to-face assessment. However, this is not a feasible approach for estimating who may be potentially eligible. Therefore, we premise the estimate on the assumption that people who are “unlikely to survive safely in the community without supervision” or whose “condition is substantially deteriorating” would have likely experienced hospitalization or forensic mental health services in a more recent period than 36 months. Therefore, we narrowed the population to people with at least two hospitalizations or jail psychiatry services within the past 12 months to anticipate how many people are likely to qualify for the above listed predictive criteria.

109 adults had at least two hospitalizations or jail psychiatry services within the past 12 months in Marin County, 22 of whom met this criteria through hospitalization, 86 through jail psychiatry encounters, and 1 with a combination. This provides an estimate of how many people are likely to meet the criteria of at least two hospitalizations and/or forensic mental health services within the past 36 months and who are unlikely to survive in the community without supervision and be substantially deteriorating, as defined by at least 2 hospitalizations and/or forensic mental health services in the past 12 months.

Of these 109 individuals:
- People hospitalized are primarily Caucasian adults ages 26-45 with psychotic or mood disorders; they are equally likely to be male or female.
- People receiving jail psychiatry are predominantly Caucasian males aged 26-45.

Of the 109 adults who are likely to meet the criteria of at least two hospitalizations or forensic mental health services within the past 36 months and who are unlikely to survive in the community without supervision and be substantially deteriorating as defined by at least two hospitalizations or forensic mental health services within the past 12 months, we then look to the criteria about service engagement, including:
- The person has a history of lack of compliance with treatment for his or her mental illness.
- The person has been offered an opportunity to participate in a treatment plan by the director of the local mental health department, or his or her designee, provided the treatment plan includes all of the services described in Section 5348, and the person continues to fail to engage in treatment.
- Participation in the assisted outpatient treatment program would be the least restrictive placement necessary to ensure the person's recovery and stability.

People who engage in voluntary services by definition don’t “fail to engage.” Also, it is unlikely that AOT would be considered the least restrictive option for people voluntarily engaging in services on an outpatient basis. Recognizing that receiving a voluntary service may not imply participation in voluntary services, we then looked at whether or not the service engagement was meaningful, which we defined as

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17 For the entire service goals listed in WIC Section 5348, please refer to Appendix 1.
at least three face-to-face service encounters or at least three consecutive residential bed days in a 12 month period. This allowed us to understand how many of the people who had an open episode at an outpatient clinic were actually participating in service and how many who went to a facility did not immediately leave. We requested data on voluntary service engagement for the 109 people who had at least 2 hospitalizations or jail psychiatry encounters in the past 12 months and found that 90 identified individuals had engaged in service voluntarily.

This implies that the number of adults with at least two hospitalizations or jail psychiatry visits within the last 12 months, who are unlikely to survive in the community without supervision and be substantially deteriorating, and are unlikely to engage in voluntary services is 20 individuals.

<table>
<thead>
<tr>
<th>AB 1421 Eligibility Criteria</th>
<th>Data Element</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>❖ At least 2 hospitalizations or jail and jail mental health service within the last 36 months OR</td>
<td>❖ # of Hospitalizations in past 36 months</td>
<td>286 adults had at least 2 hospitalizations and/or arrests with jail psychiatry in the past 36 months</td>
</tr>
<tr>
<td>❖ One or more acts of serious and violent behavior toward himself or herself or another, or threats, or attempts to cause serious physical harm to himself or herself or another within the last 48 months.</td>
<td>❖ # of Hospitalizations in past 12 months</td>
<td>109 adults had at least 2 hospitalizations and/or arrests with jail psychiatry in the past 12 months</td>
</tr>
<tr>
<td>❖ There has been a clinical determination that the person is unlikely to survive safely in the community without supervision, and</td>
<td>❖ # of Arrests and Jail Psychiatry Service in past 12 months</td>
<td></td>
</tr>
<tr>
<td>❖ The person’s condition is substantially deteriorating.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>❖ The person has a history of lack of compliance with treatment for his or her mental illness.</td>
<td>❖ Participation in at least 3 face-to-face outpatient encounters or 3 consecutive residential bed days</td>
<td>20 adults had at least 2 hospitalizations and/or arrests with jail psychiatry in the past 12 months and are not meaningfully engaging in voluntary mental health services.</td>
</tr>
<tr>
<td>❖ The person has been offered an opportunity to participate in a treatment plan by the director of the local mental health department, or his or her designee, provided the treatment plan includes all of the services described in Section 5348, and the person continues to fail to engage in treatment.</td>
<td></td>
<td>3 adults met criteria through hospitalization and 17 through jail mental health services.</td>
</tr>
<tr>
<td>❖ Participation in the assisted outpatient treatment program would be the least restrictive placement necessary to ensure the person’s recovery and stability.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Recognizing that there are limitations to available data and to this methodology, MHSUS conducted individual case reviews of these 20 individuals and found:
Three (3) individuals met the initial criteria through hospitalization. Two of the 3 individuals were already enrolled in the STARS program and 1 was hospitalized for mental health symptoms related to substance use, is currently participating in substance abuse treatment with MHSUS, and has had no subsequent hospitalizations since beginning substance abuse treatment. None of these three individuals are likely to meet AOT eligibility criteria.

During the manual review of cases, MHSUS identified an additional 4 individuals who had been hospitalized at least twice who may or may not meet AOT eligibility criteria and conducted a more intensive case review. Based on this more thorough case review, MHSUS found that there may be an additional 1-2 individuals not included in the estimate who may meet AOT criteria.

Seventeen (17) individuals met the initial criteria through 2+ jail psychiatry services. Of the 17, 10 had diagnoses may meet criteria for serious mental illness while 7 had diagnoses that are unlikely to meet the criteria of serious mental illness. Additionally, 5 of the 17 are meaningfully engaged in substance abuse treatment while 12 of the 17 may meet criteria for not voluntarily engaging in service. This suggests that there are 10-12 individuals who are primarily receiving services within the jail environment that may meet AOT criteria as defined in the AB 1421 legislation.

A subset of the workgroup members then collaborated to do an additional review of the 10-12 individuals who may be eligible for AOT based on jail mental health involvement and found that these individuals are primarily receiving mental health services in the jail and are likely committing low level offenses that are unlikely to result in referral to the STAR program or active supervision with the Probation Department.

This suggests that there are 5-14 individuals in Marin County who may meet the eligibility criteria defined in AB 1421, as depicted in the following table.

<table>
<thead>
<tr>
<th>Estimate</th>
<th>MHSUS Case Review</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 individuals appeared to be eligible through hospitalizations and lack of meaningful service engagement.</td>
<td>❖ 2 of the 3 individuals were already receiving services from the STARS program and 1 was participating in substance abuse treatment. 0 of the 3 individuals are likely to be eligible. ❖ An additional 1-2 individuals who may be eligible for AOT were identified.</td>
<td>1-2 individuals may be AOT eligible as a result of hospitalizations and lack of meaningful service engagement.</td>
</tr>
<tr>
<td>17 individuals appeared to be eligible through jail mental health encounters and lack of meaningful service engagement upon release.</td>
<td>❖ 7 of the 17 did not have a diagnosis of serious mental illness; 10 of the 17 had a diagnosis of serious mental illness. ❖ 5 of the 17 appear to be meaningfully engaged in services; 12 of the 17 are not meaningfully engaged. ❖ Of the 10 with a diagnosis of serious mental illness and 12 who are not engaging in services, 5 are likely to be eligible and 7 may be eligible.</td>
<td>5-12 individuals may be eligible for AOT as a result of jail mental health services and lack of meaningful service engagement.</td>
</tr>
</tbody>
</table>
Recommendations

The workgroup narrowed its recommendations to two options to consider in making a final recommendation to the Board:

Delay possible AOT pilot pending more robust evidence of efficacy of AOT in comparison to other mental health interventions.

The workgroup discussed the timing of this decision and considered the option to delay the decision of whether to pilot AOT pending the launch of the three (3) new mental health programs, expansion of bed capacity and clinical staff, emergence of more rigorous evidence of AOT efficacy, as well as what could be learned from the launch of AOT in other communities. Specifically, the workgroup considered the option to see if the new crisis programs would adequately reach and engage persons who may otherwise be eligible for AOT.

OR

Implement AOT Pilot

If the board chooses to adopt an AB 1421 resolution, the workgroup suggested a pilot project that would allow the county to test the program in Marin. The workgroup also recommended the following provisions for AOT implementation if the Board moves forward with an AB 1421 resolution.

- Conduct an inclusive AOT planning process, in alignment with the AB 1421 legislation that includes consumers, family members, providers, and culturally specific communities.
- Apply the methodology already developed with local data to proactively identify potentially eligible individuals and begin to assertively engage them rather than waiting for AOT referrals.
- Negotiate agreements with the Sherriff and other law enforcement agencies to clarify who may be called upon for transport for court-ordered mental health evaluations.
- Continue to explore how to serve individuals who may not qualify for AOT but are still experiencing repetitive crises.

If the Board chooses to delay a possible pilot, the workgroup suggests the following provisions:

- Evaluate the success of the new mental health programs and repeat the estimate of how many people may be AOT eligible within Marin County to determine if the target population has changed in size.
- Apply the methodology already developed with local data to proactively identify potentially eligible individuals and begin to assertively engage through the three crisis programs previously described.
- Expand and widely communicate the referral and service eligibility for the new programs across stakeholder groups so that family members and other stakeholders are able to refer into the outreach and engagement programs.
- Continue to explore how to serve individuals who may not qualify for AOT but are still experiencing repetitive crises.
Appendix 1

MARIN COUNTY MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

AB1421 WORK GROUP

Roberta Chambers, PsyD
July 6, 2015

Agenda

- Introductions
- Project Purpose
- AB1421 and AOT
- Planning Process
- Next Steps
3 Introductions

About Resource Development Associates (RDA)

- Established in 1984 in Oakland, CA
- Systems approach to organizational development, planning, evaluation, and grant writing
- Community-focused, outcome-based, efficient and effective use of resources
- Related clients include:
  - Alameda County Health Care Services Agency and Behavioral Health Care Services
  - Contra Costa County Behavioral Health Services
  - Lake County Behavioral Health Department
  - Yolo County Alcohol, Drug, and Mental Health
  - Mental Health Services Oversight and Accountability Commission
Facilitation Team

- Roberta Chambers, PsyD
  - Eighteen years of experience in community behavioral health, fourteen in direct service, both inpatient and outpatient, across the US. Trained as a psychologist; clinical experience focused on people with serious mental illness, addiction, and homelessness.
  - Role: Project Manager/Facilitator

- Kelechi Ubozoh
  - Eight years of professional experience in behavioral health and social services. Specific expertise in community mental health, youth, and homelessness.
  - Role: Co-facilitator

Check-in Question

- Please share your name, organization, and role
- Why did you decide to come today?
- What is one thing you hope this workgroup accomplishes?
Purpose of the Workgroup

- Bring together the group of stakeholders named in the AB1421 legislation

- Build a shared understanding of AB1421 and AOT

- Develop recommendations for the Board’s consideration
Purpose of Today’s Meeting

- Develop a shared understanding of AB1421 and AOT
- Provide an overview of the planning process and how we will work together
- Begin the discussion to consider AB1421 and AOT

AB1421 and Assisted Outpatient Treatment
What is AOT?

- Passed in 2002, AB1421 allows local Boards of Supervisors to adopt Assisted Outpatient Treatment (AOT) in their respective counties.
- AOT provides court-ordered intensive outpatient services for adults with serious mental illness who are experiencing repeated crisis events and are not engaging in mental health services on a voluntary basis.
  - AOT is a civil matter and heard in civil court. It is not a criminal matter and has no involvement with criminal proceedings.
  - AB1421 specifies the eligibility criteria, referral process, and suite of services for an AOT program.

Why should we consider AOT?

- There is a sub-group of adults with serious mental illness who don’t engage in needed voluntary services.
  - A percentage of people with serious mental illness don’t have an awareness that they are ill and don’t recognize the need for mental health treatment.
  - Some adults with mental illness may have experienced trauma and/or stigma related to mental health services.
  - Some adults may experience difficulty accessing or navigating the mental health system.
- There are limited options available to intervene with individuals with serious mental illness who are not voluntarily engaging in mental health services and are experiencing repetitive crisis events and hospitalizations.
AOT in the United States

- Across the nation, AOT is an “umbrella” term that refers to court-ordered outpatient mental health services.
  - Each state has different legislation that specifies the eligibility criteria, referral and court process, and specific services for an AOT program.

- 45 states have legislation authorizing AOT. New York is the only state with widespread implementation.
  - Also known as Kendra’s Law, NY’s AOT program authorizes a different set of services than is specified in AB1421.

- In California, AOT can be likened to:
  - Full Service Partnership* + Legal/Court Involvement

*Full Service Partnership is a set of intensive wraparound services that provides “whatever it takes” to serve people with serious mental illness. It is a required set of services within the MHSA.
AOT in California

California counties who have implemented AOT:
- Nevada County has served 76 individuals in their AOT program since 2008. There is an average of 5 individuals with an AOT court order at any given time in the County.
- Yolo County currently has an AOT program with capacity for 5 individuals. Utilization data suggests that, at any time, 2-3 individuals are enrolled in AOT.
- Orange County is in the early stages of implementation.

California counties who have adopted but not yet implemented AOT:
- San Francisco
- Los Angeles
- Contra Costa
- Placer County
- San Diego
- Mendocino
- Fresno
- San Mateo

California counties who are currently considering AB 1421 include:
- Santa Barbara, Ventura, Marin
AB 1421 Eligibility Criteria
Welfare and Institutions Code Section 5346

- The person is 18 years of age or older.
- The person is suffering from a mental illness.
- There has been a clinical determination that the person is unlikely to survive safely in the community without supervision.
- The person has a history of lack of compliance with treatment for his or her mental illness, in that at least one of the following is true:
  - At least 2 hospitalizations within the last 36 months.
  - One or more acts of serious and violent behavior toward himself or herself or another, or threats, or attempts to cause serious physical harm to himself or herself or another within the last 48 months.
- The person has been offered an opportunity to participate in a treatment plan by the director of the local mental health department, or his or her designee, provided the treatment plan includes all of the services described in Section 5348, and the person continues to fail to engage in treatment.
- The person's condition is substantially deteriorating.
- Participation in the assisted outpatient treatment program would be the least restrictive placement necessary to ensure the person's recovery and stability.
- In view of the person's treatment history and current behavior, the person is in need of assisted outpatient treatment in order to prevent a relapse or deterioration that would be likely to result in grave disability or serious harm to himself or herself, or to others, as defined in Section 8130.
- It is likely that the person will benefit from assisted outpatient treatment.

AB 1421 Service Goals
Welfare and Institutions Code Section 5348

- The individual's personal services plan shall ensure that persons subject to assisted outpatient treatment programs receive age-appropriate, gender-appropriate, and culturally appropriate services, to the extent feasible, that are designed to enable recipients to:
  - Live in the most independent, least restrictive housing feasible in the local community, and, for clients with children, to live in a supportive housing environment that strives for reunification with their children or assist clients in maintaining custody of their children as is appropriate.
  - Engage in the highest level of work or productive activity appropriate to their abilities and experience.
  - Create and maintain a support system consisting of friends, family, and participation in community activities.
  - Access an appropriate level of academic education or vocational training.
  - Obtain an adequate income.
  - Self-manage their illnesses and exert as much control as possible over both the day-to-day and long-term decisions that affect their lives.
  - Access necessary physical health care and maintain the best possible physical health.
  - Reduce or eliminate serious antisocial or criminal behavior, and thereby reduce or eliminate their contact with the criminal justice system.
  - Reduce or eliminate the distress caused by the symptoms of mental illness.
  - Have freedom from dangerous addictive substances.
AB 1421 Service Requirements
Welfare and Institutions Code Section 5348

Community-based, mobile, multidisciplinary, highly trained mental health teams that use high staff-to-client ratios of no more than 10 clients per team member and include a personal service coordinator.

- Outreach and engagement services
- Coordination and access to medications, psychiatric and psychological services, and substance abuse services.
- Supportive housing or other housing assistance.
- Vocational rehabilitation.
- Veterans’ services.
- Family support and consultation services.
- Parenting support and consultation services.
- Peer support or self-help group support, where appropriate.
- Age, gender, and culturally appropriate services.

AOT Process

Please see AOT flowchart (handout).
AOT Process

- Who can refer an individual to AOT?
  - An adult who lives with the individual; Parent, spouse, adult sibling, or adult child of the individual; Director of an institution or facility where the individual resides; Director of the hospital where the person is hospitalized; Treating or supervising mental health provider; Probation, parole, or peace officer.

- Who can file a petition for AOT?
  - The mental health director or designee must file the petition and certify that each of the criteria set forth in AB1421 are met.

- What services are included in an AOT order?
  - The mental health professional must provide a written treatment plan to the court. In a collaborative court model, all involved parties (including the consumer) work together to design a treatment plan that meets the specific needs of the individual. The court then orders services, in consultation with the mental health director or designee, that are deemed to be available and have been offered and refused on a voluntary basis.

- Are family members included as part of the treatment team?
  - Family members may be included as part of the treatment team, with written permission from the consumer. AOT does not exempt the County from compliance with HIPAA requirements.

AOT Process (cont’d)

- What if someone refuses to comply with an AOT order?
  - If an individual refuses to participate, the court can order the individual to meet with the treatment team.
  - If the individual does not meet with the treatment team, he/she can be involuntarily transported to a hospital for examination by a licensed mental health treatment provider.
  - However, the hospital may not hold the individual if they do not meet 5150 criteria.
## Funding Considerations

<table>
<thead>
<tr>
<th>Category</th>
<th>Allowable Funding Sources</th>
</tr>
</thead>
</table>
| FSP Services | Any funding source that currently funds FSP/ACT services, including MHSA. If FSP services were to be funded by MHSA:  
  ➢ A plan update would be required and include a CPP process, 30 day public posting, public hearing, and BoS approval.  
  ➢ The costs associated with AOT implementation cannot reduce or eliminate voluntary programs  
    (i.e. must be monies not currently allocated to existing programs.) |
| Housing      | MHSA funds for housing associated with FSP participation, MHSA housing, or other non-mental health housing subsidies.                                |
| County Counsel | General Fund or other non-mental health funding  
  ➢ MHSA and/or Realignment funds cannot be used for legal costs associated with AOT implementation.               |
| Public Defender | General Fund  
  ➢ MHSA and/or Realignment funds cannot be used for legal costs associated with AOT implementation.               |
| Court        | General Fund.  
  MHSA and/or Realignment funds cannot be used for legal costs associated with AOT implementation.           |
Other AOT Costs

- Hospital costs for court-ordered evaluations for non-compliance
- Law enforcement costs to transports individuals for court-ordered evaluations for non-compliance
- Office of Patient Rights costs, who are required to be noticed of an AOT petition but are not required to participate
- Administrative oversight of AOT program
- Data collection and reporting of outcome data to DHCS

AOT Impacts on Cost

<table>
<thead>
<tr>
<th>AOT Cost Increases</th>
<th>AOT Cost Reduction</th>
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<tbody>
<tr>
<td>➢ FSP Services</td>
<td>➢ PES</td>
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<tr>
<td>➢ Housing</td>
<td>➢ Psychiatric Hospitalization</td>
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<tr>
<td>➢ County Counsel</td>
<td>➢ Emergency Room</td>
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<tr>
<td>➢ Public Defender</td>
<td>➢ Jail</td>
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<tr>
<td>➢ Court</td>
<td>➢ Law Enforcement</td>
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Do the cost reductions associated with AOT result in a “hard” cost savings
or
Do they avoid costs for enrolled individuals without reducing the overall level of spending for these departments?
AOT Funding Legislation

- **S8 585**
  - MHSA funds can be used for the service costs associated with AOT implementation.

- **Attorney General**
  - MHSA funds cannot be used for court and legal costs associated with AOT implementation.

  - Provides funding for AOT pilot projects through a competitive grant program.
  - The request for applications is expected to be released this federal fiscal year (2014-15).

- **H.R. 3717: Helping Families in Mental Health Crisis Act (pending)**
  - Requires states include AOT in the state Medicaid plan.

AOT Research
FSP and AOT Outcomes

- Do the services provided under AB1421 work when provided on a voluntary basis and when people choose to engage?
  - Full service partnership services, when provided on a voluntary basis, decrease ER visits, psychiatric hospitalizations, admissions to long-term care facilities, arrests, incarceration, and homelessness.

- Is the court order for AOT necessary or would voluntary Full Service Partnership services effectively serve the target population?
  - The research is inconsistent/inconclusive.

- Will AOT save money?
  - The research is inconsistent/inconclusive. However, the services provided under AOT, such as Full Service Partnership, are consistently associated with cost savings in the literature.

- Does AOT influence service availability on a voluntary basis?
  - In New York, services were initially focused on the “back log” of people in distress. Within 5 years, both voluntary and involuntary service availability increased.

Q&A and Discussion
Approach to Facilitation

- Build a collaborative, transparent process rooted in open, solutions-focused dialogue
- Support planning with data – about the target population, the current system, and options for intervention
- Establish working norms to inform participation
AOT Workgroup Overview

Meeting 1 - July 6, 2015
Establish a shared understanding of AB1421 and AOT

Meeting 2
Assess the current adult system of care, levels of care, and AOT alternatives

Meeting 3
Consider AOT in Marin County

Meeting 4
Consider risks, benefits, and gaps between AOT and current adult system of care

Meeting 5
Brainstorm and prioritize potential solutions

Meeting 6
Develop recommendations for Board consideration

Q&A and Discussion
Next Steps

- Develop systems map of adult system of care (RDA/HHS)
- Review adult system of care data (RDA/HHS)
- Send additional questions or new developments to RDA (all)

Thank you!

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Appendix 2

Target Population Estimate Methodology

Step 1: Consider the qualifying criteria for hospitalization of:

- At least 2 hospitalizations within the last 36 months
- One or more acts of serious and violent behavior toward himself or herself or another, or threats, or attempts to cause serious physical harm to himself or herself or another within the last 48 months.

Psychiatric Emergency Services: How many adults were seen in PES in within the past 36 months? What is the race/ethnicity, age, gender, primary diagnostic category of this group? What % had a co-occurring substance abuse disorder?

Hospitalization: How many adults had at least two hospitalizations within the past 36 months? If possible, please include state hospital data. What is the race/ethnicity, age, gender, primary diagnostic category of this group? What % had a co-occurring substance abuse disorder?

Jail Mental Health: How many adults had at least two unique encounters from jail mental health in the past 36 months? How many unique (incarceration + jail mental health) visits were there? If possible, what are the demographics of this group (if their data are available)? How many of these individuals had also been seen by mental health outside of the jail setting? How many only received mental health services while incarcerated?

Hospitalization + Jail Mental Health: How many people had 2+ encounters when you combine hospitalization and jail mental health data sets in the past 36 months? What is the race/ethnicity, age, gender, primary diagnostic category of this group? What % had a co-occurring substance abuse disorder?

* Remove individuals who are not Marin County residents.

Step 2: Consider the predictive criteria of:

- There has been a clinical determination that the person is unlikely to survive safely in the community without supervision, and
- The person's condition is substantially deteriorating.

Adults with serious mental illness who are unlikely to survive in the community without supervision and who are substantially deteriorating have likely experienced hospitalization more recently than 36 months.

How many adults had at least two hospitalizations and/or jail mental health encounters within the past 12 months?
*Remove individuals who are not Marin County residents.

**Step 3:** Consider criteria about service engagement, including:

- The person has a history of lack of compliance with treatment for his or her mental illness.
- The person has been offered an opportunity to participate in a treatment plan by the director of the local mental health department, or his or her designee, provided the treatment plan includes all of the services described in Section 5348, and the person continues to fail to engage in treatment.
- Participation in the assisted outpatient treatment program would be the least restrictive placement necessary to ensure the person's recovery and stability.

People who engage in voluntary services by definition don’t “fail to engage.” Also, it is unlikely that AOT would be considered the least restrictive option for people voluntarily engaging on an outpatient basis.

*How many individuals are voluntarily engaging in non-crisis, non-emergency services (e.g. how many are enrolled in a residential or outpatient program)?*

**Step 5:** Consider whether or not voluntary service engagement was meaningful (e.g. did they actually participate in services after enrollment or admission)?

*How many people had at least 3 outpatient, face-to-face service encounters? How many people received residential services for more than 2 consecutive days?*
Appendix 3

MHSUS Adult System of Care

Marin County Jail
13 Peter Behr Drive
San Rafael, CA
Inmate transported to Santa Clara County Jail Inpatient Unit
Inmate released and transported to PES

Jail-Based and Reentry Services
Jail Mental Health Services
AB 109 Psychologist & Recovery Support Services
Reentry Team
Reentry Case Manager [Planned]

Mobile Crisis Response Team
7 days a week
1:00 pm – 9:00 pm
(415) 473-6392
Crisis intervention services in the field [Planned]

Mental Health Services Access Line
(888) 818-1115

Consumers and/or Family Members

Law Enforcement

Psychiatric Emergency Services (PES)
Marin County General Hospital Emergency Dept.
250 Bon Air Road, Unit B
Greenbrae, CA

Marin County General Hospital
250 Bon Air Road
Greenbrae, CA
(415) 473-6666

Kaiser Medical Center
(3330 Designated Facility)
99 Monticello Rd
San Rafael, CA
(415) 444-2000

Outpatient Recovery Support Services
Law Enforcement
Consumers and/or Family Members

Residential Services and Supports

Residential Services
Homeless Shelters
Assisted Living
Supportive Housing

Outpatient Recovery Support Services

Full Service Partnership
Homeless FSP
Older Adults FSP
Behavioral Health Care FSP
TAY FSP

Outpatient Intensive Case Management
Adult Care Management Services
Homeless Case Management [Planned]

Medication Services
County Medication & Outpatient Clinics
Mental Health Integrated Physical Health Care Clinic
Medication Assisted Treatment

Recovery Services
Enterprise Resource Center
Veterans Services
Family Support Services
Senior Peer Counseling
Enterprise 2 Service Enhancement [Planned]

Outreach and Engagement
Air Team
Drop-in Outreach and Engagement; Treatment Services
Homeless Outreach Street-based Outreach

Marin Health and Human Services
Assisted Outpatient Treatment Workgroup
January 26, 2016 | 44
California Police Chiefs Association

Homeless & Mentally Ill Work Group

Edited by:
Pat Walsh, Chief of Police, Lompoc Police Department
Al Venegas, Deputy Chief, Santa Monica Police Department
**Executive Summary**

One of the consistent themes police chiefs across California discuss as an emerging issue facing law enforcement and the communities they serve, are the increasing number of interactions between the police and the homeless. Equally concerning is a large portion of this population suffers from mental illnesses and is afflicted with numerous medical problems, further complicating law enforcement’s response. As a result, the California Chiefs Association (Cal Chiefs) Board created a working group, Homeless and Mentally Ill Work Group (WG) to study the frequent interactions between the police and homeless population to provide insights into how law enforcement across the state is coping with this issue and provide alternatives to those agencies needing assistance with this growing societal issue.

It quickly became apparent there is not one methodology or program that fully addresses all facets of this complex issue. Different jurisdictions are addressing the issues in a multitude of ways with the resources they have on hand. Some jurisdictions have council support, larger budgets, and a community willing to assist with the issue. Some jurisdictions have specialized resources in their areas like psychiatric hospitals for mental evaluations while others have to drive long distances, taking valuable resources out of the field for extended periods of time. Others have on-call medical personnel that will respond to the scene or are available in their custody facility to conduct medical clearances so officers do not wait for extended periods of time in emergency rooms. However, all jurisdictions are putting forth a valiant effort to address these concerns as best they can and all need additional assistance.

It needs to be stated that Cal Chiefs, and in particular the WG, understand that being homeless and/or mentally ill alone is not a crime nor a condition that can be improved through traditional law enforcement methods. Homelessness, while unsightly, is a societal issue requiring a regional coordinated approach with every entity in a position to assist seated at the table. At times these individuals create livability problems, act out when in crisis, and instill fear in our communities that generate calls for service. Police officers, often criticized for their treatment of the homeless, are routinely called upon to deal with homeless, persons in crisis or suffering from mental illnesses, where many times there is no violation of law. Unfortunately, the reality is when the community is uninformed about who to contact, what resources are available, or how to channel their willingness to help, they call the police.

It cannot be magnified enough; to have a chance at improving the homeless situation in any community, any and all efforts must be coordinated with local and regional service providers as partners with local government. Law enforcement is not the answer to homelessness but law enforcement can be a leader in bringing all resources together to address change.

This paper is not meant as a solution to homelessness or a “how to” guide when dealing with those suffering from mental illness. What has emerged from this body of work is more of a menu or tool kit for law enforcement to use when attempting to address homeless and mentally ill persons within their communities.

The work is broken down into Medical Clearances, Psychiatric Holds, Housing, Veterans, Re-Unification, Training and Outreach, and Resources.
On behalf of the Cal Chiefs’ Homelessness and Mentally Ill Work Group we hope that this body of work is helpful. These topics are complex and difficult to navigate. All of the jurisdictions that provided information on their programs have expressed a willingness to be contacted for more information, to include having agencies come and observe their processes. This alone makes this work meaningful.

**Medical Clearances**

Many homeless individuals are afflicted with physical conditions or take medications that preclude them from being housed in a correctional facility. Jail Managers have the responsibility to ensure provisions of “emergency and basic” health care services are available to all inmates (Title 15). The staff time needed and personnel required to transport the homeless to emergency rooms was a topic that garnered much dialogue. Some agencies mentioned traveling long distances to a medical facility, while all stated waiting for the medical clearance for extended periods of time was a serious concern for their departments.

This, coupled with the rising costs of medical care and personnel shortages, mandate alternatives to incarceration when dealing with the homeless. Most times, homeless individuals commit minor violations of law when enforced and rarely seem to have meaningful outcomes that make a difference or change their behavior. Issues surrounding medical clearances have even become well known amongst the homeless population who will volunteer their medical condition to officers in the hopes of deferring a trip to jail. While the need to medically clear a prisoner will never be negated, some agencies have found ways to reduce the time officers are waiting in emergency rooms.

- The Indio Police Department indicated parts of Riverside County utilize Paramedics who come to the scene and medically clear the patient.
- The Santa Monica Police Department utilizes a private medical treatment company within their jail facility to medically clear patients for bookings. Vital Medical Services is an onsite medical healthcare provider that performs MT’s in a medical room within their Type I Jail. Vital Medical provides all medical equipment and supplies. They also perform blood draws in the field for DUI checkpoints and offer minor employee MT as well.
- The Berkley Police Department utilizes a Physician’s Assistant who responds to the scene to medically clear patients, saving time and resources. Emergency room visits are expensive and time consuming as medical emergencies take precedence.
- The Anaheim Police Homeless Outreach Team has an arrangement with Anaheim Fire Community Care program, which responds to the scene and a paramedic and nurse practitioner medically clear the individual.

Extensive wait times for officers sitting in emergency rooms may not be an issue in all jurisdictions, but the ability to streamline the medical clearance process is an option worth researching. Many departments are in need of additional personnel or are finding it difficult to fill open vacancies. The costs associated with this program could be offset by the staff time and overtime saved, returning officers to the field where they are needed most.
Psychiatric Holds

Typically, when an officer places a 5150 hold on an individual they are transported to a hospital that has the staff and capacity to house a patient for the 72-hour psych hold. The officer completes the hold paperwork, the hospital accepts the patient and places them in a psychiatric bed and the officer leaves. This is not the case in all jurisdictions. Some hospitals do not have the psychiatric staffing, beds, or capacity to accommodate subjects placed on a hold. In these jurisdictions the process becomes more complex and time consuming.

Many hospitals have discontinued their inpatient psychiatric beds or have shut down all together. Most counties have only 10 percent of the beds needed to accommodate holds. Police departments in these jurisdictions have had to forge strong working relationships with their county mental health workers and hospitals to make the 5150 WIC process work.

When a hold is written the county mental health workers are notified and respond to the hospital to conduct the assessment. Ideally, they take responsibility for the patient and paperwork. Depending on the relationship with the county worker, the behavior of the patient, and the availability of hospital security, the officer is free to go. Without good relationships with these agencies, officers are forced to guard patients for hours until a bed is located. Unfortunately, when the hospital is not equipped to house these patients, the patient is housed in the emergency room which takes away from general community needs. Sometimes they stay in the ER for days while the mental health worker searches for a psych bed.

Due to a lack of coordination amongst everyone involved, many hospitals have a hands off approach to 5150 patients and hospital security are only allowed to observe and report disturbances 5150 patients are displaying to the police. This has created situations where these patients, previously transported by the police or patients attempting to access mental health care, often walk away from the hospital without receiving the care needed. On many occasions the police are called to find the patient, many times resulting in a use of force or a deadly force encounter creating additional liability for all involved.

Some jurisdictions have actually found an open bed several counties away and had the patient transported to these facilities. This takes an inordinate amount of time dealing with a patient but is a better solution than housing them in the ER where additional calls for service can be generated when the patient acts up or walks away from the hospital. If a 5150 patient has a medical problem requiring attention, state law and department policy mandates they are taken to the closest medical facility regardless of the medical facility’s ability to house them. This further complicates issues but having an understanding of everyone’s responsibilities and an agreement to work together on an issue that will not go away is paramount.

In jurisdictions where mental health services are accessible, some departments experienced increases in this population in their areas. Despite established agreements and quarterly meetings with area hospitals, there are continued challenges with the increase of persons suffering from mental illnesses. Repeated transports to the same hospital, disruptive patients within general hospital settings and increasing costs, are but a few of the issues surrounding mental illness.
The work group did not find a solution for these complicated scenarios and given the continued increases in this population, department heads must dialogue with area hospitals, mental health providers, and emergency room directors to collectively implement strategies that address each other’s issues and craft solutions together that work for all involved.

Santa Barbara 5150’s are admitted in concert with a triage clinician at County Mental Health (12 beds) this ensures the safety of the clinician and provides the officer the ability to hand over the client so they can move onto their next call. SB also has levels of “crisis” assistance that include:

- 23-hour crisis center run by county mental health (this is voluntary, often used by high frequency 911 callers who do not meet 5150 criteria, 6 beds only)
- ANKA Behavioral Health is a stabilization center which is voluntary and intended to stabilize the client with medication and an appropriate discharge plan. This facility is not locked, has 12 beds and can be used from 2-4 weeks by the client.
- 5150 assessments can be done directly by their local VA when transported by an officer, and there is no need to involve county mental health.

It is wise to forge working relationships with local and out of area hospitals; these relationships can come in handy when attempting to locate a facility to house an individual placed on a psychiatric hold.

**Housing**

It goes without saying that life on the streets is an extremely difficult way to survive. Add substance abuse and/or mental illness and it is nearly impossible to extract oneself from a life of despair. During our discussions, the solution to homelessness starts with some form of temporary housing. Many social service providers take a “housing first” approach to dealing with homelessness. Housing first relates to securing permanent housing as quickly as possible and while housed, providing extensive supportive services to assist with ending their state of homelessness. This sounds over simplistic, but stability is needed to begin the process of helping the homeless get out of this vicious cycle.

The obvious problem here is the insufficient amount of housing to get the homeless off of the streets. Although locating supportive housing is well beyond the scope of responsibilities of law enforcement, the concept of developing a specialized unit of homeless outreach workers teamed with police officers that work daily with the homeless population was discussed as an ideal benefit.

These specialized officers have the ability to develop expertise and trust with the homeless, work alongside social service providers to build relationships with them, and most importantly, show the compassionate side of law enforcement to the entire community by coming to the aid of those less fortunate. Additional responsibilities could include collaborative efforts with social service providers, locating homeless for possible services, transportation to various government services, working with local prosecutorial offices, and the list goes on.
This will require constant engagement with the clients and also collaboration with adjoining jurisdictions, as clients are transient. If a client is not available when housing becomes available, they will miss their window. Case management and constant engagement will make this concept work.

Law enforcement is not responsible for housing the homeless and the mentally ill. That said, law enforcement can be a voice at the table when discussing housing solutions with city councils and county government. The street officer is constantly responding to homeless persons and persons in crisis or suffering from mental illness. Experts suggest that homeless individuals pose a far greater risk to repeat calls for service than those housed. The work group’s recommendation for law enforcement leaders is to join this conversation and to stay engaged in finding solutions using social service providers, and city and county resources designed to house those in need.

- Santa Barbara has two SRO’s (single residence occupancy) that provide affordable housing. They are converted old hotels; some have shared bathrooms priced from $600/month.
- Santa Barbara also works cooperatively with a local organization called C3H (Central Coast Collaborative on Homeless) which focuses on housing and wrap-around services to keep them housed.
- They have begun a “safe parking program” recently adopted by the city of Los Angeles (run by New Beginnings). A fixed number of vehicles are provided at night-time safe parking locations as long as the occupants engage in case management.

Housing is critical to the recovery of homelessness and mental illness. Stability will lead to consistent services and counseling, which will lead to fewer calls for service and re-entry into a healthy lifestyle.

**Veterans**

Veterans who find themselves homeless or suffer from mental illness have additional resources that can be utilized. Like most homeless in crisis, seeking out and obtaining these services can be difficult. However, there is currently a big push to have services more accessible to veterans.

The Veterans Administration provides the following resources that outreach workers and officers can help Vets navigate.

- **Veterans Affairs Clinics**- clinics that can be utilized by those who have served in the Armed Forces for medical as well as psychiatric services.
- **Veterans Services Offices (VSO)** - Each county has VSO’s that assist Veterans obtain benefits. These benefits can range from PTSD counseling to physical or mental disability benefits.
- **Veterans Affairs Supportive Housing (VASH)** - homeless Veterans qualify for housing assistance and the VASH offices provide Section 8 housing vouchers.
- **Veterans Center Program**- the Vet Centers are geared toward combat veterans or Veterans who have suffered from trauma. They provide counseling and help these Veterans navigate the VA system.
• **Veterans Center Outreach Workers** – some VA centers have outreach workers who specialize in assisting homeless veterans access a variety of homeless services. A specialized unit can work collectively with these outreach workers to assist homeless veterans.

• **Veteran’s Court** – Santa Barbara as well as other jurisdictions offer a court specifically designed to meet the needs of Veterans. This court requires a two-year commitment and is staffed by a Judge and a variety of services to meet the mental health and substance abuse needs of the client.

It makes sense that those working with the homeless population familiarize themselves with how to identify Veterans since resources are more accessible to them. This knowledge can greatly assist outreach workers and officers in obtaining services and housing for homeless and mentally ill or those Veterans in crisis.

**Programs**

Law enforcement must learn that enforcement is not the solution and alternatives need to be used to end homelessness. Assembly Bill 109 (Prison Realignment) has had a significant impact on law enforcement’s crime reduction efforts and placed an increased strain on local services. Proposition 47 (Reduced Penalties) further hampered crime reduction efforts by reducing the severity of certain crimes that in essence began to allow for crime to pay. These legislative actions magnify the need to find alternate solutions to combating homelessness in our respective communities that do not equate to incarceration. We cannot rely on the court process to change behavior with a population that commits minor or quality of life crimes to support their current lifestyle.

The following are a few of the innovative solutions police departments are undertaking to combat homelessness in their communities:

• **Re-Unification Program** – focuses efforts on reestablishing contact between the homeless and their families or where they were previously receiving services. Initial efforts include relationship and trust building with the homeless to learn about their past and the need to do something about improving their current situation. Contact is then made with estranged family or previous service provider to determine if they would be willing to take the homeless person back. Funds are allocated to pay for a bus/train ride back, along with meal vouchers from McDonalds. Santa Barbara, Santa Monica, and other agencies have been successful in reuniting families using this approach.
  - Follow up is also conducted to ensure the homeless person keeps on track and connected to services. These could also be success stories with before/after photos to further document a compassionate approach to homelessness.
  - Santa Barbara Restorative Policing attends a weekly meeting run by a Cottage Hospital social worker and is attended by a variety of local service providers. The purpose is to troubleshoot “high frequency” homeless clients and move them towards providers or establish a plan to reunify them with family in another area. Transient clients are most often sent back to the community they came from, enabling them to get linked back to their social services, medical providers and continue with their
health care insurance. Hospital social workers can be great allies when it comes to linking patients to services they once had in another area.

- Anaheim also works toward reunification and utilizes a non-profit to fund the transportation costs. The non-profit then conducts the follow up with the client to insure a successful transition and alleviate the police department resources.

- **Citation Clinics** – are collaboration efforts between local prosecutors or city attorneys to resolve low-grade warrants for minor offenses while emphasizing the need to accept services for housing, mental health and homeless services. Homeless individuals often report that warrants and associated fines hinder their ability to obtain employment, access housing, mental health or other critical services. These clinics work to remove obstacles to services and assist the homeless to improve their chances of success.

- **Homeless Court** – another collaborative effort between prosecutors and public defenders that emphasizes keeping minor violations of law in abeyance so the homeless accept services, follow case management, and actually complete programs. Santa Barbara calls their version “**Restorative Court**.” At the completion of the program, court cases are dismissed. The team consists of every critical agency including county mental health. Clients are managed by PD Outreach Specialists who attend court and have contact with clients frequently. Cooperation from the jail is critical since there are instances when you must arrest and HOLD a client until the next court date (and/or to stop the cycle of drinking and drugs or manic behavior). Processing clients through the courts is powerful and more effective than simply working them on the streets. They are rewarded for good behavior and reprimanded or taken into custody when they are not compliant. Since this is a voluntary court, the client can always opt out and face their charges in regular court. Similarly, there are post filing diversion programs within criminal courts, along with new legislation (AB2124) that allow for sentences to be deferred so that the homeless can obtain and complete services.

- **Mental Court** – Santa Barbara Mental Health Treatment Court provides mandatory treatment, which requires a one-year commitment and the client must have a probation officer. Probation can provide housing and wrap around services. This supervision helps insure the person follows through with treatment and is backed up by the same judge who is assigned to the mental health court.

- **Re-Entry Programs** – These programs focus on soon-to-be released inmates and provide training and assistance locating temporary housing, assistance in assimilation into society, and ideally keeps them from becoming homeless upon release from jail.

- **Homeless Management Information System (HMIS)** – this database is utilized by Orange and Los Angeles County who gather and maintain information about homeless, where they receive services, and their social service providers. This database of individuals allows for better case management, production of services reports, tracks individuals progress, identifies gaps in service, and coordinates all aspects of case management. Some departments have limited access to HMIS, yet this database has proven beneficial in finding alternate solutions and personnel to assist with the homeless.
Not all jurisdictions can afford this level of engagement or fund aspects of these programs. There are foundations and community organizations that are stepping in to fund such outreach and travel, along with grant opportunities that can be applied for to fund these opportunities. It makes sense to stabilize the family structure and research shows family connections keep individuals from slipping back into homelessness.

**Training and Outreach**

There needs to be a clear understanding amongst law enforcement that to significantly and effectively address homelessness in our communities, traditional law enforcement methods and incarceration are insufficient. Strict enforcement alone has not resolved the problem and may actually incur liability without resolving the core issues that cause and sustain homelessness.

Law enforcement must work collaboratively with all entities having a role in addressing homelessness and be open-minded toward non-traditional approaches and best practices. While not every officer needs to become a “social worker with a gun,” every officer should be trained to approach situations involving homeless and mentally ill individuals from a perspective of “what can I do to make my interaction part of a coordinated strategy to get this person off the streets?”

One approach to coordination and finding a strategy could include;

1) Identification of available resources and training.

2) Establishment of new or strengthened relationships with service providers to develop collaborative efforts to jointly address the long-term needs of homeless individuals.

3) Review of policies, procedures, and ordinances that could be added or strengthened to assist law enforcement in their duties.

4) Establish an enforcement protocol that is supportive of the above efforts.

**Motivational Interviewing**

Another training Santa Barbara Police have participated in is motivational interviewing. This type of interviewing is taught to mental health nurses and clinicians and is a necessary and successful approach to dealing with the homeless. Teaching officers and PD civilians how to conduct a dialogue that focuses on “what the client wants” and steering clear of judgment can build understanding, trust and results.

While our focus has never been to “criminalize” homelessness, in many communities, lack of appropriate services coupled with public demand for immediate action has put law enforcement on the spot as the first responders in this crisis. We should be judicious in our approach to show that
law enforcement is aware of the complexity of this problem and needs the help and support of a variety of public and private entities to bring about permanent, positive changes.

Santa Barbara PD collaborates with its business community and this relationship has helped “share the burden” while fostering an understanding of how complicated homeless issues are. These dialogues help the community understand that it is NOT a police problem, it is a COMMUNITY issue and many businesses have stepped up to help contribute funds for clients to relocate or get housed.

**Available Resources**

Departments must determine the resources they have in their respective areas that could assist them in addressing homelessness. They need to look beyond jurisdictional lines, as homeless services are regionally distributed, and develop intentional relationships with shared procedures and clear roles that support mutual goals and objectives.

While some jurisdictions will have more resources available to them than others, no one has enough to address the needs of every person who is homeless. Therefore, it is critical that you create relationships that help prioritize the highest users of police contacts for these limited resources, and that your efforts are coordinated to ensure everyone does their part. While enforcement can play a positive role in addressing homelessness, it should be used as a catalyst for motivating behavior changes that can link homeless people to services rather than being perceived as punishment. Some possible resources include:

**Social Services** – While law enforcement and social services/social advocacy groups have historically been viewed as adversarial, addressing homelessness creates an opportunity to forge a win-win relationship around the shared goal. It is important to understand what each agency does (and do not do), who is eligible for services, and to identify a “gatekeeper” that can help you get someone expedited access to care. This is especially critical if an agency has emergency or transitional shelter beds. Some law enforcement entities have been successful in forging agreements to have one or two beds set-aside for law enforcement use, but these agreements are based on trust and a cooperative relationship on both sides. Law enforcement should not be perceived to be “dumping” a homeless person in a shelter. Instead, service partnerships should be based on agreed-upon criteria, and includes a service plan for ongoing care.

**Faith-Based Community** – Communities of faith often approach homelessness with a spiritual obligation to serve those in need. Working with law enforcement can be viewed by some as contrary to this mission, based on guilt and fear of “punishing” the poor. By taking a collaborative approach, law enforcement creates an opportunity for invested faith leaders to guide their congregations and volunteers to work as part of a coordinated effort. Services such as clothing donations, sack lunches, food pantries and temporary cash assistance, are more effective and sustainable when aligned with the efforts of agencies that help homeless individuals obtain and retain permanent housing, especially if those individuals are high users of police resources.
City Resources – Homelessness touches many city departments and it is important to develop lines of effective communication between them. Some cities have departments that may fund, or at least coordinate with, local service providers. Some cities also have their own Public Housing Authority, who administers housing subsidy programs and other efforts to provide affordable housing. Wherever possible, collaboration between city departments (human services, police and fire departments, public housing authorities, city attorney’s office, etc.) can be leveraged to ensure scarce housing and supportive service resources are prioritized for the community’s most vulnerable residents. It is important that these departments understand the benefits of providing resources for high users of police services, and agree to work together to prioritize those individuals for care.

Law enforcement can also be a resource in the development of public spaces and special needs housing by providing input on proposed designs to maximize safety through lighting, accessibility, visibility, etc.

County Resources – County elected officials can also be of assistance by funding local programs and facilitating strategic partnerships that support law enforcement efforts. County departments often fund nonprofit services, so county officials can convene meetings and help broker access to those services. These resources and programs will vary between communities, but an example of such partnership is the pairing of Department of Mental Health licensed clinicians with law enforcement to better serve individuals with severe and persistent mental illness.

Federal Resources – Federal resources are generally accessed via nonprofit contractors; however, there are some grants that police agencies can apply for directly. Resources such as the Veterans Administration (VA) can also be of assistance to law enforcement. The VA has a wealth of resources for housing; mental health and health care for homeless vets depending on their discharge status. Most VA’s also maintain homeless outreach teams. Police departments should develop relationships with their local VA hospital to establish guidelines for accessing these services as a diversion for low-level offenders.

Coordination

Many police departments have realized all stakeholders need to meet so that services are coordinated. This includes Fire, City Attorney, mental health, HUD, neighboring jurisdictions and social services. With respect to the Santa Monica Police Department, they have the following meetings to stay on point:

- **Homeless working group meeting** – Meeting between city Human Services Division (HSD), PD, Fire, City Attorney, and Jail personnel to discuss top users of public safety resources and strategize regarding next steps.
- **Chronic homeless meeting** – Meeting between social service providers and city HSD to discuss area-wide issues surrounding homelessness.
- **Mental health meeting** – Quarterly meeting with area hospitals, City Attorney’s Office, HLP Team, Training Coordinator, and Deputy Chief to discuss issues surrounding 5150 holds.
- **Westside coalition of government meeting** – Quarterly meeting among city managers and/or their representatives to discuss regional issues, to include homeless.

- **Service provider partnership** – Monthly meeting to discuss homeless issues from an operational perspective. This would include HLP Team, HSD, outreach workers, and social service provider operations managers.

- **Specialized teams meetings** – Periodic meetings among specialized teams that address specific issues within homelessness.

- **Hospital meetings run by social workers for frequent users.** If the police and fire departments are seeing frequent contact with homeless and mentally ill, the hospitals are seeing the same people. This collaboration and relationship will pay dividends.

- **APS (Adult Protective Services) meetings** for discussing high resource, highly vulnerable, highly service resistant homeless. As with the hospitals, APS will also be seeing those individuals that are vulnerable and frequent users of the services and police services. Coordination and relationships here are important for law enforcement to forge.

Agencies should identify their top 10 homeless and share weekly goals (and resources) for next steps with all of these entities. This not only shares basic info but it also provides information on “how” the goals and agencies are working together. The goal is always training the police officers through these case studies that they work with and cite daily.

Not that we are advocating for more meetings, but having communication up and down and laterally ensures all systems and agencies are working in a coordinated manner. This also allows for real communication to occur and for all involved to take ownership and share accountability. Nowhere is this more important than to have local government leaders involved in these discussions and policy decisions.

**Training**

A review of your organization’s training curriculum should also be conducted to ensure attendance at Crisis Intervention Training, Mental Illness Awareness, Law Enforcement Response to Homelessness, and attendance at conferences that concentrate on homeless awareness, efforts to end homelessness, or involve regional efforts to assist the homeless.

Efforts should be focused on ensuring employees receive the most current training and understand best practices available to address homelessness. Do not overlook the opportunity to engage the community, service providers, and city and county departments in your training efforts as well. A well-informed community can assist with diverting calls for service, complaints surrounding homelessness, and help with educating others about what services are available and who to call instead of requesting police officers to address a homeless problem.

As with any training provided, it must be fully supported by the highest echelon of the organization to the line level officer. Policies must support the training, and training should support policy. With time, this will create strong habits that lead to department customs and an overall change in our policing. In keeping with the President’s Task Force on 21st Century Policing, specifically...
Community Policing, individuals experiencing homelessness are members of our community that
deserve dignity, and approached with strategic and coordinated assistance.

Additional training opportunities include:

**Interactive Video Simulation Training (IVST)**
- 4-hour course focusing on increasing officers’ ability to recognize and deescalate person
  experiencing a mental health crisis
- Also provide an 8-hour POST certified class that meets the training requirements of Field
  Training Officers under SB-29

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**Motivational Interviewing**

Santa Barbara Police works closely with county mental health clinicians. As such they were invited
to participate in training for clinicians and mental health nurses called “motivational interviewing.”

Although Santa Barbara County Mental Health does not provide this training outside of their
agency, police departments are encouraged to forge a relationship with their own county mental
health organizations. Since police and clinicians have contact with the same clients, training
together such as Santa Barbara has can only help in our work on these issues.

**Enforcement Protocol**

What we hope to magnify here is a true change in policing philosophy. Through proper training and
 collaboration, officers can begin a new approach to dealing with homeless offenders by directing
their efforts toward a collaborative response with social service providers. Instead of transporting
homeless people to jail, call their social worker, write a field interview card and refer them to a
social service. Become knowledgeable about what resources are available and hold individuals
accountable for taking advantage of the assistance available to them to get off of the streets rather
than telling them to leave the area.

*Possible interaction with homeless individuals can occur in the follow way:*


First Contact: Field interviews cards are completed for identification purposes. Absent any major law violations, advise of the resources in the area, educate on local ordinances that prohibit certain activity, possibly direct them back to where they were receiving resources previously, or to their families.

Second Contact: Field interview cards are completed to document repeated interactions, possibly write a citation for any violations, and author a report if required. A little more emphasis is placed on compliance while not necessarily taking the individual to jail.

Third Contact: Field interview cards and reports should be completed to continue the documentation of the negative activity and if need be, appropriate citations or arrest can be made.

With every contact involving homeless individuals, connecting them to services is the goal. For this to work, law enforcement and social service agencies should be working on a “shared” group of people, identified by name. A consistent protocol for communicating and sharing information must be put in place, so that police can notify agencies when they have frequent contact with a shared client. By encouraging discretion, it shows the public we care, are not quick to judge, and compassionate enough to try a different approach to aid a person in crisis. Proper documentation of all contacts involving homeless individuals is critical as we utilize analytics to better understand the magnitude of the issue in our community. Accurate measurement and reporting of data and outcomes may result in increased funding, grant opportunities, and educational awareness.

There were a few training opportunities identified by this work group and they are listed in the resources section in the back of this paper. Suffice it to say the basic CIT training given to all police academy cadets is a good start, but should not be the only training officers receive regarding the homeless and those in crisis. Ongoing training and advanced training will benefit not only the police, but the community and those we serve.

Gaps

As stated at the beginning of this paper, this work is not a “how to” guide but rather a tool kit and a place to start the conversation as to what other law enforcement agencies are doing to address these complex issues. Here is a list of issues that we have not addressed and will come up as agencies try to navigate the homeless and mental health issues their community members attempt to address:

- Affordable housing, particularly housing with case management
- Payees. Private payees are rare, making it difficult for homeless/formerly homeless to manage their money and make rent. This is a gap in services.
- Detox beds, or the time it takes to get into a detox bed
- Appointment lead times for medical and mental health services at county
- Transport time/officer availability for transporting clients to programs, particularly those that are out of county
- Supportive Services for families of the homeless/mentally ill
• Applications for SSI should be handled by trained, informed professionals (or lawyers)
• Laura’s Law is necessary when dealing with service resistant homeless who are taxing local
resources, displaying their unsightly lifestyle to the community and suffering in an
undignified manner. This can be a challenge as many county mental health agencies are
opposed to Laura’s Law commitments.
• MAT (medication assisted treatment) is very slowly becoming the standard for treating
substance abuse. These medications can help block the urges to use and come at a high cost
so they are not yet easily available.

As agencies attempt to address homelessness and those suffering from mental illness, more gaps
will arise. This is but a small number of issues that the mental health work group did not address
and realize will become issues.

**Conclusion**

Law enforcement is at a critical junction right now. The current state of distrust of police officers is
at an all-time high and we are being scrutinized at every level of our profession. Homelessness,
while extremely complex and difficult to navigate the myriad of legal loopholes and bureaucracy,
can be an opportunity to showcase the compassionate side of our community policing. The WG
courages all departments to review the programs and collaborative efforts contained within this
report that many organizations have instituted to make impacts in their struggle to address
homelessness. There may be portions of them that may work in your respective communities.

There is no quick fix to this issue and insufficient resources and funding to address homelessness
appropriately. It is for these reasons that police departments must adapt their policing strategies and
implement innovative approaches to make noticeable change.

While the above enforcement protocol sounds overly simplistic, it is a paradigm change. Officers
must understand that proper documentation of their contacts with the homeless are required to
accurately depict the level of the issue in their jurisdiction. This information will be critical to
access services and grant funding.

Lastly, law enforcement cannot remedy this issue alone and must be receptive to working alongside
social service providers and other civilian resources to address homelessness together.
## Resources

**Cal Chiefs Homeless and Mental Health Work Group**

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### Agencies with homeless outreach officers

**Santa Ana PD** - Homeless Evaluation and Response Team (H.E.A.R.T.) (714) 245-8028

**Santa Barbara PD** - Restorative Policing Officer Craig Burleigh 805-331-6453 and Restorative Policing/Court Liaison Mureen Brown 858-864-8386

**Santa Monica PD** – Homeless Liaison Program (HLP) Team (310) 458-8452

**Pasadena PD** – Homeless Outreach-Psychiatric Evaluation (HOPE) (626) 744-7054

These are not all of the agencies who have outreach officers or officers that work daily with a social worker. However, these were the agencies that were contacted and agreed to host agencies and/or discuss what they are doing in the area of homeless outreach.