New Haven LEAD Initiative

Abstract

Applicant: City of New Haven **Population:** 130,522
Funds Requested: $75,000 under Category 2
Project Period Start Date: 10/1/2017 **End Date:** 9/30/2018

The City of New Haven seeks a grant under Category 2: Strategic Planning for Law Enforcement and Mental Health Collaboration. Supporting the work of the New Haven Law Enforcement Assisted Diversion (LEAD) initiative, this process seeks to divert people with mental illness and co-occurring mental health and substance abuse disorders from the criminal justice system to best address their health and service needs. Leading the planning process with the City will be the New Haven Police Department and Connecticut Department of Mental Health and Addiction Services through the Connecticut Mental Health Center.

Planning will address two priority considerations: ensuring that evaluation is conducted during implementation; and improving information-sharing between police and mental health agencies to meet project goals.

New Haven has 130,522 residents: 33.8% African-American, 43.1% white, 5.1% Asian, and 28.1% Hispanic (any race). The poverty rates are: 26.6% overall; Black residents, 29.0%; 36.8% for Hispanics, 36.8%; and children, 37.7%. Currently, 1,428 persons from New Haven are incarcerated, and 438 are under community supervision by CT DOC. 256 (17.9%) have a mental illness diagnosis: of these, 197 (77.0%) are diagnosed with a co-occurring substance abuse disorder. Rates of serious mental illnesses of people in jail is three to six times that found in the general population.

The City will convene a Task Force with work groups that will: establish clearly defined and sustainable partnerships; develop a model policy addressing police response to persons affected by mental illness and co-occurring disorders; and ensure ongoing training and certification in mental health first responding to critical personnel.

Planning goals include: increased public safety and better access to treatment services through enhanced collaboration among the criminal justice, mental health, and substance abuse treatment systems; improved early intervention and diversion options for multisystem-involved individuals with mental illnesses or co-occurring disorders through better training, communication and collaboration; increased front-end diversion of the targeted population; and enhanced justice, mental health, and community partnerships to enable better data health and justice collection.

Outcomes sought include reduction in the number of people with mental illnesses booked into jail, the length of time they remain in jail, and the numbers who recidivate, and an increase in connections to treatment.

Grant money will be used to fund: a LEAD Task Force Project Coordinator; work of the research partner; local travel and travel to Washington for the mandatory conference; support for NHPD data services; and expenses related to the two-day planning session.

The City of New Haven is seeking a grant under **Category 2:** *Strategic Planning for Law Enforcement and Mental Health Collaboration of the Justice and Mental Health Collaboration Program* to support the New Haven Law Enforcement Assisted Diversion (LEAD) initiative in its efforts to address the needs of people with mental health and co-occurring substance use disorders. The New Haven LEAD Task Force brings together a broad collaborative that has emerged from a year-long community-wide discussion. It will address policy and practice changes needed to institute a harm reduction approach in law enforcement that will divert overrepresented groups, specifically individuals with mental illness, from the criminal justice system. The proposed work will build on 20 years of consistent collaboration and programming in the city and State around the intersection of the justice and mental health systems.[1]

Many people with untreated mental illnesses and co-occurring substance use disorders end up in jail, which can start a cycle of arrest, incarceration, release, and re-arrest that poses nearly insurmountable challenges to recovery. Worse yet, prisons can become their institutional homes. Most correctional officials agree that jails and prisons can exacerbate mental illness, posing risks to the individual, the general corrections population, and supervising staff.

This initiative aims for (a) a reduction in the number of people with mental illnesses and co-occurring substance use disorders arrested or booked into jail; (b) a reduction in the length of time people with these issues remain in jail; (c) an increase in connections to mental health and substance use treatment; and (d) a reduction in recidivism.

1. Statement of the Problem/Description of the Issue (20%)

Current responses. The New Haven LEAD partner agencies' efforts related to current

[1] Osher, Fred C., MD, Director of Health Systems and Services Policy, Council of State Governments Justice Center. "Testimony at Hearing before the Senate Committee on the Judiciary Subcommittee on Human Rights and the Law on "Human Rights at Home: Mental Illness in U.S. Prisons and Jails" September 15, 2009.

standards for addressing the needs of this population are summarized in Att. 6.[2] The New Haven Police Department (NHPD) has implemented detailed polices to guide officers in approaching and managing persons with mental illness or co-occurring disorders based on best practices in law enforcement. In partnership with the CT Alliance to Benefit Law Enforcement, Inc. (CABLE) and the Connecticut Mental Health Center (CMHC) (the Local Mental Health Agency for the CT Department of Mental Health and Addiction Services (DMHAS)), NHPD has implemented Memphis Model Crisis Intervention Teams (CITs) since participating in a 2004 federal grant with DMHAS which has continued to expand this work.[3] NHPD includes mental health issues in its Police Academy curriculum and 172 of its 450 sworn officers have CIT Certification. CIT training is also offered by CABLE to CMHC clinicians; civilian, federal and university law enforcement staff; probation and parole officers; and hospital police.

CMHC provides a broad array of behavioral health treatments and services, case management and skill building programs, and links to housing, rehabilitation and employment services (Letter, Att. 4). CMHC staffs one full-time CIT Clinician who works with the NHPD to respond to mobile crisis calls and trains both police and provider staff. She participates in weekly ride-alongs, following up with individuals who have come to police attention. Working in tandem, the Clinician and NHPD officers respond to each person with appropriate services, including from other LEAD collaborators (e.g. APT Foundation, Cornell Scott Hill Health Center). NHPD also has an over 25-year relationship with the Yale Child Study Center Child Development Community Policing program (YCSC-CDDP). Clinicians ride along to incidents involving family and child exposure to violence, and provide extensive officer training.

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[2] Scwarzfeld, Matt with Melissa Reuland and Martha Plotkin. "Improving Responses to People with Mental Illness: The Essential Elements of a Specialized Law Enforcement-Based Program." Council of State Governments, 2008. Full Toolkit can be accessed at https://pmhctoolkit.bja.gov/

[3] Information on the DMHAS/CMHC work provide by DMHAS staff from the Forensic Services Division, March 2017. See Attachment 7 and letter from DMHAS Commissioner (Attachment 4) for details on DMHAS and CIT.

In 2016, the CIT Clinician worked with NHPD on behalf of 312 individuals, and with the CMHC Acute Services Unit to respond to 198 mobile crisis calls, 79 of which involved NHPD, and 54 of which led to transport to area Emergency Departments. Some of these people were subsequently charged with a crime and referred to court. Mental health professionals working in local courts estimate that up to 40% of those involved in the criminal justice system have a mental health or co-occurring disorder based on their observation and national studies.[4]

Limitations on Collaborative Responses. Incarcerated individuals with mental illnesses differ in terms of the severity of their illnesses, charge levels, criminogenic risks, and access to community supports. As the criminal justice system lacks valid and reliable tools and processes to adequately screen, assess, and treat, it cannot effectively use its scarce resources to treat those most in need. Currently, New Haven's mental health providers lack staff to respond in-person to evening and weekend crisis calls. Inadequate coordination and communication across many providers also limits response effectiveness. The high volume of arrests and bookings in the Connecticut courts (GA-23 serves New Haven and processed 7,024 New Haven arrests in 2015), creates another block to identifying and diverting from incarceration all who would benefit.

Current costs of over-representation in correctional facilities of with people with mental health and co-occurring disorders. People with mental illnesses, most of whom have co-occurring disorders, are overrepresented at every stage of the criminal justice system -- 2 to 4 times the general population in probation and parole.[5] 14.5 % of male and 31 % of female inmates have serious mental illness,[6] 3 to 6 times the rates found in the general population.[7] An

[4] Communication with Forensic Drug Diversion Clinic, Yale Department of Psychiatry, March 2017

[5] Prins, Seth J and Laura Draper, "Improving Outcomes for People with Mental Illnesses under Community Corrections Supervision: A Guide to Research-informed Policy and Practice," Council of State Governments Justice Center, 2009.

[6] http://www.safealternativestosegregation.org/

average of 56.2% of incarcerated individuals have some form of mental health problem, compared to 10.6% in the general population.[8]

The first step in an analysis of the costs that this over-representation adds to incarceration is to evaluate the process by which the people become incarcerated. Basic incarceration costs in CT average $50,262 per inmate per year.[9] Specialized mental health care significantly adds to that cost. In 2016, 23,000 prison and jail admissions were reported in CT.[10] Whereas New Haven is home to only 3.7% of the state population, an estimated 2,145 (9.3%) of these admissions were New Haven residents, with as many as 1205 (56%) having mental health problems based on national research data.[11]

DOC assesses all inmates on admission and then periodically during incarceration. Currently 1,428 persons from New Haven are incarcerated and 438 are under DOC community supervision. 256 (17.9%) inmates have a Mental Health assessment score of MH3 or more (on a 1-5 scale).[12] Of these, 197 (77.0%) have a co-occurring substance abuse condition while the community co-occurrence rate is only 3.2%, an overrepresentation of 191 people, representing potentially millions in extra incarceration costs compared to their successful diversion.[13]

A second difficult to quantify cost of incarceration is related to the duration of the illness

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[7] Henry J. Steadman, Fred C. Osher, Pamela Clark Robbins, Brian Case, and Steven Samuels, "Prevalence of Serious Mental Illness among Jail Inmates," Psychiatric Services 60, no. 6 (2009): 761–765.

[8] James, Doris J. and Lauren E. Glaze, "Mental Health Problems of Prison and Jail Inmates." NCJ 213600. U.S. Department of Justice, Office of Justice Programs, September 2006. https://www.bjs.gov/content/pub/pdf/mhppji.pdf

[9] Vera Institute of Justice, "The Price of Prisons: What Incarceration Costs Taxpayers," January 2012 (Updated 7/20/16) Retrieved April 1, 2017 http://archive.vera.org/sites/default/files/resources/downloads/price-of-prisons-updated-version-021914.pdf

[10] Connecticut Office of Policy and Management, Monthly Correctional Population Indicators. Retrieved April 1, 2017 from http://www.ct.gov/opm/cwp/view.asp?a=2976&Q=383680

[11] Ibid, James, 2006 2006. https://www.bjs.gov/content/pub/pdf/mhppji.pdf

[12] A score of 5 is "crisis level mental disorder requiring 24 hr. care (a temporary code) to MH1 which is no mental health history or need.

[13] Center for Behavioral Health Statistics and Quality. (2015). Behavioral health trends in the United States: Results from the 2014 National Survey on Drug Use and Health (HHS Publication No. SMA 15-4927, NSDUH Series H-50). Retrieved from http://www.samhsa.gov/ data/

itself: incarceration delays the recovery and worsens the mental health of these individuals.

Current channels of communication and information sharing between law enforcement and mental health agencies. NHPD and CMHC have collaborated for over 20 years, effectively protecting and exchanging information as stipulated by statute and HIPAA. The CIT Clinician attends weekly NHPD CompStat meetings to review the latest crime patterns and devise strategies to reduce it. While not available in person on evenings, weekends and holidays, she is available by phone to facilitate effective collaboration with officers. NHDP and YCSC-CDDP meet weekly to review cases and communicate regularly around specific cases.

Current capacity to measure and track key data measures. Currently the City tracks calls for service to the City's Emergency Response Department through a 911 emergency line and a non-emergency line. Calls for mental health services are also tracked by the 211 Infoline system. CMHC tracks all contacts made by the CIT Clinician and by the Acute Services Unit. NHPD holds weekly CompStat meetings to which they invite other agencies and the community. Participants review and discuss analyzed crime and other data prepared by the NHPD Crime Analysis Unit. Through regular meetings with CMHC, the CIT and the YCSC-CDDP team, NHPD reviews patterns and trends to inform its engagement with people with mental illness.

2. Project Design and Implementation

Upon award, the City will convene the LEAD planning process through formalization of the New Haven LEAD Task Force composed of a broad group of stakeholders from government, nonprofit agencies, and the community (List, Att. 5 and Att. 4 MOU, and Design of Structure, Section 3). The City and the Task Force will select a community agency to staff and facilitate the planning process and, if successful, implementation. The Task Force will form Work Groups based on the initial review of planning needs. The experience of Albany LEAD suggests: a Policy Work Group to assess possible policy changes; a Community Leadership Team to

facilitate effective communication with the community; an Operational Work Group to work with the LEAD Coordinator to review data and operations and handle communications; and a Data and Evaluation Team to work with the research partner.

During the planning period, the Task Force will: cement clearly defined and sustainable partnerships required to implement LEAD; deliver a model policy addressing police response to persons affected by mental illness and co-occurring substance use disorders; and institutionalize ongoing training and certification to sworn officers and selected non-sworn and other partner staff in Mental Health First Aid for Public Safety, CIT procedures, and LEAD best practices.

Inventory of current policies, programs, and services. To find gaps, the initial Planning Team reviewed the policies, programs and services concerning police responses to and work with people with mental illness and co-occurring substance use disorders. During the planning period, the Policy Work Group will produce an analysis of these sectors to plan for more effective responses to avoid their deeper involvement in the criminal justice system.

Processes to change policies and realign budget, programs and services. After completing the inventory, the Task Force will form *ad hoc* policy review teams composed of a cross-section of members to conduct the technical reviews and recommend changes. The LEAD Team will work through these *ad hoc* and ongoing work groups to devise policy changes that will improve how law enforcement interfaces with persons with mental illness and those dually-diagnosed.

The Data and Evaluation Team will develop a plan for evaluating the efficacy of the proposed LEAD interventions. If this plan proves effective, the Team will incorporate a cost-effectiveness component to assess the relative costs of serving the target population through the justice system versus through service providers. Through diversion, the Task Force seeks to achieve savings across the system that can be redirected to community services and supports.

The Policy Work Group will work with the NHPD to produce the following deliverables: review data on calls for service; assess policies and procedures related to police response to individuals with mental illness; assess current practices in information systems and communications; and review agency training curricula, delivery, and peer support. The group will then deliver recommendations for revamped policies, programs and budgetary allocations towards reducing justice system involvement of those with mental illness and co-occurring substance use disorders. Through this grant, NHPD will also develop relationships with additional community providers.

Nonprofit community mental health service providers, including the Cornell Scott Hill Health Center and the APT Foundation, will work with NHPD and CMHC to ensure that services are immediately available to individuals requiring them.

Stakeholder engagement in the planning process. The City has engaged a wide range of stakeholders in the process, with over 60 people on the Task Force contact list to date (Att. 5). The Operational Work Group will recruit people involved with comparable policy and advocacy efforts such as the Warren Kimbro Reentry Project, Project Longevity, criminal justice reform groups, and formerly incarcerated individuals. They will also recruit persons involved in existing local policy efforts (e.g., membership of local criminal justice coordinating council). LEAD provides an opportunity to expand the partnership engaged in criminal justice reform and to effectively assess which improvements would result in improved outcomes for people with mental illness. The LEAD Coordinator will perform broad outreach to advocates, the formerly incarcerated, and their families through service providers, social media, and the LEAD website. The Coordinator will facilitate community meetings to bring these voices into project planning.

Personnel costs related to a police–mental health coordinator position. The City, acting

as Fiscal Agent, will work with the Task Force to contract with a community-based organization (CBO) to facilitate the planning efforts. This CBO will host the LEAD Coordinator[14] using funds from the grant and private sources (see budget for salary details). The Coordinator will organize and lead the planning process, and then, if successful, lead implementation.

Consulting Assistance. The Task Force will seek technical assistance from the LEAD National Support Bureau, the organization that helped facilitate the startup of Albany LEAD and advises many communities. The Task Force will seek consulting assistance to improve data and performance measurement systems; revise policies/procedures; improve staff performance evaluations; and deliver trainings through internal partner or philanthropic resources.

Evaluation. The City's Research Partners, Drs. Emily Wang and Cindy Crusto of Yale University's School of Medicine, have over 20 years of experience in implementation science and in evaluating interventions with justice-involved individuals, many of which have focused on people with mental health disorders (Att. 3). While resources are insufficient for a full evaluation of collaborative police-mental health efforts, the Research Partners will perform a process evaluation to evaluate the effectiveness of collaboration efforts and help the Task Force design and secure resources for a full program evaluation and a randomized controlled trial.

Planning meetings/strategic planning session with top officials. The planning process will include a mandatory multi-day strategic planning session to include senior representatives from NHPD, DMHAS/CMHC, DOC, CT Office of Policy and Management, the City, mental health and substance abuse providers, civil rights experts, and community partners. Planning meeting expenses will be shared among the Task Force.

Visit to an approved law enforcement–mental health learning site(s). The City will be joined by representatives from the initial Planning Team, community service providers and

[14] New Haven position name for the Police-Mental Health Coordinator

advocates in a team visit to Seattle in April 2017 for a 2-day hands-on learning session with the Seattle LEAD team. The delegation will report their findings to the Task Force. If necessary, a team will visit one of the learning sites designated by the Bureau of Justice Assistance such as New York City (mental health courts) or Portland, ME (law enforcement).

3. Capabilities and Competencies (20 percent)

Dr. Martha Okafor, the City's Community Service Administrator, will direct planning efforts. As faculty at Morehouse School of Medicine where she headed the Behavioral Health Division, Okafor trained physicians, health centers and hospitals on the integration of mental health and substance abuse treatment into medical care, and has published extensively on this topic (Att. 3, Resumes). The LEAD Coordinator, hired within 2 months of award, will lead the process and be supervised by the community agency selected to facilitate planning (Att. 2).

Describe the project collaboration structure. A Steering Committee consisting of major partners and advocates will drive project collaboration and guide the work of the full Task Force and Work Groups. This Committee, supported by the LEAD Coordinator and drawing on technical assistance consultants, will ensure successful project planning, implementation, and/or expansion. The Task Force will operate under a policy of full transparency, documenting and publishing all meeting notes and decisions made on the web. The Memoranda of Understanding (MOU) and letters from collaborating partners demonstrate joint commitment to the process.

Qualifications of the research partner. Drs. Emily Wang and Cindy Crusto of the Yale University School of Medicine will conduct the evaluation. Attachment 3 details their qualifications in program evaluation.

Project Task and Timeline. The Project Timeline (Att. 2) depicts goals, objectives, activities, expected completion dates, and responsible entities for all activities.

Potential barriers to project implementation and strategies to overcome them. A major

barrier would be divisions within the Task Force over approaches to the work and policies to be implemented. To thwart the rise of this a barrier, the process will include extensive dialog among all parties that will address current data and diverse perspectives and build trusting relationships that can move the disparate members to a common vision.

Two other barriers may be: (a) insufficient resources for treatment and basic services (e.g. housing, food) in light of promised state and federal budget cuts, and (b) insufficient community engagement. LEAD will engage community members so their voices are heard and they understand the new approach to accessing much needed services.

4. Plan for Collecting the Data Required for this Solicitation's Performance Measures

The LEAD Coordinator will work with the Research Partner to verify completion of all project deliverables and to collect relevant data from NHPD, DOC, DMHAS and CMHC and 911/211 call centers. NHPD will review trends using its own data and that of CMHC and YCSC.

5. Plan for Measuring Program Success to Inform Plans for Sustainment

Stakeholder participation and buy-in will be tracked through meeting attendance and survey responses. Improved service coordination will be measured by delivery of improved policies and strategies for effective diversion. The Research Partners and Task Force have committed jointly to securing additional resources to fund comprehensive performance measurement, including securing resources for a Randomized Controlled Trial and to expand successful strategies based on the successful delivery of the plan for LEAD implementation. The 60 plus collaborators engaged in planning—mental health providers, advocates, funders, and justice agencies–have demonstrated their interests in implementing the strategies developed through this planning (Att. 5).

6. Budget. The budget for the New Haven LEAD initiative is $93,750 composed of $75,000 requested under this application (see Budget Detail Worksheet and Budget Narrative).