Intercept 0 Community	Intercept 1 Law Enforcement	Intercept 2 Jail	Intercept 3 Courts	Intercept 4 Re-Entry	Intercept 5 Community Corrections
•Crisis Line •Warm Line •Mobile Crisis Outreach Teams •Receiving Center •VOA detox •ACT Teams •VA/VOA Outreach •NAMI •USARA •MAT •Sober Living Housing •Permanent Supportive Housing •Rapid Rehousing •Homeless Resource Centers •Downtown Ambassadors •Senior Housing (homeless)	•CIT Officers •SLCPD Community Connections Team •UPD Mental Health Unit •Lethality Assessment (SB 117)	•Mental Health Services •CATS •Community Response Team •Jail Competency Restoration Unit •MAT •CJS Pretrial Services •County Pretrial Intervention Program	•Mental Health Courts •Drug Courts •Veteran's Courts •LDA Mental Health and social services positions •Case Resolution Coordinator •Homeless Courts	•TOP 10 •JDOT •CORE 1&2 •ATI Transport •Odyssey House MH Residential programs •JRRP •FACT •DORA •MH/SUD Programs •4th Street Clinic •Medicaid Eligibility Specialists •Gap Funding	•CJS Intensive Supervision Program •APP OMI •CJS Case Managers

ACT= Assertive Community Treatment
AP&P = Adult Probation and Parole
ATI = Alternatives to Incarceration
CATS = Correction Addiction Treatment Svcs
CIT = Crisis Intervention Team
CJS = Criminal Justice Services

CORE=Co-occurring Reentry & Empowerment
CPIP=County Pre-File Intervention Program
CRT = Community Response Team
DORA = Drug Offender Reform Act
ED = Emergency Department
FACT= Forensic Assertive Community Treatment
JDOT = Jail Diversion Outreach Team
MAT = Medication Assisted Treatment

JRRP=Jail Resource Reentry Program
MCOT = Mobile Crisis Outreach Team
MHC = Mental Health Court
MH = Mental Health
MHL=Mental Health Liaison
NAMI = National Alliance on Mental Illness
OMI: Offender with a Mental Illness
OH=Odyssey House

SUD = Substance Use Disorder
SW = Social Work
UHP = Utah Highway Patrol
UPD = Unified Police Department
USARA = Utah Support Advocates for Recovery Awareness
VOA = Volunteers of America

Intercept 0 Gaps

Connects people who have mental and substance use disorders with services before they come into contact with the criminal justice system.

Supports law enforcement in responding to both public safety emergencies and mental health crises.

Enables diversion to treatment before an arrest takes place.

Reduces pressure on resources at local emergency departments and inpatient psychiatric beds/units for urgent but less acute mental health needs.

- **CRISIS Lines: Policy:** State working to coordinate efforts between 988 and 911. 988 is a national line – routes calls based on area code of the number calling in, not actual location of the caller.
- **MCOT Teams: Funding:** Current funding available for 5 teams in SLCounty. County should have 9-13 based on population.
    - **Staffing:** Personnel for MCOT, especially overnight shifts for licensed mental health professionals
    - **Procedure**: Inability of MCOT teams to respond currently has reduced law enforcement referrals.
- **Transportation: Policy/Procedure**: Lack of consistent assistance from law enforcement with involuntary transportation of individuals. Need to transport individuals to services.
- **Post-Acute Care: Staffing:** Connection to post-acute care is limited by capacity issues across community providers. Coordination needed between hospitals and behavioral health services to address individuals cycling between Emergency Departments.
- **Housing: Funding:** Housing crisis limits ability to provide long-term stable housing supports necessary for treatment success. Also limits on housing for medically frail homeless seniors, other populations. Shortage means individuals are not always housed with the appropriate level of services.
- **Services for People with Disabilities: Funding and Staffing:** Division of Services for People with Disabilities wait lists, lack of screening in criminal justice and homeless systems.
- **Detox: Funding and Staffing:** Insufficient detox beds-to be expanded summer 2023. Unable to keep individuals in detox long enough to be effective.
- **Domestic Violence Services: Funding:** Homesafe program underfunded, could be effective prevention opportunity.
- **Seniors**: **Funding and Staffing:** 100 bed assisted living style facility needed with varying levels of care for aging seniors who prefer communal living.

Intercept 1 GAPS

Involves diversion performed by law enforcement and other emergency service providers who respond to people with mental and substance use disorders. Allows people to be diverted to treatment instead of being arrested or booked into jail.

Begins when law enforcement responds to a person with mental or substance use disorders.

Is supported by trainings, programs, and policies that help behavioral health providers and law enforcement to work together.

- **CIT and MCOT**: **Policy:** Consistent Crisis Intervention Team policies and practices across jurisdictions, regular training, and an application process to ensure CITs have the skills and temperament to work with individuals in a mental health crisis could improve outcomes for those individuals and ensure officers called to respond to such situations have the support they need. Best practice is to not have law enforcement respond to lifestyle crime issues but to send MCOT. Seeing law enforcement can exacerbate a situation with someone in a mental health crisis.
- **Funding:** Additional funding needed to bring MCOT teams to best practice of 9-13 for a county our size.

- **Capacity: Staffing/Funding:** Behavioral health, law enforcement and case managers needed to create positive collaborations for success are all in short supply. Are there opportunities to work with local schools of social work, POST, and other programs to develop internships and other interactions with providers and agencies to encourage more involvement. Other incentives, such as housing subsidies?

- **Diversion: Policy:** Utah law provides for a 24-hour temporary commitment of someone law enforcement has probable cause to believe is suffering from a mental illness and poses a substantial danger to self or others. The commitment may be extended an additional 48 hours under certain conditions. Legislative action may be needed to extend the categories for outpatient, court ordered treatment to include individuals who lack the capacity to make decisions regarding treatment and who, in the absence of consistent treatment, present a substantial risk of harm to self or others. (Equitas Project model legislation)

Intercept 1 GAPS (continued)

- **Detox**: **Funding**: Volunteers of America detox is typically full, leaving officers with little choice but to take the person to jail. Additional beds are coming online, but review of future potential resource needs may be warranted.
- **Policy:** Once a person is taken to detox, they are under no obligation to remain, sometimes with tragic results as in the case of Brandon Nykon. https://www.washingtonpost.com/nation/2022/08/29/nykon-brandon-utah-police-death/https://www.washingtonpost.com/nation/2022/08/29/nykon-brandon-utah-police-death/ Consider policy option of secure detox facilities with a legal mechanism to ensure people are held. Law enforcement may be hesitant to use an unsecure facility.
- **Peer Navigators: Staffing/Funding:** Many familiar faces have no family members or other supports to help navigate complex systems. The need for peer supporters dedicated to specific individuals to ensure successful entry and exit from services into situations conducive to long-term stability would benefit the system.
- **Data Sharing**: **Policy:** Pulling together data from law enforcement, pretrial services, courts, jail facilities, health providers, and housing continuums of care would enable us to analyze the number of people who have mental illnesses, substance use disorders, and co-occurring illnesses and how this population moves through the system. This type of data analysis can reveal potential areas where one or more diversion interventions are needed as part of an overarching strategy.
- **Housing: Funding:** One of the key missing components to this intercept is supportive housing for long term success. Connecting criminal justice data with housing data may create a more accurate and consistent count of needed permanent supportive, transitional and rapid rehousing resources for individuals who fall into the mentally ill, addicted and/or homeless situations. We have come a long way in identifying the familiar faces in the criminal justice system. Ensuring these individuals have access to stable housing is a critical next step.
- **Evaluation**: **Policy:** Centralized and continual evaluation of current programs to determine effectiveness, make changes as necessary.

Intercept 2 GAPS

Involves diversion to community-based treatment by jail clinicians, social workers, or court officials during jail intake, booking, or initial hearing. Involves people with mental and substance use disorders who have been arrested and are going through intake, booking, and an initial hearing with a judge. Supports policies that allow bonds to be set to enable diversion to community-based treatment and services. Includes post-booking release programs that route people into community-based programs.

- **Screening For Mental And Subtance Use Disorders And Developmental And Intellectual Disabilities**: **Funding and Policy:** Limits to the screening tools, limited capacity at the jail for more in-depth screening, inconsistent funding for screening tools. CJS can screen, but court may already have probable cause statement from officers.

- **Referral To Jail-based Or Community-based Services**: **Staffing:** Limited capacity in both systems to serve the population. Staffing shortages across both. Limited number of providers capable of working with the population on mental health and substance use disorders. As learned in Miami and elsewhere, incarceration conditions such as crowded living quarters, lack of privacy, increased risk of victimization, and exposure to punitive segregation are strongly correlated with emerging and worsening psychiatric symptoms (including self-harm). (NAMI infographic on mental illness and incarceration, Cornell University fact sheet on incarceration impacts on mentally ill), Northwestern University Law review analysis of the impacts of prison on people with mental illness

Intercept 2 GAPS (continued)

- **DATA-MATCHING**: **Policy:** Need to link jail and community-based behavioral health providers with homeless and housing services to more comprehensively address immediate needs. Determine means for sharing treatment data to more effectively track outcomes for individuals cycling between the three systems.

- **PRE-TRIAL SUPERVISION And DIVERSION**: **Procedure:** Need to review what we are measuring across programs. Raw numbers of diversion tell a portion of the story. To determine effectiveness of programs, we need to develop metrics that include short and long-term results of a diversion - was the person diverted to detox and exited detox shortly after law enforcement moved on? Did the individual leave detox for a voluntary long-term treatment program? Are individuals being re-arrested for additional crimes after diversion? Address releasees based on failure of officer to timely file report.

- **Post-booking Release**: Released to what? Community-based support services are critical, as is housing with intensive supports. Supportive housing is needed at all intercept levels. Continued mental health and substance use treatment success requires stable housing.
  - **Staffing:** Develop more robust methods to ensure compliance with release conditions – navigators across intercepts to guide individuals through requirements, processes to help ensure people are not faced with additional consequences based on not understanding when or where to go to complete next steps.
  - **Funding:** People released from incarceration are at greatest risk of homelessness immediately after release. Stable housing is a key element of successful reentry and should be secured immediately upon exiting incarceration. Lack of stable housing (including episodes of homelessness) makes success in other domains of reentry more tenuous and increases the risk for re-arrest and a return to incarceration. Reentry-and-Homelessness_Synthesis-of-the-Evidence.pdf (evidenceonhomelessness.com) The county began the process to implement the FUSE (Frequent Users System Engagement) model but no action was taken between 2018 and 2020. FUSE relies on having a stock of permanent supportive housing. Building the needed stock would take several years, but creative options might lessen the time frame, from using existing building to seeking cooperative landlords to provide housing under leases that are conducive to intensive supportive services. CJAC has reconnected with Corporation for Supportive Housing regarding FUSE.

Intercept 3: Gaps

Involves people with mental and substance use disorders who are held in jail before and during their trials.

Includes court-based diversion programs that allow the criminal charge to be resolved while taking care of the defendant's behavioral health needs in the community.

Includes services that prevent the worsening of a person's mental or substance use symptoms during their incarceration.

- **Treatment courts for high-risk/high-need individuals:**
- **Alternatives to prosecution programming**
- **Jail-based programming and health care services**. NEED TO UNDERSTAND WHAT IS HAPPENING AT SLCOUNTY JAIL -Jail health care providers are required to provide medical and behavioral health services to people who are detained and need treatment. Trauma-informed and evidence-based spaces and programs for people with mental and substance use disorders help ensure that a jail stay does not worsen a person's illness. Jails can also use suicide prevention plans and procedures to prevent suicide among people with and without known mental health concerns.
- **Partnerships with community-based providers of mental health and substance use treatment**. NEED TO UNDERSTAND WHAT IS HAPPENING AT SLCOUNTY JAIL When jails partner with community-based providers, they can increase the number of treatments and services that people can access during their detention. This can also help build relationships between patients and providers, making it more likely that the person will feel comfortable with continuing services after they are released from jail. These "in-reach" services can also help identify people with mental and substance use disorders who may be better placed in community-based or inpatient treatment.
- **Mental health jail liaisons or diversion clinicians**. Mental health jail liaisons and diversion clinicians can determine what resources are available to an individual to continue treatment upon release.
- **Collaboration with Veterans Justice Outreach**.

Intercept 4: Gaps

Provides transition planning and support to people with mental and substance use disorders who are returning back to the community after incarceration in jail or prison.

Ensures people have workable plans in place to provide seamless access to medication, treatment, housing, health care coverage, and services from the moment of release and throughout their reentry.

- **Transition planning by the jail or in-reach providers** improves reentry outcomes by shaping services around a person's needs before they are released. Planning for reentry should begin at intake and continue during the person's incarceration; it should involve providers and resources across criminal justice, behavioral health, and physical health care systems. Examples: Risk-Needs-Responsivity (RNR) Simulation Tool, Collaborative Comprehensive Case Plans (CC Case Plans)
- **Medication and prescription access upon release from jail or prison**. When they are released, people should have enough medications and prescriptions to allow them to follow their treatment plans and avoid relapse while waiting to see their community-based medical provider.
- **Warm hand-offs from corrections to providers increases engagement in services**. Funding and staff for JRRP. Need 24/7 hours of operation. Time served and over-crowd releases in hours when there is no access to services for homeless and/or SMI individuals.
- **Benefits and health care coverage immediately following or upon release**. States are encouraged to suspend rather than end Medicaid coverage. This allows people coming back to the community to quickly access important treatment services and medications. Where possible, paperwork to start or restart benefits and/or health care coverage should be done before release. That way, these essential resources are available to people with mental and substance use disorders during their transition back to the community. Examples: SSI/SSDI Outreach, Access, and Recovery (SOAR); Medicaid and Medicare: An Overview; Health Insurance Marketplace
- **Peer support services**. Individuals who have gone through the transition from jail or prison to the community can provide valuable peer support. They can help people plan for reentry, identify safe housing, and learn about triggers or issues that could lead back to the justice system. Peer staff may be employed by the jail or by in-reach providers to deliver transition planning services.
- **Reentry coalition participation**. Many communities have a group that meets and plans for supporting people reentering the community from prison or jail. Partners from criminal justice, behavioral health, and all types of supportive services should be involved. These partners can help coordinate the processes and resources available to people with mental and substance use disorders as they plan for transition

Intercept 5 Gaps

Involves individuals with mental or substance use disorders who are under community corrections' supervision.

Strengthens knowledge and ability of community corrections officers to serve people with mental or substance use disorders.

Addresses the individuals' risks and needs.

Supports partnerships between criminal justice agencies and community-based behavioral health, mental health, or social service programs.

- **Mental health training for all community corrections officers** should be provided. Officers with specialized caseloads should receive additional, more in-depth training to learn about the specific needs of the people under their supervision.
- **Specialized caseloads of people with mental and substance use disorders**. The use of smaller and specialized mental health or substance use caseloads shows promising results. Specialized caseloads allow community corrections officers to provide support that keeps their clients on the path to recovery, increases connections to services and appointments, and reduces the chance of violations and jail stays.
- **Community partnerships**. By the time someone qualifies or housing, they are off paper. Job skills programs with housing are not always an appropriate fit for individuals (high barriers to access, skills developed are for low paying jobs, no pay until completion)
- **Medication-assisted treatment**.
- **Access to recovery supports**. Housing and work with a livable wage are just as important as access to behavioral health services. However, many things can be barriers to employment and housing for people who have been in jail or prison. Community corrections officers can help reduce these barriers by helping their clients get government-issued photo identification, start or reinstate health care coverage, and access criminal record expungement.

Housing Units SMI/SUD

Project	Program Capacity	Serving
Homeless Assistance Rental Program	60	SUD
Project RIO	55	SMI
Fisher House (First Step House)	6	SMI
Denver Apartments (VOA)	22	SMI
The Theodora (VOA)	13	SMI
Central City (First Step House	75	SMI
State Hospital Diversion Program	60	SMI
Sunstone and Jasper (Odyssey House)	27 (9F, 27M)	SMI
Sober Living Voucher Program	300 vouchers	SUD
Medina Apartments (First Step House)	75	SMI
VBH Supportive Housing Programs	277	SMI/SUD
Pamela's Place	100	SMI/SUD/Disability
Valor House	72	SMI/SUD/Disability
Total	1,142	

Housing Units – Homeless/DV

Project	Program Capacity	Serving
Magnolia Apartments (TRH)	65	PSH
Bud Bailey Apt (Housing Connect)	34	PSH
HASLC PSH units	327	PSH
Palmer Court (TRH)	201	PSH
Wendell Apartments (TRH)	32	PSH
Grace Mary Manor (Housing Connect)	84	PSH
South Valley Services	57	DV
YWCA	181	DV
HASLC Subsidized/subsidy welcome	1,171	Low Income (rent)
The Point		Low Income (rent)
Sunrise Metro	100	Homeless
VASH Vouchers	515	Veterans
Kelly Benson	60	PSH
Total	2827	

Impact of Housing Resources on Criminal Justice-Homelessness Cycle

SALT LAKE COUNTY
CRIMINAL JUSTICE ADVISORY COUNCIL

(No available actions)

Comparisons - Demographics

Emergency Shelter	Person Count 25,868	Ave Age 38.0	Ave Enroll Days 58.6	Pct Female 33.6%	Pct Booked 30.1%
Rapid Rehousing	Person Count 7,779	Ave Age 36.8	Ave Enroll Days 103.0	Pct Female 57.3%	Pct Booked 4.3%
Homeless Prevention	Person Count 4,180	Ave Age 33.7	Ave Enroll Days 110.2	Pct Female 56.8%	Pct Booked 0.7%
Permanent Housing (Disability)	Person Count 4,040	Ave Age 44.3	Ave Enroll Days 652.1	Pct Female 42.5%	Pct Booked 13.4%
Transitional Housing	Person Count 1,941	Ave Age 42.2	Ave Enroll Days 169.2	Pct Female 25.2%	Pct Booked 4.5%