

Appendix B:

Taxonomy of Local Initiatives to Address Untreated SUD and SMI

October 2017

Informed by interviews with local programs and a review of publicly available literature, this appendix provides additional detail on the programmatic features of local initiatives, viewed through the lens of the key taxonomy elements described below.

Taxonomy of Local Initiatives to Address Untreated SUD and SMI

Element	Description
Initiative Objective and Target Population	Purpose of treatment and recovery initiatives targeting individuals with SMI and/or SUD that consume a disproportionate share of community resources.
Points of Engagement (“Intercept Points”)	Places and interactions in which initiatives engage individuals, including: (1) homeless shelters and places on the street where individuals experiencing homelessness may be living; (2) law enforcement and the criminal justice system; (3) other emergency first responders; and (4) schools.
Intervention Model	Models for engaging individuals and providing a therapeutic setting to deliver mental health and substance use disorder treatment and recovery services.
Sponsoring and Participating Agencies and Organizations	Lead agencies or organizations and partner entities involved in the initiative.
Type of Locality ¹	<ul style="list-style-type: none"> > Small: fewer than 100,000 inhabitants > Large: 100,000 or more inhabitants
Funding Sources	City, county, and state general funds, earmarked fees and levies, Medicaid, and philanthropy.
Evidence of Success	Evaluations or other findings of return on investment, improvements in health outcomes and/or reductions in ED utilization, incarceration rates, recidivism, and homelessness.

1. United States Census Bureau, *Population estimates, July 1, 2016*, available at: <https://www.census.gov/quickfacts/>.

The following page provides a summary of common features across local initiatives, including the initiative objective, points of engagement, and funding sources. Subsequent pages profile each local initiative in further detail.

Common Features of Local Initiatives

Note: Definitions for each category are provided on the next page.	Initiative Objective and Target Population					Points of Engagement ("Intercept Points")				Intervention Model						Funding Sources			
	Reducing Drug-Related Crimes and Overdoses	Alleviating Calls to First Responders	Reducing Homelessness	Reducing Volatile Confrontations with Law Enforcement	Reducing Overcrowded Courts and Jails	Criminal Justice System (police, courts, jails)	Homeless Shelters and the Streets	First Responders (e.g., EMS, EDs)	Schools	CIT	LEAD and Post-Booking Diversion	Community Paramedicine and Integrated Mobile Health Teams	Harm Reduction	Housing First	Jail-Based Programs	City, County and State	Medicaid	Other Federal	Private
Jail and Hospital ED Diversion (Bexar County, TX)		√	√	√	√	√	√	√	√	√	√	√			√	√	√	√	√
The Champion Plan (Brockton, MA)	√	√				√							√			√	√		√
Mayor's Office of Drug Control Policy (Huntington, WV)	√				√	√		√			√		√	√		√		√	√
Jail Substance Abuse Program (Kenton County, KY)	√		√		√	√									√	√			√
Familiar Faces (King County, WA)	√		√		√	√	√	√		√	√		√	√		√	√		√
Jail and Hospital ED Diversion (Lee County, FL)			√	√	√	√		√		√	√					√		√	√
Integrated Mobile Health Teams (Los Angeles County, CA)			√				√				√	√	√		√	√			
Safe Stations (Manchester, NH)	√	√						√	√				√			√	√		√
Criminal Mental Health Project (Miami-Dade County, FL)	√		√	√	√	√	√			√	√	√				√	√	√	√
SMART Jail Diversion Program (San Diego, CA)	√	√	√	√	√	√	√	√		√	√	√	√			√	√	√	
Crisis Intervention Teams (San Francisco, CA)			√	√	√	√				√	√		√	√	√	√	√	√	√
Law Enforcement Assisted Diversion (Santa Fe, NM)	√				√	√					√		√			√	√	√	√
Advanced Practice Paramedics (Wake County, NC)	√	√						√		√	√				√				

Taxonomy Elements Definitions

Points of Engagement (“Intercept Points”)

Criminal Justice System: Includes several pre- and post-booking intercept points across the criminal justice continuum, including interactions with law enforcement in the community, court hearings, jails, and release into the community.

Homeless Shelters and the Streets: Includes emergency shelter and interim/bridge housing for families and adults, as well as places in the community where homeless individuals congregate such as homeless encampments.

First Responders: City- and county-run 911 systems that include fire departments, ambulance services, and law enforcement. Responders often include paramedics with advanced medical and crisis response training, and law enforcement trained in de-escalation tactics.

Schools: Includes engagement with teachers, guidance counselors, and other school staff to engage at-risk youth exhibiting early signs of mental illness and substance use before they experience a crisis.

Intervention Model

CIT: A community policing, pre-arrest jail diversion model that trains law enforcement and other first responders to safely de-escalate behavioral health crises and increase the chances of peaceful resolutions.

Community Paramedicine: An emerging model of care in which paramedics and other EMS personnel receive specialized training to provide limited behavioral health services in the field and facilitate referrals to ongoing treatment. Community paramedics also support care management as individuals transition from the hospital to the home or community-based treatment settings.

Harm Reduction: A spectrum of substance use treatment strategies from safer use (i.e., sterile syringe exchange programs), to managed use, and meeting drug users “where they’re at.” Harm reduction programs aim to minimize the harm individuals might cause to themselves and those around them, rather than requiring sobriety to remain in treatment.

Housing First: Prioritizes connecting individuals to stable housing before delivering treatment and services, recognizing that safe and stable housing is a prerequisite to engaging in SMI or SUD treatment.

Integrated Mobile Health Teams: Multi-disciplinary teams comprised of clinical and non-clinical providers that engage homeless individuals in behavioral health treatment in the community and facilitate referrals to long-term services.

Jail-Based Programs: Uses the more controlled environment of incarceration to stabilize an individual with SUD or SMI and provide them with short-term treatment services. These programs also aim to link individuals to continued treatment and services in the community upon release.

LEAD: A pre-arrest/pre-booking intervention that trains law enforcement to refer individuals to a treatment case manager instead of arresting them for misdemeanor offenses. Cases are dropped by prosecutors when enrollees meet program milestones.

Post-Booking Diversion: Includes jail, court, and mental health or drug court diversion efforts that deploy specialized personnel who screen and assess justice-involved individuals for mental health and substance use disorders, and develop diversion and treatment plans with oversight from the courts and consent of judges, prosecutors, and public defense attorneys.

Funding Sources

City, County, and State: General city, county, and state funds, and taxes, fees, and other levies established expressly for the purposes of supporting programs to reduce the impact of untreated SMI and/or SUD.

Medicaid: Medicaid program funds used to support local initiative program operations, case workers, transportation, employment, housing, and clinical services.

Other Federal: Primarily grant funding, including funding from SAMHSA and the 21st Century Cures Act.

Private: Philanthropic funding and private insurance.

Jail and Hospital Emergency Department Diversion: Bexar County, TX ^{1,2}

Initiative Objective and Target Population	Bexar County implemented several jail and ED diversion initiatives to reduce rates of incarceration, recidivism, and avoidable use of emergency response services by individuals with SMI and SUD.
Points of Engagement (“Intercept Points”)	The County engages individuals in the community during encounters with law enforcement, identifies individuals with behavioral health conditions as they are booked into jail, and those who use the ED for behavioral health crises.
Intervention Model	<p>In 2003, the County launched a jail and ED diversion program that focused on training law enforcement officers in the CIT model to de-escalate behavioral health-related interactions with police and refer individuals to a local Crisis Care Center to receive further psychiatric care, substance use services (including counseling and rehabilitation), health care services, and transitional housing. Patients who arrive at the County hospital’s ED who do not require inpatient services are also diverted to the Center.</p> <p>Building on the Crisis Care Center, the County launched the Restoration Center in 2008 to provide additional referral capacity for individuals with SMI and SUD who may otherwise end up in jail or the hospital. Approximately 1,800 to 2,100 individuals receive services through the Restoration Center each month. Individuals may walk in for treatment at the Center or be referred by law enforcement, hospitals, courts, and community-based organizations. The Center includes a secure public safety unit, which provides a safe sobering space, as well as a medical detox unit and intensive outpatient substance use and counseling services. The Center also has a 16-bed extended observation unit for more serious cases, which has an average length of stay of 20 hours. The unit is certified by the State and is staffed by psychiatrists and licensed practical nurses.</p>
Sponsoring and Participating Agencies and Organizations	The Restoration Center and related initiatives are operated by the Center for Health Care Services (CHCS), a San Antonio-based mental health provider. Services are provided in partnership with the Bexar County Mental Health and Retardation Authority, law enforcement, local public hospitals, and community-based organizations.
Type of Locality	Large (2015 population: 1,897,753)
Funding Sources	Local, state, and private funding supports the County’s various diversion initiatives. The sobering unit is funded by the City of San Antonio (\$1.9 million per year), the residential detoxification program receives funding from the Department of State Health Services (\$1.9 million per year), and Medicaid reimbursement for inpatient detox clinical services (\$138 per patient per day). Medicaid funding is also leveraged for reimbursable services in the extended observation unit, which also receives support from the State General Fund, Medicare, and private insurance. The County hospital system provides \$1 million per year for three beds in the extended observation unit. Private donations have also supported services offered through Haven for Hope, which provides housing and other support services to program participants.
Evidence of Success	Evaluations of the County’s efforts are managed by the Bexar County Mental Health and Retardation Authority. Those evaluations have shown that since opening in 2008, the Restoration Center has treated 50,000 people and saved more than \$50 million in County and State funds, due in part to the reduction in uncompensated care from hospital ED diversions. More than 100,000 law enforcement hours have been freed up for reallocation to other community needs as law enforcement has access to quick diversion resources and has fewer repeat encounters with frequent users of the emergency response system. Prior to opening the Restoration Center, Bexar County was considering adding 1,000 beds to its jails, but the success of the jail diversion initiatives obviated the need for additional capacity. ³

1. Gonzales, Gilberto, “Bexar County’s Restoration Center Offers Alternatives to Jail and the Streets,” *National Council Magazine*, 2010.
2. “National Association of Counties,” *Mental Health and Criminal Justice: Bexar County Case Study*, 2015, available at: <http://www.naco.org/sites/default/files/documents/Bexar%20County%20-%20Mental%20Health%20and%20Jails%20Case%20Study.pdf>.
3. Klass, Kym, “Restoration Center: San Antonio’s answer to mental health,” *Montgomery Advertiser*, January 28, 2017, available at: <http://www.montgomeryadvertiser.com/story/news/2017/01/27/restoration-center-san-antonios-answer-mental-health/96457170/>.

The Champion Plan: Brockton, MA ¹

Initiative Objective and Target Population	The Champion Plan was launched to decrease barriers to treatment, stigma of addiction, drug addiction rates, overdoses and their impacts to the community.
Points of Engagement (“Intercept Points”)	Individuals seeking SUD treatment are engaged at the Brockton Police Department where they are screened and connected with treatment options.
Intervention Model	<p>The Champion Plan was launched in February 2016 to allow individuals to approach the Brockton Police Department as an entry point to treatment options without fear of arrest if they do not have an outstanding warrant.² Individuals who agree to participate in the program are connected with recovery coaches from the Gandara Center, a local non-profit behavioral health treatment provider, and transported to the Champion Plan office where they establish a treatment plan, which may include detox or outpatient medication-assisted therapy. Individuals that select detox are transported via ambulance to local treatment centers when a bed becomes available, where they may receive further SUD treatment services. Those eligible for care from the Veterans Administration are sent to Brockton’s Veterans Affairs Medical Center, which has an overnight treatment facility for mental health and substance use with 123 beds. Limited housing services are also available through Father Bill’s Mainspring, a social service agency.</p> <p>Regardless of placement, each participant is paired with a recovery coach within 72 hours of entering the program who provides care coordination support. Recovery coaches follow-up with program participants at regular intervals within the first two years of engaging in the program to help participants comply with their recovery plan.</p>
Sponsoring and Participating Agencies and Organizations	The Champion Plan was launched out of the Mayor’s office in partnership with the Brockton Police Department, Gandara Center, and Brewster Ambulance Service. The program is part of a broader Opioid Overdose Prevention Coalition organized by the Mayor’s office, which focuses on opioid overdose awareness and prevention. ³
Type of Locality	Small (2015 population: 95,314)
Funding Sources	The Champion Plan currently receives funding from a local marijuana dispensary, which is required to contribute funding to address the prevalence of SUD as a condition of its operation through a community host agreement. Limited Medicaid and private insurance funding also supports ambulance transportation to treatment. Services provided by the Gandara Center are supported through small grants from the State and private donors.
Evidence of Success	A state-funded external evaluation by Kelly Research & Associates assessed the types of clients served by the program, as well as the services they accessed and engagement with recovery coaches. Between February 29, 2016 and December 31, 2016, 75 percent of clients had one intake and 25 percent had multiple intakes. Almost two-thirds were homeless at their last intake, and staff conducted 1,364 follow-ups for 387 clients. While the evaluation did not assess the program’s impact on the prevalence of substance use and overdoses in the community, a survey of former program participants suggested that many remain connected to treatment, with 50 percent of participants reporting that they were in inpatient treatment and 66 percent reporting working with recovery coaches. ⁴

1. Brockton Mayor’s Opioid Overdose Prevention Coalition, “The Champion Plan,” available at: <http://opioidoverdoseprevention.org/bmoocp/champion-plan/>.
2. Individuals with active arrest warrants are placed into custody until their warrant clears.
3. Larocque, Marc, “Fighting addiction in Brockton: The Champion Plan claims victory in round 1,” *The Enterprise*, March 11, 2017, available at: <http://www.enterpriseneews.com/news/20170310/fighting-addiction-in-brockton-champion-plan-claims-victory-in-round-1>.
4. Kelley Research and Associates, “The Champion Plan 2016 Evaluation,” March 2017, available at: <http://opioidoverdoseprevention.org/bmoocp/wp-content/uploads/2017/03/Champion-Plan-One-Year-Powerpoint.pdf>.

Mayor's Office of Drug Control Policy: Huntington, WV ¹

Initiative Objective and Target Population	The Mayor's Office of Drug Control Policy (MODCP) launched several initiatives to reduce drug use, overdoses, and related criminal activity for Huntington and surrounding area residents with substance use disorders.
Points of Engagement ("Intercept Points")	Law enforcement and first responders engage individuals in the community during emergency response calls to divert them from jails and hospital emergency departments to behavioral health treatment services. Individuals who are arrested on drug charges may be referred to specialized drug courts that provide additional counseling and support. At-risk individuals and their families are also engaged in the community through MODCP-led initiatives such as syringe exchanges and Naloxone administration training.
Intervention Model	<p>The MODCP, modeled on the White House Office of National Drug Control Policy, was launched in 2014 to develop strategies to address rising rates of drug addiction in the community through prevention, treatment, and engagement with law enforcement.² In partnership with public and private stakeholders, the MODCP supports the implementation of the following strategic initiatives:</p> <ul style="list-style-type: none"> > <u>LEAD (Law Enforcement Assisted Diversion)</u>: Based on the Seattle LEAD model, law enforcement redirects low-level offenders engaged in drugs or prostitution activity to treatment services instead of jail and prosecution. > <u>Harm Reduction Programs</u>: Includes a syringe exchange program, Naloxone training and kits for friends and family members of drug addicts, and recovery coaches to connect individuals to resources for detox, treatment, family support, and education. > <u>Centralized Information System</u>: A mobile phone application that assists first responders, providers, and the public in locating treatment options. > <u>Women's Empowerment and Addiction Recovery (WEAR) Program</u>: A specialized drug court for prostitutes with SUD that combines traditional drug court services with behavioral health counseling and therapy. <p>Other long-term strategies include expanded programs at community centers, intensive outpatient services, transitional housing, felony forgiveness, and school-based prevention initiatives. The office is also developing a Center for Excellence at Marshall University to help providers work with pregnant women with SUD.</p>
Sponsoring and Participating Agencies and Organizations	The City's programs are championed and organized by the Mayor's Office, in partnership with the Huntington Police Department, Cabell-Huntington Health Department, U.S. Attorney's Office, the Pretera Center, and the Day Report Center (behavioral health providers). Marshall University also provides subject-matter expertise and advises on best practices for SUD treatment.
Type of Locality	Small (2015 population: 48,638)
Funding Sources	Funding support for the City's initiatives is limited, but the City received a \$750,000 SAMHSA grant to support the WEAR program, along with a \$2 million grant from an epi-pen manufacturer to support dissemination of Naloxone in the community. The Mayor's Office has also supported fundraising efforts from private donors and is in the process of applying for state and federal grants. ³
Evidence of Success	A formal evaluation of the City's initiatives and their impact has not yet been conducted.

1. City of Huntington, West Virginia, available at: <http://www.cityofhuntington.com/city-government/mayors-office-of-drug-control-policy>.

2. Mayor's Office of Drug Control Policy, *Two-Year Strategic Plan for Addressing the Opioid Crisis in the City of Huntington/Cabell and Wayne Counties, West Virginia*, May 2017, available at: http://www.cityofhuntington.com/assets/pdf/MODCP_two_year_plan_May_2017.pdf.

3. Ibid.

Jail Substance Abuse Program: Kenton County, KY ^{1,2}

Initiative Objective and Target Population	The Kenton County Detention Center created the Jail Substance Abuse Program (JSAP) targeted to individuals with substance use disorders to address the 83 percent of jail bookings related to an opioid addiction and the jail's 70 percent recidivism rate.
Points of Engagement (“Intercept Points”)	Inmates with a substance use-related charge are offered access to a treatment program in the County detention center at booking. Approximately 70 percent of program participants are voluntary. Inmates may also be ordered into the program by a judge or referred by the State Department of Corrections.
Intervention Model	<p>JSAP was launched in 2015 to help inmates with SUD recover and reduce their likelihood of relapse at release. The program implemented SUD treatment curricula developed by the Hazelden Betty Ford Foundation, and operates a bio-psychosocial model of treatment.³ Eligible inmates are identified during screening at intake in the jail and, unless ordered by a court to participate, may accept or decline an offer to join the program. The six-month program uses a peer-driven support model that includes cognitive behavioral therapy, individual and group 12-Step counseling, and spiritual programming.</p> <p>After 30 days in the program, participants are assessed for medication-assisted treatment to mitigate withdrawal symptoms and the risk of relapse after release. A week prior to release, participants are given a Naltrexone or Vivitrol injection to block the effects of opioids for 30 days. Upon release, re-entry specialists help connect participants to housing, transportation, education, and other community resources and benefits, including Medicaid coverage. Participants are also referred to an intensive outpatient program for counseling and are encouraged to maintain their involvement in a 12-step support group.</p>
Sponsoring and Participating Agencies and Organizations	The program is managed by the Kenton County Detention Center and the State Department of Corrections, and is affiliated with the northern Kentucky Heroin Impact Response Task Force (HIRT), a collective of behavioral and physical health providers, law enforcement, state and county legislators, academic institutions, and advocates. HIRT's mission is to ensure access to addiction treatment to mitigate the impact of untreated SUD in northern Kentucky.
Type of Locality	Large (2015 population: 165,012)
Funding Sources	The program receives grant funding from HIRT and the State for the program staff's salaries and other program expenses. The program also receives foundation funding for various program components, including Naloxone kits for participants exiting jail. The County Department of Corrections funds the first dose of Vivitrol administered before an individual is released, Medicaid pays for the second dose for enrolled beneficiaries.
Evidence of Success	A Kentucky Department of Corrections evaluation of corrections-based substance use treatment services found \$4.29 in cost offsets for every \$1 spent, but the analysis did not specifically call out savings generated by Kenton County's jail-based program. ⁴ However, an internal analysis by the Kenton County Detention Center observed that by mid-2016 the recidivism rate was less than 30 percent for the nearly 200 inmates that completed the treatment program, compared to 70 percent for the jail's general population. ⁵

1. Axelrod, Jim, *Kentucky jail using new drug treatment for inmates addicted to opioids*, October 19, 2016, CBS Evening News, available at: <http://www.cbsnews.com/news/kentucky-jail-pioneering-treatment-for-inmates-addicted-to-opioids/>.
2. Gregory, John, *Helping Inmates Overcome Addiction*, June 25, 2016, Kentucky Educational Television, available at: <https://www.ket.org/opioids/helping-inmates-overcome-addiction/>.
3. Habegger, Becca, *KY jail wants to share with TN successful addiction treatment program*, August 19, 2016, WBIR, available at: <http://www.wbir.com/news/local/ky-jail-wants-to-share-with-tn-successful-addiction-treatment-program/303115321>.
4. Kentucky Department of Corrections, *Criminal Justice Kentucky Treatment Outcome Study*, 2015, available at: http://cdar.uky.edu/cjktos/Downloads/CJKTOS_FY2015_Report.pdf.
5. Merrick, Jason, "Kenton County Detention Center." Email, July 25, 2017.

Familiar Faces: King County, WA ¹

Initiative Objective and Target Population	<p>King County launched the Familiar Faces program to reduce the high rates of incarceration and recidivism among individuals who are incarcerated in the King County jail four or more times within a 12-month period, and who also have a mental health and/or substance use condition.</p>
Points of Engagement (“Intercept Points”)	<p>Familiar Faces engages individuals before and after booking, and during the community re-entry process. The County also conducts outreach to homeless individuals with behavioral health conditions.</p>
Intervention Model	<p>The King County Health and Human Services Transformation Plan was released in 2013, which outlined a vision for shifting the County’s focus from responding to crises in the community to prevention and recovery. The Plan served as the catalyst for launching the Familiar Faces program, which utilizes LEAN process improvement concepts to create a person-centric system of care for individuals with behavioral health conditions who frequently cycle in and out of jail. The program includes:</p> <ul style="list-style-type: none"> ➤ The Vital Program: An Intensive Care Management Team (ICMT), consisting of care managers, nurses, community health workers, and occupational therapists who provide integrated physical and behavioral health services to adults with mental health conditions and/or substance use issues and who frequently cycle through the County jail. Sixty individuals involved in the initial pilot are connected with the ICMT when diverted from jail through the County’s LEAD program or upon release from jail during the re-entry process.² The King County Prosecuting Attorney’s Office provides assistance to dismiss outstanding warrants for program participants. Several community-based organizations provide behavioral health services and permanent supportive housing. ➤ Jail Release Planning and Coordination: King County’s Familiar Faces initiative partnered with a local misdemeanor jail and a local Medicaid managed care organization (MCO) to develop a pilot program that will allow community health workers to work with release planning staff to provide transitional care services for MCO enrollees. Community health workers will also provide enrollment assistance for individuals who lack coverage at release. The pilot program will test strategies to ensure care continuity for individuals with behavioral health needs as they transition into the community and reduce the likelihood that they will experience recidivism.³ ➤ Single Diversion Portal: The County is currently developing a unified portal that will provide first responders with a triage function to identify and coordinate options for a health and human services response rather than incarceration, and to divert individuals experiencing a behavioral health crisis from hospital EDs and the criminal justice system to lower-cost mental health and substance use treatment options. <p>The County is also pursuing several data integration initiatives that will aggregate data from law enforcement, courts, first responders, and social service agencies to enable more effective outreach and tracking of Familiar Faces clients across intercept points and sites of care. The County also implemented a housing first pilot program that targets chronically homeless individuals with behavioral health conditions and engages them in supportive housing and treatment.</p>
Sponsoring and Participating Agencies and Organizations	<p>Familiar Faces is a community effort, with large cross-sector participation by community providers, local criminal justice system partners, and law enforcement, and is hosted and staffed by the King County Department of Community and Human Services and Public Health, in partnership with other public health and criminal justice agencies within the County and City of Seattle. Community partners include behavioral health providers, housing agencies, a Medicaid MCO, and local advocacy organizations.</p>
Type of Locality	<p>Large (2015 population: 2,117,125)</p>
Funding Sources	<p>Familiar Faces was launched in 2014 with support from private foundation funding. The program is currently supported through county general funds, as well as three local tax levies focused on mental illness, substance use prevention, and housing. Medicaid is also leveraged to support the delivery of clinical services and permanent supportive housing services (e.g., housing case management), and the County is exploring opportunities to leverage funding from the State’s Section 1115 Medicaid transformation waiver.</p>

Continued

Evidence of Success

The County has dedicated significant resources and staff to internally evaluate the Familiar Faces program and its underlying initiatives. An April 2016 cost analysis found that the County spent \$35,230,000 on services for 1,252 Familiar Faces in 2014 (\$28,139 per Familiar Face). Approximately 87 percent of that spending was for criminal justice or crisis response programs; about 13 percent was for housing, re-entry, or health care. The analysis also found that the Familiar Faces population is disproportionately people of color, male, and under age 35, and, at the time of the evaluation, had spent a total of 112,597 days in County jail. These analyses will serve as baselines to estimate the impact of the program in the future.⁴

The County's housing first pilot program was evaluated in 2013 using a pre- and post-comparison group design, which observed significant reductions in emergency department use, hospital admissions, and jail bookings among program participants. The evaluation also found that estimated costs for participants and comparison group members were \$62,504 and \$25,925 per person per year respectively.⁵

1. King County Health and Human Services Transformation, *The Familiar Faces Initiative*, June 2016, available at: <http://www.naco.org/sites/default/files/documents/Familiar%20Faces%20Brief.pdf>.
2. King County, *The Vital Program: Familiar Faces Intensive Care Management Team*, available at: <http://kingcounty.gov/depts/community-human-services/mental-health-substance-abuse/diversion-reentry-services/Familiar-Faces-ICMT.aspx>.
3. King County Health and Human Services Transformation, *Familiar Faces Implementation Strategies Underway*, September 2016, available at: http://www.icjia.state.il.us/assets/ddj/pdf/Post-Conference-Materials/Familiar%20Faces%20Implementation%20Strategies%20Underway_sept%202016.pdf.
4. King County Familiar Faces Initiative, *Familiar Faces Cost Analysis Summary of Findings: Phase 1*, April 7, 2016.
5. Debra Srebnik, PhD, Tara Connor, PhD, and Laurie Sylla, MHA, BSW, "A Pilot Study of the Impact of Housing First-Supported Housing for Intensive Users of Medical Hospitalization and Sobering Services," *American Journal of Public Health*, February 2013, Vol 103, No. 2, pp 316-321, available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3558756/>.

Jail and Hospital ED Diversion: Lee County, FL ¹

Initiative Objective and Target Population	Lee County established a jail and hospital ED diversion program, using CIT-trained law enforcement, to reduce incarceration rates, recidivism, and hospital ED utilization among individuals with known mental illness or SUD.
Points of Engagement (“Intercept Points”)	The Lee County Human Services Department partnered with the Bob Janes Triage Center and Low Demand Shelter (“the Center”) to develop a program to divert individuals with mental illness and SUD from the criminal justice system and local EDs. Law enforcement officers are trained in the CIT model to safely engage individuals in the community who are experiencing a mental health crisis and have a co-occurring SUD, are homeless, or are at-risk of being charged with a minor ordinance or non-violent offense (e.g., disorderly conduct). Law enforcement may divert these individuals from jail to the Center for assessment and triage. The Center also accepts referrals from Lee Health (the local public health system), local drug and mental health courts, and at first-appearance hearings.
Intervention Model	<p>The Center has 58 beds and is located on the campus of SalusCare, a local behavioral health provider. Health and social service needs assessments are conducted within 72 hours of intake by clinicians employed by SalusCare. Individuals are provided a bed and invited to participate in the Center’s treatment programs, which have an average participation rate of 30 days. Services offered through the Center and its referral partners include:</p> <ul style="list-style-type: none"> ➤ Mental health, psychosocial, and nursing assessments ➤ Referrals to outpatient SUD and mental health treatment programs ➤ Linkages to social support services and benefits (e.g., permanent housing, Medicaid, veteran’s services) ➤ Life skills training and employment services ➤ Medication assistance ➤ Assistance obtaining ID and documentation (e.g., birth certificate) ➤ Care plan development
Sponsoring and Participating Agencies and Organizations	The Center is operated by the Salvation Army through a partnership with the Lee County Human and Veterans Services Department. SalusCare, a behavioral health provider, is co-located with the Center to provide on-site behavioral health treatment. Other partners include local law enforcement and Lee Health, which refer individuals to the Center for triage.
Type of Locality	Large (2015 population: 701,982)
Funding Sources	The Center’s \$1.2 million annual budget is administered by the Board of County Commissioners. Funding sources include county general funds (\$500,000 annually), state and federal grants, and private contributions from Lee Health, Salvation Army, and United Way. The Center does not leverage Medicaid funding nor does it have a process for enrolling clients in Medicaid.
Evidence of Success	A formal evaluation of the program has not been conducted, but the County tracks near-term outcomes for program participants, including interactions with law enforcement and incarceration rates/length of stay.

1. “Bob Janes Triage Center and Low Demand Shelter,” *About Us*, available at: <http://triage.leegov.com/AboutUs.html>.

Integrated Mobile Health Teams: Los Angeles County, CA ^{1,2}

Initiative Objective and Target Population	Integrated Mobile Health Teams (IMHTs) were established to assist individuals who are homeless with SMI or serious emotional disturbance (SED) and co-occurring disorders of substance use and/or physical health issues by helping them successfully transition from homelessness into housing. ³
Points of Engagement (“Intercept Points”)	IMHTs identify homeless individuals in the community with SMI or SED and co-occurring SUD or physical health issues and enroll them into IMHT services and provide assistance in accessing housing resources.
Intervention Model	<p>The IMHT program was launched as a three-year pilot project under the County’s Mental Health Services Act (MHSA) Innovation Program, which tested models to integrate physical and behavioral health care for high-need populations.⁴ The IMHT is based on the housing first model, which emphasizes stable housing as a prerequisite for engaging individuals in behavioral health treatment. IMHTs are multi-disciplinary teams comprised of physicians, nurse practitioners, physician assistants, mental health professionals, substance use counselors, case managers, and peer supports. Teams are deployed in communities within the County that have high rates of homelessness and the teams meet daily to review assigned clients and current needs.</p> <p>Once an individual is identified in the community, the IMHT immediately works to meet their basic needs of food and shelter while trying to engage them in services. The services are intense, field-based, and individualized depending on the needs of the client. Services include individual and group counseling, physical health care, crisis intervention, housing services, employment assistance, transportation, benefits establishment, medication support, and family supportive services. A local federally qualified health center (FQHC) is part of an integrated team and provides physical health services to program participants. An integrated medical record is used to support care transitions and coordination across settings.</p>
Sponsoring and Participating Agencies and Organizations	The IMHT program is administered by the Los Angeles County Department of Mental Health, in partnership with local housing agencies, behavioral health providers, and an FQHC. The IMHTs are staffed by a local FQHC.
Type of Locality	Large (2015 population: 10,170,292)
Funding Sources	The initial three-year pilot was supported by MHSA funding, which leveraged Medi-Cal (Medicaid) funding. After the pilot ended, the County continued to provide funding for programs that had successful outcomes using a combination of MHSA and Medi-Cal funds to support case management, individual and group therapy, crisis intervention, and medication support. A local FQHC provides staffing support for the IMHTs and leverages Medi-Cal funding for physical health services.
Evidence of Success	The County published an extensive evaluation of the IMHT program in 2014, which found that 40 percent of clients experienced clinically meaningful improvements to their health and reductions in alcohol and substance use. A majority of clients also maintained stable housing for at least one year after entering the program. A subsequent evaluation in 2015 found significant reductions in Illness Management and Recovery scores, indicating improved mental health. Changes in self-reported health in the 2015 evaluation occurred more quickly than changes on physical health indicators, such as BMI, blood pressure, or cholesterol. ⁵

1. County of Los Angeles Department of Mental Health, *Mental Health Services Act (MHSA) Innovations Programs*, available at: [http://file.lacounty.gov/SDSInter/dmh/185505_Innovations_Brochure_FINAL\(3\).pdf](http://file.lacounty.gov/SDSInter/dmh/185505_Innovations_Brochure_FINAL(3).pdf).
2. County of Los Angeles Department of Mental Health, UCSD Health Services Research Center, Harder and Company Community Research, and University of Southern California School of Social Work, *Los Angeles County MHSA Innovation Program: Annual Report*, December 2014, available at: http://file.lacounty.gov/dmh/cms1_226026.pdf.
3. County of Los Angeles Department of Mental Health, *DMH Homeless Services and Resources*, 2016, available at: http://file.lacounty.gov/SDSInter/dmh/246506_HousingInstitute2016-DMHHomelessServicesandHousingResources.pdf.
4. County of Los Angeles Department of Mental Health, *Mental Health Services Act (MHSA) Innovations Programs*, available at: [http://file.lacounty.gov/SDSInter/dmh/185505_Innovations_Brochure_FINAL\(3\).pdf](http://file.lacounty.gov/SDSInter/dmh/185505_Innovations_Brochure_FINAL(3).pdf).
5. UCSD Health Services Research Center, *Integrated Mobile Health Team Housing Outcomes*, June 2015.

Safe Stations: Manchester, NH

Initiative Objective and Target Population	To address the highest rate of overdoses and Naloxone administration in the State, the Safe Stations program was launched to reduce rates of drug addiction and opioid-related overdoses among residents with SUD in Manchester, New Hampshire.
Points of Engagement (“Intercept Points”)	Individuals with SUD and/or experiencing an overdose can walk into any of Manchester’s ten fire stations to receive first aid and referrals to local SUD treatment providers. The fire department may also refer individuals with SUD encountered during emergency response calls to treatment providers. Additionally, the fire department partners with local schools to provide education to students on substance use prevention.
Intervention Model	<p>Once individuals approach a Manchester fire station for help, they receive an initial medical assessment, which includes documenting vital signs and past drug use. Firefighters can also administer Naloxone to individuals who are experiencing an overdose. The fire station then arranges for transportation to Serenity Place, a local behavioral health provider that is located next to the fire department’s headquarters. Firefighters also conduct in-field assessments and referrals to Serenity Place, and administer Naloxone if needed, to individuals encountered during emergency response calls.</p> <p>Serenity Place uses the harm reduction model and offers outpatient SUD treatment, high-intensity inpatient treatment (ten-bed capacity), case management, and enrollment assistance for public benefits. Staff include a clinical psychologist, social workers, and licensed mental health, alcohol, and drug counselors. The primary role of Serenity Place is to stabilize the individual, develop care plans, and connect individuals to treatment services in the community. The average length of stay at Serenity Place is four to five days, after which individuals are referred to other community providers to receive ongoing treatment and recovery services. Peer support groups are also leveraged to facilitate connections to other service providers and assist individuals during relapse.</p>
Sponsoring and Participating Agencies and Organizations	Safe Stations was established by the Manchester Fire Department, in partnership with Serenity Place and other local treatment and social service providers.
Type of Locality	Large (2015 population: 110,229)
Funding Sources	The fire department has mostly operated Safe Stations without additional funding, though it has received private contributions from Blue Cross Blue Shield and the Robert Wood Johnson Foundation. Services at Serenity Place are supported through a combination of funding from the State’s Bureau of Drug and Alcohol Services, and private donations. Serenity Place also bills Medicaid for outpatient clinical services, counseling, and other treatment services, and for some transportations services.
Evidence of Success	Safe Stations has not been formally evaluated, but the fire department tracks several program-related statistics and near-term outcomes. While not directly attributed to the program, as of early 2017 suspected overdose rates in Manchester decreased by 44 percent, and the suspected fatality rate was down 53 percent compared to 2016. ¹ The number of fire department-administered Naloxone doses also decreased since the launch of Safe Stations and the local police department has reported that Safe Stations has given them greater freedom to focus their resources on targeting drug dealers.

1. Recent Manchester OD numbers show rates are down 44 percent thanks to Safe Station, February 24, 2017, New Hampshire: NH1 Radio, available at: <http://www.nh1.com/news/recent-manchester-od-numbers-show-rates-are-down-44-percent-thanks-to-safe-station/>.

Miami-Dade Criminal Mental Health Project: Miami-Dade County, FL¹

Initiative Objective and Target Population	<p>Miami-Dade’s Criminal Mental Health Project (CMHP) was launched to reduce the number of individuals with untreated mental illness and co-occurring SUD in the County’s criminal justice system.</p>
Points of Engagement (“Intercept Points”)	<p>Launched in 2000, the CMHP uses multiple intercept points to engage justice-involved individuals and divert them to treatment. Pre-arrest diversion for misdemeanor offenses is supported by the largest CIT-trained squad in the country, screenings during the jail booking process help identify incoming inmates with behavioral health conditions, and court-based diversion initiatives allow court case management specialists to connect individuals with untreated SMI and SUD with treatment. CMHP also partners with schools and has trained more than 500 teachers and staff to identify students with potential mental illness and connect them to services to decrease the likelihood of truancy, substance use, and criminal activity.</p>
Intervention Model	<p>The CMHP currently operates four major initiatives:</p> <ul style="list-style-type: none"> ➤ Pre-Booking Jail Diversion: CIT-trained law enforcement officers de-escalate behavioral health crises and refer individuals to community-based treatment programs. ➤ Post-Booking Jail Diversion for Misdemeanors: All jail inmates are screened for behavioral health conditions at intake and those with misdemeanor offenses may be placed in a crisis stabilization unit within 24-48 hours of booking rather than in the general jail population. Those individuals may be then referred to community-based treatment programs and connected with housing and other social services. CMHP staff monitor their progress for up to one year after leaving the jail. ➤ Post-Booking Jail Diversion for Felonies: Public defenders, state’s attorneys, judges, and other justice system officials may recommend that individuals be placed in a program that diverts felony offenders from jail into community-based treatment. Felony charges may be reduced or dismissed upon successful completion of the program. ➤ Post-Booking Forensic Hospital Diversion: Individuals with acute behavioral health disorders who are found incompetent to stand trial may be diverted from state hospitals to community-based treatment. <p>The County is building a \$42 million, 181,000-square foot mental health diversion complex to support all of its diversion programs. Services will include: housing for up to one year, primary and dental health, employment assistance, and social services. All participants in the CMHP are screened for public benefits eligibility (e.g., Medicaid, SSI/SSDI) using the SOAR model (SSI/SSDI, Outreach, Access and Recovery). The complex will also include a crisis stabilization unit, short-term residential treatment, respite services for individuals that don’t require crisis stabilization, “drop-in” supportive and psycho-educational services, and immigration status resolution assistance.</p>
Sponsoring and Participating Agencies and Organizations	<p>Development of the CMHP was led by the 11th Judicial Circuit of Florida, in partnership with the State Attorney and Public Defender’s Offices, Department of Corrections, public and private providers, family members, consumers, and other stakeholders.</p>
Type of Locality	<p>Large (2015 population: 2,693,117)</p>
Funding Sources	<p>Launch of the CMHP was supported by a three-year SAMHSA grant. County and state funds were leveraged to sustain and expand the program after the grant ended, including a local tax levy specifically targeted to support programs that help address homelessness. A state grant supports a Jail In-Reach Team project, which expedites identification, assessment, and transition planning for diversion and community re-entry assistance. The Florida Department of Children and Families also provides funding for case management and peer specialist staff, as well as housing, treatment, medication, and other ancillary services. Medicaid funding is used to pay for some clinical services.</p>
Evidence of Success	<p>The CMHP has been the focus of numerous internal and external evaluations, which have found significant reductions in incarceration rates and cost savings. Between 2010 and 2016, CIT-trained officers fielded 71,628 mental health calls but made only 138 arrests. Recidivism rates for the misdemeanor diversion initiative dropped from 75 to 20 percent, while jail bookings for felony diversion program participants dropped 75 percent. As a result of the CMHP’s collective initiatives, the average daily inmate population at the County jail fell 31 percent between 2005 and 2014, enabling the County to close an entire jail saving more than \$12 million per year.²</p>

1. “National Association of Counties,” *Mental Health and Criminal Justice Case Study: Miami-Dade County, FL*, June 1, 2016, available at: <http://www.naco.org/sites/default/files/documents/Miami-Dade%20County%20-%20Mental%20Health%20and%20Jails%20Case%20Study.pdf>.

2. Meyer, Harris, “Q&A: Addressing behavioral health recovery with a population health model,” *Modern Healthcare*, May 27, 2017, available at: <http://www.modernhealthcare.com/article/20170527/MAGAZINE/170529968/qamp-a-addressing-behavioral-health-recovery-with-a-population>.

San Diego Misdemeanants At-Risk Track (SMART) Program: San Diego, CA^{1,2}

Initiative Objective and Target Population	Launched in 2016, the SMART program seeks to reduce rates of incarceration and recidivism among repeat misdemeanor offenders with acute drug addictions, mental health needs, and/or complex social service needs. Targeted individuals must have one or more drug arrests in the past three years, or have been arrested at least twice in the past six months for a quality-of-life offense (e.g., trespassing). ³
Points of Engagement (“Intercept Points”)	Individuals are engaged during contact with law enforcement, during arraignment and sentencing for a quality-of-life or drug offense, and by community outreach workers. Program eligibility is determined by the City Attorney’s Office and participation is voluntary.
Intervention Model	Individuals that accept an offer to participate in the SMART program following an arrest are diverted from jail and prosecution. The program is similar to the housing first model and immediately places homeless participants in interim/bridge housing for up to two years until permanent housing can be secured. Participants are also placed in tailored drug treatment programs through Family Health Centers of San Diego, a local treatment provider. Case managers are assigned to participants who connect them to needed services and help enroll them in public benefit programs. Civil legal assistance is provided to participants for employment and housing issues. Bus passes and job training are also available to program participants.
Sponsoring and Participating Agencies and Organizations	The program was created by the City Attorney’s Office, in collaboration with the San Diego Police Department and the San Diego Sheriff’s Department. It is now led by the City Attorney’s Office with support from the Police and Sheriff’s Departments, the San Diego County Public Defender’s Office, Family Health Centers of San Diego, American Civil Liberties Union, and other community service providers.
Type of Locality	Large (2015 population: 1,394,928)
Funding Sources	The program is primarily supported by \$3 million in Proposition 47 funds provided by the State. The City of San Diego will also provide an additional \$1.8 million in funding over the next three years.
Evidence of Success	While a formal evaluation of the SMART program has not been conducted, the City Attorney’s Office tracks program cost and near-term outcomes for participants. Initial data suggest that overall EMS costs for program participants have been reduced.

1. San Diego Office of the City Attorney, *San Diego Misdemeanants At-Risk Track (SMART)*, April 2016, available at: <http://www.downtownsandiego.org/wp-content/uploads/2016/04/Handout.pdf>.
2. San Diego Office of the City Attorney, *SMART Pilot Program Q&A*, available at: https://webcache.googleusercontent.com/search?q=cache:HZsaUMBlyNUJ:https://www.sandiego.gov/sites/default/files/smart_qanda_12-2.pdf+&cd=1&hl=en&ct=clnk&gl=us.
3. Passed in November 2014, Proposition 47 reduced the penalty for certain drug possession felonies and petty theft to misdemeanors. Following the passage of Proposition 47, San Diego saw significant increases in misdemeanor charges for drug possession and theft.

Crisis Intervention Teams: San Francisco, CA

Initiative Objective and Target Population	Reduce adverse outcomes (e.g., hospitalization, injury, death) resulting from encounters between law enforcement and people with SMI and/or SUD.
Points of Engagement (“Intercept Points”)	San Francisco deploys crisis intervention teams to de-escalate and promote non-violent resolutions to behavioral health crises in the community.
Intervention Model	<p>San Francisco first implemented crisis intervention training for law enforcement officers in 2001. Following a series of officer-involved shootings, the Police Department’s Community Advisory Board, a civilian oversight board that recommends policy for the police department, advised the department to expand the program and adopt the Memphis CIT model in 2011. The department developed a formal policy for its CIT program, which describes training requirements, field procedures, and reporting policies.¹ The standard CIT curriculum includes training on behavioral health crises, suicide intervention, conflict resolution, homeless outreach, and de-escalation tactics for handling other crises in the community. The City expanded on the standard curriculum to include an additional 10 hours of de-escalation training and has trained more than 700 law enforcement officers to date.²</p> <p>Building on the CIT program, in 2016 the San Francisco Department of Public Health deployed five mental health clinicians, including three psychologists, a senior behavioral health clinician, and a behavioral health clinician, to support law enforcement officials responding to behavioral health crises.³ These Crisis Intervention Specialists assist the police department in de-escalating behavioral health crises during potentially volatile confrontations between police officers and individuals in crisis, and facilitate connections to treatment and recovery services. The specialists are an addition to and complement the City’s existing Comprehensive Crisis Services Unit, which provides mobile crisis response, assessments, and case management for children and adults affected by violence in the community.⁴ The police department also collaborates with the District Attorney’s Office to divert individuals to the City’s Collaborative Court Program, which refers individuals to behavioral health court and the City’s Community Justice Center where they receive behavioral health treatment.</p>
Sponsoring and Participating Agencies and Organizations	The San Francisco Police Department operates the CIT program. A Community Advisory Board that includes representation from the District Attorney and Public Defender’s offices, the Mayor’s Office on Disability, mental health advocates, and other members of the community provide recommendations to the police department. The San Francisco Department of Public Health operates the Crisis Intervention Specialist initiative, in coordination with the police department. The Department of Emergency Management also catalogues calls that require a specialized crisis response from law enforcement. ⁵
Type of Locality	Large (2015 population: 864,816)
Funding Sources	The CIT program is funded through the police department, with the Department of Public Health providing funding for the Crisis Intervention Specialists. Funds from California’s Mental Health Services Act and Medi-Cal (Medicaid) also support outpatient services and case management activities for individuals after a crisis. ⁶
Evidence of Success	Data released by the San Francisco Police Department found that the number of use-of-force incidents between January and March of 2017 dropped 15.8 percent and the number of assaults against law enforcement dropped 45 percent, compared to the same time period the year before. Less than 1 percent of the 161,648 calls law enforcement responded to in the first quarter of 2017 resulted in a use-of-force incident. ⁷

1. San Francisco Police Department, *General Order: The Crisis Intervention Team Response to Person in Crisis Calls for Service*, December 21, 2016, available at: <http://sanfranciscopolice.org/sites/default/files/Documents/PoliceDocuments/DepartmentGeneralOrders/sfpd-dgo-5.21-cit.pdf>.
2. San Francisco Police Department, *SFPD Crisis Intervention Team (CIT)*, available at: <http://sanfranciscopolice.org/crisis-intervention-team>.
3. City and County of San Francisco. Office of the Mayor, “Mayor Lee Announces Expansion of Comprehensive Crisis Services To Support Police Response Capabilities,” *News release*, October 4, 2016, available at: <http://sfmayor.org/article/mayor-lee-announces-expansion-comprehensive-crisis-services-support-police-response>.
4. Ibid.
5. Emslie, Alex, *S.F. Police Shooting Raises Questions About City’s Response to Psychiatric Crises*, February 16, 2017, San Francisco, CA, KQED News, available at: <https://ww2.kqed.org/news/2017/02/16/s-f-police-shooting-raises-questions-about-citys-response-to-psychiatric-crises/>.
6. Molina, Mario. Interview with San Francisco Police Department conducted by Manatt Health. In-person site visit. April 14, 2017.
7. *Use Of Force Incidents On Decline For San Francisco Police*, May 9, 2017, San Francisco, CA, CBS News, available at: <http://sanfrancisco.cbslocal.com/2017/05/09/use-of-force-incidents-on-decline-for-san-francisco-police/>.

Law Enforcement Assisted Diversion (LEAD) Program: Santa Fe, NM^{1,2,3}

Initiative Objective and Target Population	Reduce the rates of arrest, incarceration, recidivism, and overdoses for low-level adult offenders with SUD.
Points of Engagement (“Intercept Points”)	<p>Law enforcement officers identify individuals in the community with SUD who may be arrested for committing a low-level drug offense. Law enforcement may also engage individuals in the community who are not in an arrest situation but who have committed a low-level drug offense in the past or may in the future. These are called “social referrals,” and account for about half of all LEAD referrals.</p> <p>Individuals are offered the opportunity to participate in the LEAD program, diverting them from the criminal justice system to community-based supports. Participation in the program is voluntary and acceptance into LEAD is determined upon review of the individual’s criminal history by the District Attorney’s Office, which is conducted within 24 hours of the referral.</p>
Intervention Model	<p>Once an individual accepts an offer to participate in LEAD, the referring officer brings them to Life Link, a local behavioral health service provider. The individual is connected with a Life Link case manager, who provides “hands-on” assistance in accessing benefits (SSI, housing vouchers, student loans), basic needs (food, transportation), employment assistance, and SUD treatment services (medication-assisted, inpatient).</p> <p>Santa Fe LEAD uses a harm reduction approach and does not require that participants abstain from drug or alcohol use. Participants may stay in the program for an indefinite amount of time, except in cases of violent behavior or subsequent criminal activity.</p>
Sponsoring and Participating Agencies and Organizations	The program was originally established in 2014 by the Santa Fe District Attorney’s Office, New Mexico Office of the Public Defender, City of Santa Fe Police Department, City of Santa Fe Community Services Department, Santa Fe County Community Services Department, Drug Policy Alliance, and the New Mexico Criminal Defense Lawyers Association. These agencies and partners continue to collaborate in the oversight and coordination of the program, along with Life Link and other treatment and community service providers.
Type of Locality	Small (2015 population: 84,009)
Funding Sources	The program was established with an initial \$300,000 allocation from the Santa Fe City Council and \$600,000 from the Open Society Foundation for a three-year pilot, and continues to be supported by an annual \$250,000 City appropriation. Medicaid is leveraged for counseling, treatment, and case management (about 40 percent of total program costs) and HUD funding is leveraged for housing support (about 20 percent of total program costs). The program also received funding support from the County, McCune Foundation, Just Woke Up Fund, and Santa Fe Community Foundation.
Evidence of Success	Prior to launching LEAD, the City found that 25 of the most frequent offenders were responsible for four to five times the number of arrests and length of jail stays compared to other offenders and cost an average of \$56,000, compared to \$37,000 for other offenders. ⁴ A preliminary analysis of the program in June 2015 found that the average annual service cost per LEAD client was \$6,000, significantly below projected costs (\$34,000 over three years). ⁵ As of October 2015, no LEAD participants have overdosed on drugs and 10 participants were engaged in medication-assisted treatment. ⁶ The Open Society Foundation has provided a \$100,000 grant to the University of New Mexico Institute for Social Research to conduct an evaluation that will be completed Spring 2018. ⁷

1. LEAD Policy Coordinating Committee, *LEAD Santa Fe Overview*, October 19, 2015, available at: [https://www.nmlegis.gov/handouts/LHHS%20101915%20Item%206%20Law%20Enforcement%20Assisted%20Diversion%20\(LEAD\).pdf](https://www.nmlegis.gov/handouts/LHHS%20101915%20Item%206%20Law%20Enforcement%20Assisted%20Diversion%20(LEAD).pdf).
2. Krasnow, Bruce, “LEAD initiative changes rules of drug treatment,” *Santa Fe New Mexican*, June 18, 2016, available at: http://m.santafenewmexican.com/news/health_and_science/lead-initiative-changes-rules-of-drug-treatment/article_b0c6cf72-b5ca-58d0-9505-0d3066ab6286.html?mode=jqm.
3. City of Santa Fe, “City Launches LEAD Putting Santa Fe in Proactive Spotlight,” *News Release*, May 5, 2014, available at: http://www.santafenm.gov/news/detail/city_launches_lead_putting_santa_fe_in_proactive_spotlight.
4. “Santa Fe Community Foundation and LEAD Santa Fe,” *LEAD Cost Benefit Analysis: Initial Rough Estimate*, June 24, 2013, available at: <http://www.lead-santafe.org/file/LEAD-Cost-Benefit-Analysis.pdf>.
5. “LEAD Santa Fe,” *System Cost, Program Cost and Funding Support*, available at: <http://www.lead-santafe.org/about/cost-and-funding>.
6. “LEAD Santa Fe,” *An Overview of the Program*, October 19, 2015, available at: [https://www.nmlegis.gov/handouts/LHHS%20101915%20Item%206%20Law%20Enforcement%20Assisted%20Diversion%20\(LEAD\).pdf](https://www.nmlegis.gov/handouts/LHHS%20101915%20Item%206%20Law%20Enforcement%20Assisted%20Diversion%20(LEAD).pdf).
7. “Panel to evaluate Santa Fe drug-offender program,” *Santa Fe New Mexican*, December 1, 2016, available at: http://www.santafenewmexican.com/news/briefs/panel-to-evaluate-santa-fe-drug-offender-program/article_d514ca2a-3c5f-533e-ba65-878f69257dcc.htm.

Advanced Practice Paramedic Program: Wake County, NC ^{1,2}

Initiative Objective and Target Population	Divert individuals experiencing mental health or substance use crises from hospital EDs to 24-hour crisis centers in the community.
Points of Engagement (“Intercept Points”)	Advanced Practice Paramedics (APPs) respond alongside EMS personnel to mental health and substance use crisis incidents and divert individuals to crisis centers in the community.
Intervention Model	<p>APPs are paramedics that receive additional intensive training on topics and techniques designed to help them manage individuals in crisis, including clinical decision-making, 40 hours of CIT training, and pharmacology review. The County has trained 20 APPs who operate up to five APP response units simultaneously in a given day. Each response unit operates out of a single vehicle and accompanies traditional EMS personnel on substance use and mental health-related crises calls.</p> <p>In the APP program, 911 operators call APPs to respond alongside EMS personnel to mental health or substance use crises in the community. Once on scene, EMS personnel conduct an individual assessment, after which the APP screens the individual for potential ED diversion to one of three 24-hour crisis centers. The crisis centers provide stabilization services, such as detox, and facilitate referrals to longer-term outpatient behavioral health treatment. The County established a robust data sharing infrastructure to track individuals that are engaged by APPs, including whether they are connected with ongoing community-based treatment or are admitted to hospital EDs. The APPs use these data for reporting purposes, as well as to coordinate care for individuals that frequently interact with the EMS system.</p>
Sponsoring and Participating Agencies and Organizations	Wake County EMS established the APP program in 2009 and has operated the program since launch. Local community behavioral health partners include WakeBrook Recovery Center, Holly Hill Hospital, the Healing Place of Wake County, and Alliance Behavioral Healthcare.
Type of Locality	Large (2015 population: 1,024,198)
Funding Sources	Initially the program was entirely supported by County general funds, but has since begun participating in a North Carolina Department of Mental Health (DMH) EMS pilot project that provides some state funding. Under the pilot project, the County receives funding from the DMH for transporting APP clients to other community settings outside of the hospital ED. Previously, APPs did not receive any reimbursement for this service.
Evidence of Success	The APP program has also been the subject of two University of North Carolina studies, one of which found that the program saved 2,448 ED bed hours and reduced care costs by \$500,000. ³ As part of its participation in the DMH pilot, the County also provides regular data to the State on the number of APP responses and ED diversions. As part of these efforts, the program reported that it diverted 167 patients from the hospital ED in one six-month period, freeing up approximately 2,400 ED bed-hours. ⁴

1. Mazurek, Paul, “APPs: A new breed of responder,” EMS1.com, March 23, 2010, available at: <https://www.ems1.com/ems-education/articles/773808-APPs-A-new-breed-of-responder/>.
2. Guillaume, Greg, “Taking Substance Abuse and Mental Health Out of the Emergency Department,” *EMS World*, January 6, 2014, available at: <http://www.emsworld.com/article/11289649/advanced-practice-paramedics-and-alternative-destinations>.
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Support for this research was provided by the Robert Wood Johnson Foundation. The views expressed here do not necessarily reflect the views of the Foundation.

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