Early Mental Health Diversion in Los Angeles County

An Implementation Evaluation of the Intake Booking Diversion Program

by Jennifer A. Tallon, Viet Nguyen, and Elise Jensen

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Center for Justice Innovation

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Guide to Los Angeles County Agencies and Programs

The **Los Angeles County Sheriff Civilian Oversight Commission** provides oversight to LASD, including guidance on expanding alternatives to traditional policing like MET.
The **Community Safety and Implementation Team** is currently housed within the LA County Chief Executive Office. Formerly named the Jail Closure Implementation Team and housed under JCOD, the team is working to develop a plan to close the Men's Central Jail maintained by LASD.
Civilian clinicians from the **Los Angeles County Department of Mental Health** have worked with MET since 1991 as part of LASD's specialized police response to mental health calls for service. They also oversee a network of community-based treatment providers across the county.
The Intake Booking Diversion (IBD) program is housed within MET. It is a law enforcement-based diversion program that identifies people with mental health disorder at the point of booking and diverts them to community-based treatment.
The **Justice, Care, and Opportunities Department (JCOD)** was created by the LA County Board of Supervisors to promote collaboration and transparency while addressing systemic issues such as homelessness, poverty, mental health illness, and substance use disorders. It currently houses the court-based Rapid Diversion Program.
The **Justice, Care, and Opportunities Department - Alternative to Incarceration (JCOD-ATI)** program was a community-based pre-filing diversion program implemented in select LASD stations in 2021.
The Los Angeles County Sheriff's Department (LASD) is responsible for providing law enforcement services to 141 unincorporated communities and 42 contract cities, providing security services to the superior court, and maintaining the seven facilities that constitute the local jail system (including the Inmate Reception Center and Twin Towers).
The **Mental Evaluation Team (MET)** spearheads LASD's specialized police response to mental health calls for service. This includes 34 co-response teams, the 24/7 triage desk that assists with mental health calls for service, training, and specialized programs like RAMP and IBD.
The **Office of Diversion and Reentry** was previously housed under JCOD and now exists under LA County's Department of Health Services. Since 2015, they have offered pretrial diversion through the superior court for detained individuals with co-occurring mental health and substance use disorders who require supportive housing.
The **Rapid Diversion Program** was originally piloted by the Los Angeles County Public Defender's Office and is now housed under JCOD. Since 2019, the program has offered pretrial diversion at the point of arraignment for individuals with mental health or substance use disorders facing misdemeanor or felony charges.
The **Risk Assessment Management Program** is housed within MET and supports high system utilizers with serious mental illness who present risk of harm to self or others. The program provided case management for IBD participants during the initial 2020 pilot.

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Executive Summary

The Los Angeles County Sheriff's Department (LASD) developed the Intake Booking Diversion (IBD) Program as an innovative early-intercept strategy to divert individuals with mental health disorders away from jail and into community-based treatment. This implementation evaluation—conducted by the Center for Justice Innovation in partnership with LASD's Mental Evaluation Team (MET)—documents the program's development, evolution, implementation, and early outcomes across two pilot periods (2020 and 2024).

The IBD program offers a model for early mental health diversion at the point of booking. Although no cases were enrolled at the point of booking during the 2020 pilot, 102 cases were screened for IBD during the 2024 relaunch. However, only six cases were enrolled. An unintended benefit of embedding MET deputies within pilot stations is that IBD screening enabled them to identify 26 cases in which individuals' mental health crises rendered them gravely disabled or a danger to self or others, thus requiring 72-hour involuntary psychiatric hospitalization (5150 hold). In other words, these individuals were experiencing mental health crises so severe that MET deputies determined they were unable to knowingly or willingly consent to diversion via IBD. The extension of field-based crisis response into the booking environment created an opportunity to identify individuals in crisis prior to their transfer to the central jail processing facility, the Inmate Reception Center, avoiding jail stays that may have led to further decompensation and deepened crisis. While IBD did not achieve scale during pilot periods, it illustrated clear opportunities for law enforcement agencies to intercept individuals in crisis earlier and reduce jail exposure.

Overview. Nationwide, law enforcement agencies are increasingly required to respond to mental health crises, often without sufficient resources or specialized support. In Los Angeles (LA) County, half of the jail population has a mental health need, and operational pressures on the jail system—particularly at the Inmate Reception Center—have intensified the need for early diversion options.

In 2018, California Assembly Bill 1810 (codified as PC § 1001.36) established a policy lever for courts to engage in pretrial mental health diversion. MET, the unit that oversees LASD's specialized police responses to mental health, recognized the legislation as an opportunity to divert cases *before* they enter the court system. The IBD model builds on MET's experience in field-based co-responder work but shifts the intercept point to the moment of station

booking. MET deputies identify individuals where there is a nexus between the alleged crime and their mental health disorder and determine whether they can be safely diverted to community-based treatment and case management for a period of 45 to 90 days. During this period, detectives will hold the case. If an individual is successful (e.g., engages in treatment, remains arrest-free), MET will notify detectives to circumvent filing charges. Charges will be filed for noncompliant individuals.

Methods. The implementation evaluation used a mixed-methods approach, including:

1. Review of documentation of the model development (2019–2025);
2. Two site visits (2024 and 2025) including:
    a. Observation of operations at two station jails and the Inmate Reception Center;
    b. Eighteen semi-structured interviews with MET leadership, deputies, and clinicians; LASD station personnel and custody division staff; and representatives from court-based diversion programs; and
3. Analysis of administrative data from MET databases, LASD booking systems, and jail incident records for 420 cases, including 102 IBD-screened cases and 318 comparison cases.

The study focused on how IBD differed from standard booking practices, whether it had potential to improve safety and outcomes, and implementation challenges.

Results. The initial IBD model evolved due to several major events, including the COVID-19 pandemic, calls to defund law enforcement following the killing of George Floyd, and LA County bail reform.

- **2020 Launch** MET teams paired a specially trained MET deputy with a clinician from the Department of Mental Health and responded to calls from station jail staff when an individual flagged for a mental health need at booking. The COVID-19 pandemic delayed IBD implementation, while the court's emergency bail schedule significantly shifted the types of cases subject to custodial booking. This challenge was further exacerbated due to a competing community-based booking diversion program and MET staff turnover. As a result, no IBD diversions from stations occurred during this period.

- **2024 Relaunch** MET pivoted from a co-response approach due to resource constraints. Three MET deputies were reassigned as dedicated IBD deputies and embedded within four pilot stations to facilitate on-site engagement aimed to increase referrals. While the

COVID-19 emergency bail schedule ended in 2022, LA County implemented bail reform in 2023, which expanded upon the pandemic era policies and dramatically reduced the number of individuals booked with IBD eligible offenses, limiting the diversion pool.

Across the 2024 pilot, 102 cases were screened for IBD, but only six enrolled. These six had no prior jail bookings within the past three years and low-level charges, suggesting that those accepted into the program may represent lower-risk or lower-need individuals. A third of cases were disqualified due to the nature of the offense and a quarter required 5150 holds due to a mental health crisis. Approximately two out of five cases were disqualified due to refusals on the part of the arrested individual (n = 20), detective (n = 13), watch commander (n = 3), or victim (n = 3).

Given that we cannot make statements about IBD's efficacy due to low enrollment numbers, we applied OLS regression with and without propensity score matching to compare how IBD screened cases varied in terms of jail bookings and system contacts (MET contacts, custodial violations for physical or fighting-related infractions during jail stay, and future jail bookings within 3 or 6 months of release) relative to comparison cases. IBD screening is associated with a 26.9 percentage point increase in remaining out of jail. The remaining estimates show non-significant differences—suggesting that those screened by IBD were no more likely to have future system contacts. In short, IBD screening did appear to alter the trajectory of cases and identify where a 5150 hold may be more appropriate than jail detention.

The feedback on IBD from interviewees was largely positive. IBD deputies reported that the booking environment allowed them to capture cases missed in the field and intervene early, before individuals reached the jail system's central intake. Station staff valued having the IBD deputies at their stations and the option of mental health diversion, but expressed concerns about public safety for more serious charges and individuals with repeat offenses. Interviewees also noted MET's resource limitations given the unit's primary mission is to respond to mental health crisis calls for service. Finally, interviewees identified several operational challenges associated with IBD including:

- Low case volume due to bail reform and narrow eligibility criteria;
- Extensive time (2-4 hours per case) required for each IBD screening;
- Dependence on securing diversion approval from multiple parties (station jail staff, watch commanders, detectives, victims, and the arrested individual);
- Persistent staffing shortages in MET (including deputies and clinicians); and

- Significant administrative gaps, including booking system limitations and inconsistent completion of mental health screening forms.

Discussion. The IBD pilots highlighted several potential benefits:

- **Early Identification of Mental Health Crises** IBD screening reduced jail intake for individuals in crisis through the early identification of those requiring 5150 holds before they were transferred to the Inmate Reception Center.
- **Rapid Specialized Assessment Within the Booking Environment** The physical presence of IBD deputies ensured they could immediately conduct specialized mental health evaluations and de-escalation, rather than waiting for a field-based co-responder team to arrive at the station.
- **Improved Coordination** Station personnel reported valuing the presence of IBD deputies, who offered support for diversion activities as well as broader MET-related needs.

Notably, interviewees also described several key barriers to program scalability:

- **Complex Interacting Factors** IBD's success is highly dependent on system-level conditions, notably bail policy, the program's formalization within LASD's policy, and cross-agency coordination.
- **Barriers to Intake** Volunteer-based participation, layered approval requirements, and charge eligibility restrictions significantly narrowed the diversion pool.
- **Inconsistent Staffing Capacity** MET's resource constraints limited the ability to maintain the consistent on-site presence of the MET deputies.

In terms of lessons learned, interviewees noted that booking diversion is feasible, but it requires strong administrative infrastructure, dedicated staffing, and reliable screening processes that are reinforced through top-down directives and ongoing education. Additionally, cross-system collaboration (courts, prosecutors, behavioral health providers) is essential to ensure IBD's alignment with other diversion efforts in LA County.

In conclusion, although IBD had limited reach as a diversion program, the program's success lies in diverting individuals in crisis from station jails to hospitals prior to their transfer to the Inmate Reception Center. For law enforcement practitioners, the evaluation highlights the significance of monitoring court-based diversion policies to inform program adaptations, the potential benefits of embedding staff with specialized mental health expertise within booking

environments, the value of strong partnerships with behavioral health providers, and the ways in which early screening and data tracking can further enhance specialized police responses to mental health crises.

Chapter 1

Introduction

Across the country, law enforcement agencies are increasingly called upon to respond to community mental health crises, creating significant risks and challenges for all involved. Officers are often the first to encounter individuals in crisis, despite limited specialized training. These situations can escalate quickly and lead to arrest, use of force, or other harmful outcomes—highlighting the urgent need for alternatives to traditional policing (Fuller et al. 2015; Laniyonu and Goff 2021; Reuland, Schwarzfeld, and Draper 2009; Saleh et al. 2018). In response, jurisdictions across the country have developed specialized police responses (e.g., crisis intervention teams focused on de-escalation, co-responder teams that pair officers with mental health professionals), and non-law enforcement mobile crisis teams.[1] These approaches reflect a growing recognition that the complex needs of people with mental health disorders cannot be met through the criminal justice system alone.

Within this broader movement of specialized police responses, the Intake Booking Diversion (IBD) program was developed by the Los Angeles County Sheriff's Department's (LASD) Mental Evaluation Team (MET) in 2019 as a pilot program to divert arrested individuals with mental health disorders away from jail and toward community-based treatment. The program was initially launched in 2020 at the height of COVID-19 and subsequently went dormant due to the pandemic and a competing community-based booking diversion program. Ongoing challenges in identifying collaborative solutions to address the jail's mental health population helped reignite MET's interest in relaunching IBD in February 2024. This interest, however, would continue to be impacted by changing local policy and practice.

[1] For the purposes of this report, we limit our focus to specialized *police* responses to mental health disorders. However, there are examples of community-led alternatives that minimize the involvement of the criminal legal system. Mobile Crisis Intervention Teams (MCITs) are mental health crisis response units comprised of clinicians, counselors, or peer or family support specialists—not law enforcement. They respond to people in crisis where they are, providing de-escalation, support, and connections to mental health and medical services. These teams emerged as an alternative to police involvement in mental health emergencies in the 1960s and have expanded significantly following a series of high-profile incidents between law enforcement and individuals in mental health crisis that involved harm. MCITs apply a public health framework, not a criminal legal one, to reduce unnecessary arrests or hospitalizations (Watson, Compton, and Pope 2019).

Sweeping bail reform in 2023 significantly restructured the county's custodial booking practice, leading to a pressing need for booking alternatives with demonstrable success.

This implementation evaluation documenting the development and implementation of the IBD program was funded by the National Institute of Justice (Award No. 15PNIJ-23-AG-03563-RESS) and builds upon the partnership established between MET and the Center for Justice Innovation (the Center). We applied a mixed-methods approach to chart the progression of IBD amidst significant national (COVID-19, public outcry associated with the killing of George Floyd) and local (county bail reform) events to address the following research questions:

1. How does the IBD process differ from LASD's business-as-usual booking practices?
    a. What is the potential for this program to improve outcomes for individuals with mental health disorders?
    b. What is the potential for this program to improve the safety and well-being of LASD deputies?
2. What were the practical successes and challenges encountered during IBD implementation?
    a. What is the potential for the IBD program to be translated to other law enforcement agencies?
3. From the perspective of LASD command staff and front-line deputies, how did IBD implementation affect work environments, deputy decision-making, and safety?
4. What were the characteristics of individuals identified and/or diverted through IBD?
5. If taken to scale, could IBD potentially decrease the number of individuals with mental health disorders who are booked into jail?
    a. What are the implications for correctional facility safety?

This report presents implementation evaluation findings as follows. The current chapter describes the evaluation methodology before continuing with an overview of prior literature on mental health and jails and specialized police response to mental health disorders. Chapter 2 details LASD's MET and the IBD program model. Chapter 3 offers an in-depth examination of IBD planning and implementation. Chapter 4 presents a description of the cases screened for the IBD program, including personal characteristics and outcomes relative to individuals with mental health needs who experienced standard booking practices in comparison stations. Chapter 5 features a discussion of the strengths and challenges identified during the IBD pilot. Chapter 6 concludes with lessons learned from the implementation process and offers insights for improving the IBD model, as well as guidance

for other law enforcement agencies considering similar diversion initiatives.

Mental Health and the Criminal Legal System

The IBD programs grows out of a mounting concern in the United States, as police, jails, and prisons increasingly encounter individuals with serious mental health disorders but lack the resources and infrastructure to provide adequate care. In response, law enforcement agencies across the country have implemented innovative strategies at the point of law enforcement contact or initial detention, including Crisis Intervention Teams (CIT) and co-responder models that pair officers with mental health professionals. These early intercept points can complement post-booking diversion programs designed to connect individuals to treatment rather than jail. This section explores the challenges of jails, prisons, and mental health populations and the feasibility for specialized police responses to address mental health disorders in the community at the point of arrest.

Mental Health in Jails and Prisons

The high prevalence of individuals with mental health disorders who are incarcerated in the U.S. is a significant public health concern. In 2011-12, an estimated 44% of individuals in local jails reported having previously been diagnosed with a mental health disorder (Bronson and Berzofsky 2017). However, these figures likely underestimate the true scale, as many incarcerated individuals exhibit symptoms but lack a formal diagnosis. Serious mental illnesses (SMI) such as schizophrenia, major depression, and bipolar disorder are especially common among incarcerated populations (Steadman et al. 2009).

Many advocates contend that jails and prisons have effectively become mental health institutions, yet most lack the resources for effective intervention (Treatment Advocacy Center 2016). A Bureau of Justice Statistics survey in 2016 found that among individuals who reported a history of mental health disorders, 63% of those detained in state and 58% of those detained in federal prisons had received treatment since their admission (Maruschak and Bronson 2021). Treatment services are even more limited in jails, with anywhere from 17% to 44% of individuals with a mental health indicator reporting they received treatment post-admission (Bronson and Berzofsky 2017; James and Glaze 2006). The stressful correctional environment often exacerbates poor mental health, negatively impacting the safety of both incarcerated individuals and officers (Osher et al. 2012; Police Executive Research Forum 2018).

The complexity of addressing mental health disorders among incarcerated individuals nationally is echoed locally in Los Angeles (LA) County, which has the largest jail system in the country and has been referred to as the country's largest mental health provider (Brooks Holliday et al. 2020). As of October 2025, 50% of those held in the LA County jail system have mental health needs, a 21% increase since 2020.[2] This has prompted county-wide jail reform efforts to address meeting the complex needs of individuals with mental health disorders in a correctional setting. The LA County Board of Supervisors made efforts to improve conditions in the county's short-term jail facility (Inmate Reception Center) and to expand pre-plea diversion programming, such as the Rapid Diversion Program, to the jail's mental health population.[3]

Given the unlikelihood of services to be provided in the context of jail or prison, early off-ramps offer a promising opportunity for the criminal legal system to connect appropriate individuals with mental health disorders to community-based services. Given that one in four individuals diagnosed with a mental health disorder has a history of arrest, there is a critical need to explore the role of law enforcement in facilitating these diversion opportunities (Livingston 2016). As we will explore below, alternatives to traditional policing hold the potential to create treatment linkages to these vital services as well as to enhance safety for individuals with mental health disorders, law enforcement, and communities.

Specialized Police Responses to Mental Health Crisis

Law enforcement often acts as the first responder to mental health crises. It is estimated that one in ten calls for service involves someone experiencing a mental health crisis or diminished mental capacity (Fuller et al. 2015). Many of these calls are driven by repeat encounters with a small group of individuals who are high utilizers of both the criminal legal and behavioral health systems (Reuland et al. 2009). Traditional policing methods are often ineffective or counterproductive when responding to individuals with mental health disorders (Blevins, Lord, and Bjerregaard 2014; Morabito et al. 2018). Mental health-related calls for

[2] Accessed from the *Care First LA: Tracking Jail Decarceration* dashboard using data from LASD. This dashboard was created for the Jail Population Review Council in partnership with the Vera Institute of Justice.

[3] Pre-plea programs typically come after an individual is arrested and charged, but before they enter a plea in court, with the possibility of having the charges dismissed upon meeting certain conditions (e.g., completion of a program). Pre-filing programs like IBD and pre-plea programs like the Rapid Diversion Program seek to improve the efficiency of the diversion process via early identification and service linkages coordinated by mental health experts to ensure that eligible individuals do not fall through the cracks or languish in custody.

service can place a heavy resource burden on agencies and create inefficiencies in responding to other calls for service, as responding officers often face long wait times for medical transport or an available psychiatric bed (Reuland et al. 2009).

These encounters carry significant risks. Although national estimates for law enforcement fluctuate, five officers were killed between 2014 and 2023 and in 2023, approximately 4% (n = 3,422) of all assaults on an officer occurred while they were handling an individual with a mental health disorder (U.S. Department of Justice 2025). The risks for individuals in crisis are well documented. According to reporting from *The Washington Post*, roughly 20% of fatal police shootings between 2015 and 2025 (total n = 10,430) involved someone with a mental health disorder (Jenkins et al. 2025). Comparative studies have shown that individuals with a mental health disorder are 16 times more likely to be killed during a police encounter relative to those without a disorder (Fuller et al. 2015). This disproportionality is also evident in non-lethal incidents; those with a mental health disorder are nearly 12 times more likely to experience use-of-force and 11 times more likely to be injured during police contact (Laniyonu and Goff 2021).

Crisis Intervention Teams To protect the well-being of both law enforcement and individuals in crisis, a number of specialized police response models have been developed. One widely used approach is the Crisis Intervention Team (CIT) model, first developed in Memphis in 1988. The model involves 40 hours of training related to mental health disorders and de-escalation techniques to prepare CIT-designated officers to be dispatched to mental health calls for service where, theoretically, they are better prepared to de-escalate the situation and connect the individual to mental health services in lieu of arrest (Compton et al. 2008). In the traditional approach to CIT, officers volunteer for the assignment; some jurisdictions, however, require elements of CIT training for all officers (Fiske, Songer, and Schriver 2021; Watson, Pope, and Compton 2021). The model is also built on partnerships with mental health providers and advocacy groups (Dupont, Cochran, and Pillsbury 2007; Shapiro et al. 2015). Today, over 2,700 CITs operate across the U.S. (National Alliance on Mental Illness 2025).

The strongest effects for the model have been documented at the officer level, as those who received CIT training show improved confidence, greater knowledge and more positive attitudes about mental health disorders, better decision-making around referrals, greater success in connecting individuals to community resources, and enhanced de-escalation skills relative to untrained officers (Compton et al. 2008, 2014a; Crisanti et al. 2022; Taheri 2016; Tartaro et al. 2021). The effect of a CIT response on outcomes at the level of calls for service

are more complex. Although research has demonstrated that CIT consistently yields increased service referrals and linkages, its effect on arrest (Compton et al. 2014b; Kubiak et al. 2017; Teller et al. 2006; Watson, Owens, et al. 2021) and use of force (Compton et al. 2014b; Morabito et al. 2012; Willis et al. 2023) remain mixed. Such findings could be driven by the low base rate of such events during calls that receive a CIT response, how studies define use of force, and wide variability in how agencies apply the model (Watson, Compton, and Pope 2019).

In interpreting the findings related to CIT, jurisdictional characteristics must also be considered. These include aspects at the level of police operations such as how dispatchers communicate mental health calls for service and the availability of good community-based treatment options (Watson et al. 2021). For example, even officers who receive specialized training and are willing to use alternatives end up taking people to jail for lack of community-based options (Cross et al. 2014; Steadman et al. 2000). This makes it harder for CIT to work as intended, connecting people to care in lieu of being detained in jail.

Co-Responder Model The co-responder model pairs law enforcement officers with clinicians to collaboratively respond to mental health calls for service. The model has been widely adapted across the globe, but in the U.S. it is often in the form of officers and clinicians responding in a shared vehicle, both parties arriving to a call separately, or responding officers receiving tele-support from a clinician (Puntis et al. 2018; Watson et al. 2019). Scaling these programs can be difficult due to resource constraints and logistical challenges, including scarce funding for social and health services, challenges in coordinating effective collaboration between law enforcement and mental health agencies, and identifying and hiring appropriate civilian crisis responders (Carroll et al. 2021; Shapiro et al. 2015). The consequence of these barriers is a limited uptake of the co-responder model. A recent national survey of law enforcement agencies found that fewer than half (47%) of the 568 respondents reported that their agency had a co-responder team, while the majority (88%) utilize CIT-trained officers (Uding, Moon, and Lum 2025).

Much of the research on the co-responder model is descriptive in nature and, like CIT, has yielded promising to mixed results. Systemic reviews (Marcus and Stergiopoulos 2022; Puntis et al. 2018; Shapiro et al. 2015) have found some evidence that the teams can respond to crisis calls more quickly, make fewer arrest, facilitate greater service linkages, and reduce time on the scene. However, these reviews note that the findings vary by jurisdiction and methodology. Additionally, findings show that officers paired with clinicians report increased confidence in decision-making and improved awareness of available services

(Morabito et al. 2018; Plassmeyer, Gute, and Stauss 2024). Officers and individuals with mental health disorders often report high satisfaction with co-response approaches, in particular, clinicians' de-escalation skills, empathy, and respectful communication (Evangelista et al. 2016; Scott 2000; Shapiro et al. 2015; Stauss, Plassmeyer, and Anspach 2025).

Despite these promising findings, more rigorous evaluations have not found significant effects for the model. For example, an evaluation of a jurisdiction that implemented a co-response program applied difference-in-differences analysis to study the effect of the model on pre/post calls for service, reported incidents, and use of force and found no significant change during the implementation period relative to a comparison site (Gill, Jensen, and Vovak 2025). There have also been randomized controlled trials that systemically vary the dispatch of a co-response team or a traditional police response to mental health calls for service. These trials have revealed null effects on distal outcomes including emergency medical service events, jail bookings, outpatient encounters, emergency department visits, and general or mental health related calls for service (Lowder et al. 2024; Yang et al. 2024). Collectively, these mixed findings also reflect methodological differences and implementation challenges like the inconsistent availability of services, variation in co-responder team structure, low rates of treatment uptake, and the fact that officers in comparison groups had received CIT training. The authors caution that this is not to say that co-responder programs do not "work," but is illustrative of why more research is needed to understand a model that, unlike CIT, has no formal guidelines and takes different forms (Puntis et al. 2018).

Shifting Specialized Police Responses from the Field to Booking Both CIT and co-responder programs show promise as pre-booking diversion options. However, the reach of these programs at the point of law enforcement contact in the *field* can be limited by resource constraints and the ability of dispatch to identify and communicate mental health calls for service (Lowder et al. 2024; Marcus and Stergiopoulos 2022; Watson et al. 2021). For those with mental health disorders who are arrested, the *booking* stage is a second intercept point to identify and divert individuals from jail to treatment.

While jurisdictions may offer post-booking diversion options (e.g., pre-plea diversion, problem solving courts), it can take a considerable amount of time to move through the process. This creates serious ramifications for those detained pretrial. For example, a defense attorney describing the traditional court-based diversion process in LA County observed that, "by the time you get a report back from that doctor, your client could be sitting in jail for six

months decompensating, getting much worse" (Brooks Holliday, Marsolais, and Matthews 2024). Moreover, post-booking diversion programs may not be appropriate for every individual; they often require lengthy periods of mandated services and intense supervision relative to pre-booking diversion programs, with one early study suggesting the two approaches serve different populations (Lattimore et al. 2003).

In subsequent chapters, we will describe how LASD's MET unit designed and implemented a pilot program that shifted their specialized police response from the field to the point of booking. Moreover, we will explore where IBD falls on the continuum of diversion options for those with mental health disorders in LA County.

Methodology

The primary collaborating organization within LASD was the MET unit, a partnership between LASD and the Department of Mental Health. As described below, this collaboration enabled us to conduct interviews with 26 program stakeholders at the beginning and end of the pilot period to document the program model and distill lessons learned. MET also played a key role in facilitating connections to LASD's Population Management Bureau, which enabled us to construct a sample of 420 cases (102 IBD-screened cases and 318 comparison cases) for outcome analysis. Sample characteristics are described in Chapter 4.

Establishing a Research-Practice Partnership

The opportunity to partner with MET originated from the Center's involvement in the MacArthur Foundation's Safety and Justice Challenge. As practitioner experts from the Center worked with system actors to cultivate opportunities to safely reduce jail populations, MET leadership identified IBD as a pilot that would be implemented independently of the initiative. MET leadership wanted to partner with researchers to show "proof of concept" that they could use as the basis to scale and sustain the program. The Center's practitioner experts worked with the research team to facilitate conversations with MET about the importance of data tracking, establishing and maintaining implementation and comparison stations, and documenting changes to the model. These early efforts were key to building and sustaining a relationship with MET that withstood the pandemic and staff turnover.

Documenting Planning and Implementation

Beginning in 2019, we worked with MET to collect documentation related to the IBD model, including eligibility criteria, workflow documents, and relevant forms. This established a basis for understanding how the target population and process evolved over several years.

We convened regular check-in meetings with MET to document changes on the ground and how they were shaped by issues related to implementation (e.g., station buy-in) and local policy (e.g., pandemic-era safety protocols). We supplemented the information derived from these status calls through ongoing media scans to lend additional context to the events that shaped IBD implementation (Appendix A).

Conducting Site Visits

Although we could not conduct a site visit during the original launch of IBD in 2020 due to pandemic safety protocols, we maintained detailed notes of our ongoing virtual and phone meetings with MET from 2020 through 2025. During the relaunch, we conducted two site visits. The first visit happened three months into the relaunch (April 2024) and the second was one year later (May 2025).

During the first site visit, we focused on (1) documenting the planning and early implementation of the 2024 iteration of IBD through stakeholder interviews and (2) observing operations in two implementation stations and the short-term jail facility, the Inmate Reception Center. With the assistance of MET, we recruited 23 people to participate in 13 individual or group interviews, including:

- MET and Department of Mental Health leadership (n = 2);
- MET and Department of Mental Health staff involved in implementing IBD (n = 8);
- LASD staff at two IBD implementation stations (n = 7); and
- LASD custody division staff (n = 6).

The interview protocols were tailored to each group and took 30-90 minutes to administer, depending on the interviewee's role.[4] All interviewees underwent a verbal informed consent process, and the interviews were recorded with permission.[5] The protocols addressed numerous domains related to IBD implementation, including planning, goals, resources, training, referral process, case management and oversight, early feedback, strengths, and challenges. We also asked interviewees about events that impacted IBD (e.g., COVID-19, bail reform, changes to prosecutorial and law enforcement practices) and other diversion programs targeting similar populations. Finally, we asked about the potential for IBD to

[4] Study materials are available at the National Archive of Criminal Justice Data and upon request. All protocols were approved by the Center's Institutional Review Board.
[5] Four of the seven LASD staff we interviewed across the two IBD implementation stations spoke to us while monitoring operations. In these instances, we took detailed written notes rather than record the interviews.

impact the safety and wellness of individuals with mental health disorders and law enforcement officers, as well as the potential to reduce the jail mental health population.

During the second site visit, we conducted five interviews with seven interviewees. Four interviewees from the 2024 site visit were still assigned to MET and willing to participate in follow-up interviews to distill lessons learned from implementation, provide recommendations for other law enforcement agencies, and discuss the future direction of IBD. The three additional, new interviewees included a Department of Mental Health staff member from MET unaffiliated with IBD and two representatives from court-based diversion programs to elucidate where IBD is situated along the continuum of diversion programs in the county.

To synthesize interviewee feedback, we conducted a grounded thematic analysis of interview transcripts and notes. We started with the domains established in the interview protocols before looking for common themes within these broad categories. For example, within the categories of "planning" or "case management," we distinguish what was observed in the 2020 iteration of the program relative to the 2024 relaunch. For this report, all qualitative results are aggregated across interviewees.

Reviewing Administrative Data

The descriptive analysis drew on administrative data from several sources, which were merged to allow for more expansive analysis of the program and its outcomes. The **IBD tracker** contained information about individuals screened for the IBD program, including demographics, arrest dates and charges, reasons for exclusion if ineligible, and whether participants completed the program. For individuals taken to comparison stations who flagged for mental health needs, the **MET database** included case information such as demographics and arrest date and charges. **LASD's Automated Justice Information System**, allowed us to document criminal history and recidivism. To evaluate in-custody behavior, we included jail incident data from the **Inmate Report Tracking System**, which documents custodial violations (e.g., physical altercations, verbal altercations).

The descriptive analyses provide a better understanding of the population encountered by the IBD program relative to those in comparison stations who met IBD criteria but encountered "business-as-usual" booking practices. We compare demographics, top charges, criminal history, whether a case was booked into jail, and recidivism for several different samples: all cases, comparison station cases, all IBD screened cases, IBD participants, and IBD cases that initially qualified for IBD based on the preliminary screener but who were subsequently

disqualified by station staff or victim objections. We also examine differences in descriptive statistics for the five different disqualification reasons (i.e., emergency hospitalization, participant refusal, disqualifying charge, detective refusal, watch commander refusal). Finally, we assess the association between IBD screening and being booked into jail or having future MET or LASD contact using two methods (OLS regression, with and without matched samples).

Chapter 2

The Intake Booking Diversion Program Model

This chapter describes the Intake Booking Diversion (IBD) model. First, we provide an overview of the LA County policy context to establish the need for earlier mental health diversion options. Next, we describe the Los Angeles County Sheriff's Department's (LASD) specialized police response to mental health crisis, the Mental Evaluation Team (MET). Finally, we outline how the eligibility criteria and diversion process for IBD changed over time, an area we will expand upon in Chapter 3.

Policy Landscape

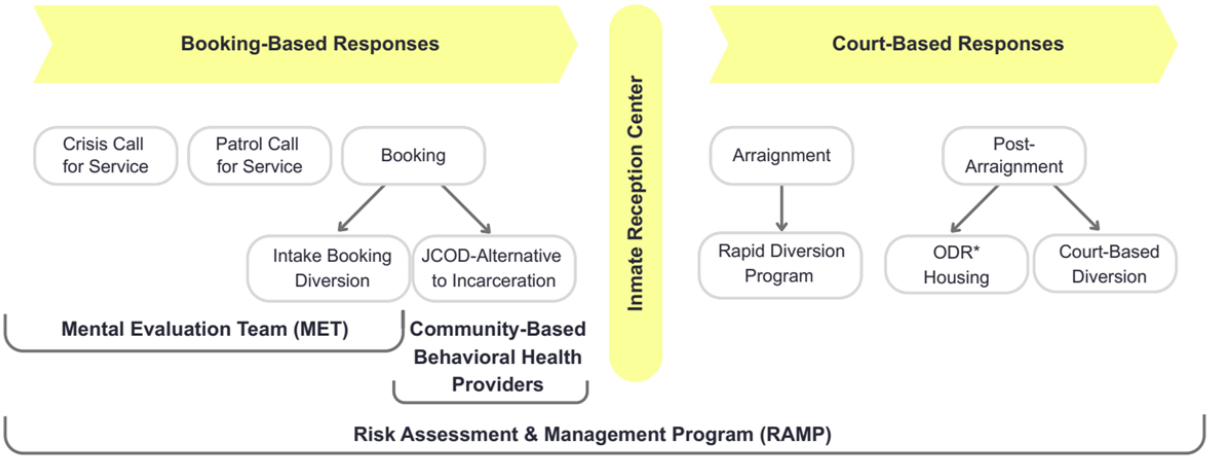
Los Angeles is the most populous county in the United States, comprising nearly 10 million individuals across 4,084 square miles (U.S. Census Bureau 2020). Correspondingly, LASD is the largest sheriff's department, with responsibilities including providing law enforcement services to 141 unincorporated communities and 42 contract cities, providing security services to the superior court, and maintaining the seven facilities that constitute the local jail system (Los Angeles County Sheriff's Department 2022). The LA County jail system is also the largest in the country, with an average daily population that currently hovers between 12,000 and 13,000 (John D. and Catherine T. MacArthur Foundation 2025)**.** Although the jail population was significantly reduced during the COVID-19 pandemic on account of California's emergency bail schedule, the percent of the population with a known mental health disorder *increased* (Marcellino 2020). Today, half of those in jail have a mental health need, effectively rendering the Twin Towers Correctional Facility the largest mental health facility in the nation (Twin Towers Correctional Facility n.d.; Vera Institute of Justice n.d.)**.**

As Appendix A illustrates, LASD has grappled with federal monitoring and multiple lawsuits focused on improving the conditions of confinement for those with mental health disorders since 2015. This has prompted county officials, legal system stakeholders, and community organizations to collaboratively develop diversionary opportunities including off-ramps from jail to treatment. The county established the Office of Diversion and Reentry in 2015 to spearhead such cross-system collaboration. The office expanded in 2019 to explore community-based approaches under the *Care First, Jails Last* initiative. Presently, the

Justice, Care, and Opportunities Department (JCOD) has become the centralized hub for the county's efforts to address diversionary programming for individuals experiencing homelessness, poverty, mental health disorders, and substance use disorders.

Below, we describe LASD's specialized police response for individuals experiencing a mental health crisis and how the field-based co-response approach evolved into a booking diversion model. Figure 2.1 illustrates how some MET programs offering mental health diversion function within the broader context of non-law enforcement diversion programs.

Figure 2.1. Examples of Pretrial Mental Health Diversion



*Office of Diversion and Reentry.

The Mental Evaluation Team

LASD's MET has grown steadily since its inception in 1991 as a field-based response to mental health calls for service. LASD and the Department of Mental Health implemented the co-response model as a pilot project in 1992, expanded to ten MET teams providing countywide coverage in 2016, and currently support 34 MET teams (Mental Evaluation Team 2023). As the co-response teams grew, so did MET's training, data infrastructure, and programming investments. Two specific enhancements essential to IBD include:

- **MET Triage Desk** The 24/7 triage desk assists with incoming calls for service that involve a mental health component. Launched in late 2017, the triage desk is staffed by a MET deputy and a clinician who coordinate review of records from LASD (e.g., prior contacts with MET) and the Department of Mental Health (e.g., prior hospitalizations) to advise personnel in the field and/or dispatch a MET team. Triage desk staff also coordinate with hospitals for pre-admittance should a MET team be unavailable. The

triage desk is jointly staffed for 20 hours (omitting a clinician between 2:00 AM and 6:00 AM).

- **Risk Assessment and Management Program (RAMP)** MET teams refer high system utilizers who have serious mental illness and pose a significant risk of harm to themselves or others to RAMP. Established in 2018, RAMP is comprised of MET deputies, clinicians, and crime analysts who provide 24/7 support that combines intensive case management, patient advocacy, and assertive community treatment. The goals of RAMP are to reduce future hospitalizations and contacts with law enforcement.

Despite these advances, MET has faced significant challenges. MET teams struggle with inadequate staffing, ever-increasing calls for service, and dispatching teams across a county the size of Delaware and Rhode Island combined. In 2017, the Los Angeles County Board of Supervisors approved two separate motions that directed: (1) LASD, the Department of Mental Health, and other agencies to develop a timeline and funding strategy for MET team expansion and (2) the Sheriff's Civilian Oversight Commission to form an ad hoc committee to identify MET improvements needed. The ad hoc committee recommended in 2018 that MET increase the number of co-response teams from 23 to 60 to provide adequate countywide coverage (Los Angeles County Civilian Oversight Commission 2018).

LASD planned to expand to 45 MET teams in 2020 and 2021 but were unable to meet that goal due to hiring challenges. Notably, clinical hiring challenges coincided with the COVID-19 pandemic and public outcry in the wake of George Floyd's death. In 2023, the board of supervisors approved a new motion directing the Department of Mental Health and partner agencies to pilot a hiring and retention program for civilian clinical staff (Los Angeles County Civilian Oversight Commission 2023). Nevertheless, the expansion of the MET team has not progressed significantly (the current staffing is 34 teams) since the Sheriff's Civilian Oversight Commission issued its initial recommendations.

As a result of these challenges, MET teams currently function primarily as a diversion-to-treatment program rather than a crisis de-escalation *and* diversion program. In 2022, MET teams were responsible for approximately 79% of emergency hospitalizations in LASD patrol regions (n = 5,068) and had an average response time of 30 minutes. However, that same year there were 15,249 patrol calls for service involving a mental health component, leaving patrol deputies—many with limited crisis training— to serve as first responders in numerous incidents. These deputies must make rapid decisions (e.g., release, book into jail, or transport to a mental health facility), each with significant implications for safety and

liability (Mental Evaluation Team 2023). Given the high stakes that patrol deputies face when responding to calls for service that involve a person with a mental health disorder, it is unsurprising that—despite the longstanding presence of MET teams as an option for field-based diversion—many of these individuals are booked into jail due to the seriousness of the presenting charge or to address perceived safety concerns.

Intake Booking Diversion Model

The catalyst for the creation of IBD was an incident that MET responded to in 2019 involving a college student arrested for kidnapping. As one interviewee reported:

> He was arrested on a couple of felonies, but when you really dissected the case, we found out about him and realized that he had not actually kidnapped anybody. He had moved someone from point A to point B in the gas station while having a mental health breakdown, and he got arrested . . . They arrested him as the only means to make him stop. [MET was] called because he was having trouble in the local station jail. That's what caused the discussion between us at MET and the detectives involved, saying, "We really should look for ways to divert more like this. Where the case is weak, or it could maybe be adjudicated without going through the IRC [Inmate Reception Center]."

During the same period, MET leadership recognized that California Assembly Bill 1810 (codified in 2018 as PC § 1001.36) created an opportunity to address such cases by expanding mental health diversion from field-based diversion to station house diversion. Under PC § 1001.36, a qualified mental health expert is required to speak to the nexus between an individual's mental health disorder and the alleged crime and the appropriateness of treatment. The change to the penal code established general criteria for the court to consider when diverting those charged with misdemeanors or felonies with a mental health disorder through *court-based* diversion (PC § 1001.36 2018). The specialized mental health training MET deputies complete (over 750 hours), along with their partnership with Department of Mental Health clinicians were felt by MET leadership to equip them with ample expertise to make such determinations at an earlier intercept point. In essence, MET adapted the court-based diversion criteria and applied it at the point of booking to divert cases before they even entered the court system. Diversion at the point of booking would also create a second opportunity for MET to intercept cases that the co-responder MET teams might miss in the field.

While PC § 1001.36 established the general criteria, PC § 849(b)(5) would be the lever enabling law enforcement to divert individuals to community-based treatment and case management via cite and release (PC § 849(b)(5) n.d.). Applied in practice, MET originally envisioned IBD as a somewhat automated process initiated by station jail staff completing their section of the LASD Arrestee Medical Screening Form (SH-R-422).[6]

- If an individual was identified as having a mental health disorder and it was determined by station staff that it played a significant role in the alleged offense, the booking system would halt the intake process until staff called the MET triage desk.
- The MET triage desk would determine if the individual initially qualified for IBD, issue a MET case number allowing station jail staff to continue the booking process, and dispatch the first available MET team to the station for an assessment.
- The MET team would determine if treatment was an appropriate option given the individual's mental state and history, the severity of the current charge, and any past offenses. They would also consult with the arresting officer, watch commander, and detective bureau, to gauge any risk to public safety.
- If all parties agreed that diversion was appropriate and the individual volunteered to join IBD, they would be cited and released under PC § 849(b)(5). The MET team or an ambulance would then divert the individual to a treatment provider or hospital while the clinician coordinated mental health services.
- The individual would participate in 45 to 90 days of case management under RAMP's supervision while the detective bureau held the case. If the individual engaged with treatment and remained arrest-free during this period, RAMP would submit a supplemental report to the detective bureau to circumvent the filing of charges. For noncompliant individuals, RAMP would notify the detective bureau to file charges.

Although the process was envisioned as occurring primarily at the station during booking, IBD could apply to four potential intercept points.

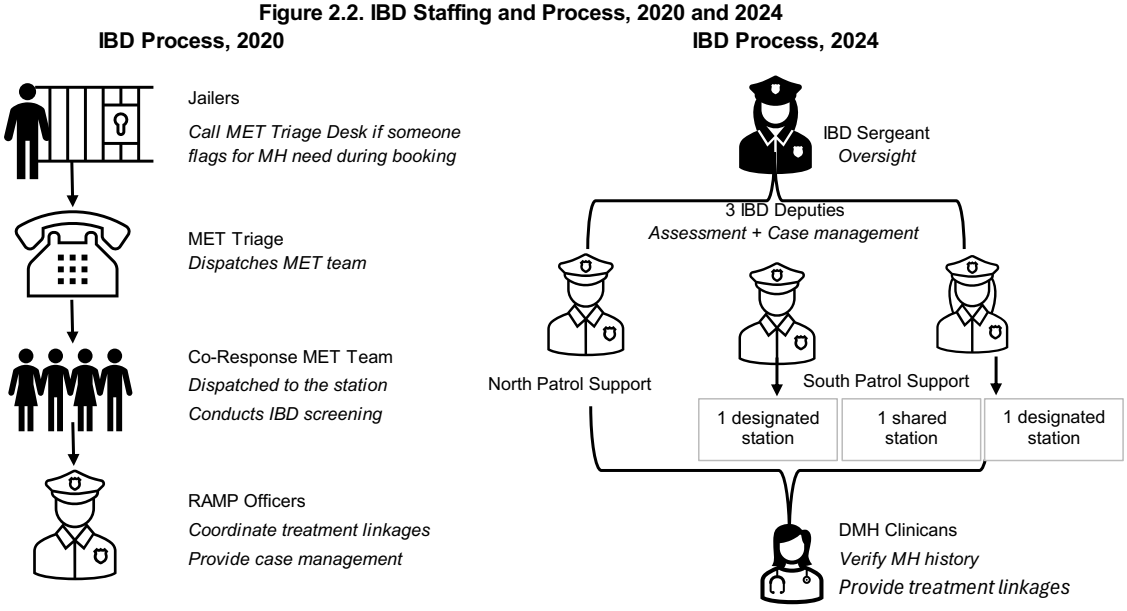
- In the field before booking,
- During the booking process at the station (as described above),
- After the initial booking at the station, but before execution of the probable cause declaration (approximately 48 hours), and

[6] The form is divided into three sections: Arrestee Questionnaire, Arrested Deputy/Officer Observations, and Jailer Observations. This allows for self-disclosure and behavioral observations from LASD staff. Affirmative responses to items associated with the risk of suicide trigger the completion of a Behavioral Observation and Mental Health Referral (SH-J-407).

- Upon rejection of the case filing by the district attorney (at station or court).

While what we described above was the initial vision for how the IBD model would be implemented, there were significant changes from the initial launch in 2020 and the relaunch in 2024. Figure 2.2 displays how the structure and process differed during each phase of the pilot. We will expand upon the rationale for these changes in Chapter 3 and provide additional details on how eligibility criteria evolved over time. Appendix B presents the theory of change behind the 2024 IBD model.

Figure 2.2. IBD Staffing and Process, 2020 and 2024



Chapter 3

Implementation of the Intake Booking Diversion Program

This chapter presents findings from 18 semi-structured individual and group interviews with 30 LASD staff and program partners at two points: three months into the 2024 relaunch and one year later. The interview findings are supplemented by a review of planning and programmatic materials from 2019-2025. This chapter details implementation of the model during the 2020 iteration of IBD, shifts to the model and implementation during the 2024 relaunch, and documents how events such as the COVID-19 pandemic, public calls to defund law enforcement, and local bail reform impacted both implementation and the IBD model itself (see Appendix C for a comparison of pilot periods). We also highlight the overlap and divergences between IBD and other mental health diversion programs in LA County (see Appendix D for program descriptions).

Implementation of the 2020 IBD Pilot

Planning 2020

In 2019, MET presented the idea of the IBD pilot as described in Chapter 2 to a county workgroup that consisted of representatives from Department of Mental Health, the county chief executive's office, the county council, probation, parole, prosecution, public defense, and members who comprised early iterations of JCOD. All parties supported the pilot, but there were outstanding questions about how to scale the program. For example, MET was interested in engaging smaller police agencies that relied on LASD booking facilities to broaden the reach beyond select LASD stations. These considerations would shape site selection.

Site Selection 2020 MET had strong buy-in from leadership in LASD's East Patrol Division, which selected six stations to participate in the pilot. MET would implement IBD in three stations (Industry, Walnut, Altadena) while working with the research team to collect data from three comparison stations (Temple, San Dimas, and Crescenta Valley). The pilot sites were selected based on their volume of mental health calls for service and their proximity to MET's central office, which would enable an expedited response.

Staffing 2020 As described in Chapter 2, staffing would generally parallel the operations of the MET teams (i.e., station jail staff would call the MET triage desk to identify a potential IBD case and the next available MET team would be dispatched for assessment), with RAMP staff providing case management. The MET lieutenant at the time was closely involved with implementation and was supported by a MET sergeant.

Training 2020 MET convened briefings at the implementation stations in late 2019 to go over the IBD process with the intent of launching the program in February 2020. As a trial, RAMP diverted three felony cases via IBD during this period.

Shortly thereafter, courts and jail operations experienced significant shifts in operations as a result of COVID-19, the implications of which are discussed in greater detail below. However, MET capitalized on the increased availability of staff during this period to develop an online course for MET teams further explaining the diversion process and how to record IBD cases. MET also conducted follow-ups to the 2019 briefings throughout 2020 to reengage the implementation stations in the project, with a particular focus on station watch commanders. Watch commanders were considered crucial gatekeepers in the case referral process, as they needed to approve specific diversions and maintain staff awareness of the program as an operational function available across shifts.

Case Identification 2020 Concurrent with the 2019 briefings, MET developed the infrastructure to identify diversion-eligible cases. The Arrestee Medical Screening Form was revised to require station jail staff to notify the MET triage desk anytime an individual was flagged for a mental health need during booking. Although MET had prepared to work through the administrative approval process (e.g., approval of the forms from LASD's union), they encountered an unexpected delay when they suddenly learned that the booking forms were being transitioned from paper to an electronic format captured by the Automated Booking System around the time of their intended launch. MET worked with programmers to upload the revised forms and test that the system could halt the booking process if a mental health flag was generated. The update was completed in August 2020, but the programming proved unsuccessful in halting the booking process.

Despite the implementation delay caused by the required form adaptation, the electronic format created unanticipated opportunities for the IBD program. First, the migration from paper to digital enabled MET to extract the prior year of medical screening data to identify how many people *would* have potentially qualified for IBD across the department. This data provided insight into potentially scaling the program up moving forward. Second,

automating the booking forms expedited triage desk consultations, as MET's database was able to interface with the Automated Booking System via the booking number to import data fields (e.g., name, date of birth, address). Below, we expand on how this system upgrade proved key to planning the 2024 pilot.

Implementation 2020

The seven-month delay introduced by the booking forms was further exacerbated by two unprecedented events that significantly shifted the landscape for IBD.

- **COVID-19** On March 4, 2020, California Governor Gavin Newsom declared a state of emergency related to the COVID-19 pandemic and issued a stay-at-home order to slow the spread of the virus, which impacted IBD in three major ways (County of Los Angeles Department of Public Health 2020). First, the Los Angeles County Superior Court issued an emergency bail schedule, which was superseded by a statewide zero bail policy issued by the California Judicial Council in April 2020. The emergency bail schedule mandated that $0 be set in all misdemeanor and felony cases with several exceptions (Los Angeles County Sheriff's Department 2020). As a result, more individuals were cited in the field rather than booked at the station reducing the pool of possible eligible IBD participants.

  Second, the total number of mental health incidents MET was responding to increased dramatically. MET teams experienced a 10% increase in mental health calls for service following the stay-at-home orders (Mental Evaluation Team 2021). Interviewees noted increases in both the severity of crises they encountered and in the total number of calls countywide. Finally, community-based treatment providers shifted to telehealth services, reducing the number of available referral partners for IBD participants.

- **The Movement to Defund Law Enforcement** The death of George Floyd sparked hundreds of protests and civil unrest in cities across the world in May and June 2020. IBD was deprioritized as MET was pulled out of its standard operations to support LASD's response to demonstrations across the county. At the same time, Sheriff Alex Villanueva (2018-2022), and the board of supervisors disagreed about how to respond to the county budget deficit. Sheriff Villanueva proposed closing stations (including the IBD implementation station of Altadena, which would be absorbed by comparison site Crescenta Valley) and eliminating LASD's community partnership bureau, which houses MET (Tchekmedyian 2020). As county government navigated constituents' demands to

defund law enforcement, MET was projected to lose four deputies (and, by proxy, four MET teams) plus the MET sergeant and lieutenant overseeing IBD in July 2020.[7]

MET staffing stabilized in the fall of 2020, and the unit retained their lieutenant (the developer and champion of IBD), onboarded a new sergeant to manage IBD, and identified a RAMP sergeant to oversee IBD case management. Santa Clarita was added as a new comparison station to account for combining the Altadena and Crescenta Valley stations. After additional briefings described above, the IBD pilot officially launched in East Patrol in November 2020.

MET identified several practical challenges during the initial rollout. First, some individuals presented as potentially eligible based on their behavior, but were revealed to have presenting symptoms associated with substance use rather than a mental health disorder. Second, the update to the Automated Booking System did not halt the booking process when people flagged for mental health needs, which in turn meant fewer cases than expected were identified for IBD screening. MET conducted weekly station booking audits and worked with the programmer to explore options to halt the booking process if someone generated a mental health flag. However, MET prioritized using targeted station briefings to bolster buy-in rather than invoking a top-down mandate. Finally, the emergency bail schedule meant that fewer individuals were subject to custodial booking. Those who were eligible for booking faced more serious charges—generally ineligible for IBD—or raised station staff concerns about the appropriateness of diversion.[8]

Expansion 2020 These challenges compelled IBD to expand in two ways:

- **Expansion from Booking to Pre-Filing** To overcome some of the enrollment challenges, the IBD intake point was pushed further back in the process for cases prosecutors deemed appropriate. Rather than solely offering the program at booking, prosecutors began to route additional eligible cases to IBD following booking but prior to filing charges. This created legal leverage for individuals to engage in treatment. IBD was also presented as an option for people who may be eligible for traditional court-based diversion but whose charges and mental health needs did not necessitate two years of treatment and supervision. In practice, the prosecutor screened for cases that were likely overcharged (e.g., felony vandalism) and referred them directly to IBD. An investigator

[7] Email communication between Principal Investigator and IBD point of contact dated 6/25/20.
[8] As shown in Appendix C, any felony charge subject to a prison sentences and specific felony charges (e.g., DUI causing injury, sex crimes, domestic violence) were excluded from IBD.

from RAMP contacted the individual and detective to explore their willingness to divert the case. If all parties agreed, the RAMP investigator provided case management while the prosecutor held the case. Completing IBD resulted in a dismissal, whereas non-compliance resulted in charges filed.

- **Expansion to North Patrol** MET recognized an opportunity to expand IBD into the North Patrol region to serve the communities of Lancaster (IBD station) and Palmdale (control). In comparison to the southern region of the county, the Antelope Valley is very isolated and resource sparse. At this point in implementation, the region accounted for about 30% of all mental health calls for service in the county. However, in late 2020, a new urgent care facility opened, expediting the time it took MET teams to divert individuals to services. Additionally, the deputy district attorney who served the Antelope Valley at the time was receptive to using IBD pre-filing.

MET spent the end of 2020 briefing staff in North Patrol to prepare for IBD expansion, which launched in January 2021. They continued collaborating with prosecutors and auditing booking data to inform the timing of targeted briefings. Although MET prioritized building buy-in among station staff rather than introducing mandates, they initiated the process of including IBD in LASD's official policy guide. This would enable recourse in response to staff who were noncompliant with IBD protocols. However, the threats to implementation described below derailed this process.

Threats to Implementation 2020

IBD evolved to respond to the challenges created by shifts in booking practices associated with the COVID-19 emergency bail schedule. However, two additional events disrupted IBD implementation in Spring 2021:

- **Competing Programming** Capitalizing on conversations related to the need to minimize the footprint of law enforcement and elevate community-based programming, the county's Alternatives to Incarceration workgroup under the *Care First, Jail Last* initiative launched its own pre-filing diversion program in 2021 (Gilliam et al. 2022). Referred to as JCOD-ATI, the pre-filing program was intended to have a staggered rollout in ten LASD and Los Angeles Police Department stations in 2021, including one IBD implementation station (Lancaster). The target population, identification process, and programming were nearly identical to IBD, with two major exceptions (see Appendix D). First, rather than relying on law enforcement, the county would contract with a social service agency that would staff a civilian clinician to conduct assessments 24/7 in the

station whereas MET would have to dispatch an available co-response team. Second, prosecutors were required to sign off on the decision to divert cases; IBD only did so if the prosecutor referred directly to the program. MET struggled to reconcile how the two programs could co-exist, especially considering JCOD-ATI was better resourced than MET. In response to this challenge, MET decided to concentrate IBD on diversions in the field rather than compete for cases with JCOD-ATI at the point of booking. Ultimately, like the IBD challenges described further in Chapter 5, the voluntary nature of the new pre-filing diversion program led to low enrollment, and JCOD-ATI largely ceased operation in 2024.

- **MET Turnover** During the same period, the lieutenant who championed IBD was promoted and transferred from MET. MET attempted to sustain contact with the research team, but there continued to be a significant turnover in staff with historical and programmatic IBD knowledge. MET experienced challenges in staffing a permanent lieutenant until fall 2023.

As a result, IBD screening protocols fell dormant through 2022; the only cases screened came through direct referrals from the prosecutors during this time. Interviewees estimated that 17 cases (all originating out of the East Patrol stations) were referred by prosecutors for pre-filing diversion. Aside from the cases diverted by RAMP as a test back in 2019, interviewees recalled that no IBD cases were diverted at the point of booking due to the lingering impact of the pandemic.

Implementation of the 2024 IBD Pilot

In the summer of 2023, the original project champion reconnected with the research team and MET in his new assignment as a commander with oversight of the jail population at the Inmate Reception Center as he saw an opportunity to relaunch the IBD pilot. Through his participation in JCOD, he noted efforts to document community-based diversion options available in the county for the purposes of improving coordination and collaboration across agencies (Appendix D). In essence, JCOD was actively working to avoid repeating what had happened with JCOD-ATI and IBD (duplicating diversion at the same intercept point). Further, JCOD sought to build more cross-agency approaches that tailored diversion to each case. The commander briefed current MET staff on the history of IBD and the opportunity created by JCOD. The process re-established the research-practice partnership with the new MET lieutenant and a sergeant who would oversee IBD.

The commander was also interested in exploring whether IBD could be moved from the stations to the Inmate Reception Center, which serves as the jail system's main intake and processing facility. After an individual is booked at the local station, they are transported to the facility for further mental health screening and classification before arraignment. As demonstrated in the timeline included in Appendix A, conditions for individuals with mental

Table 3.1. LASD Stations Included in 2024 Pilot

Patrol Region	IBD	Control
East	Industry	San Dimas + Walnut/Diamond Bar
South	Lakewood	Norwalk + Pico Rivera + Lomita
Central	Initial: East Los Angeles Final: East Los Angeles + Compton	Initial: Century Final: Century + South Los Angeles
North	Initial: Lancaster Final: Lancaster + Palmdale	Initial: Palmdale Final: Santa Clarita

Note: East Los Angeles opted out of IBD during the first month of the 2024 pilot, prompting MET to add Compton as an IBD station. Lancaster and Palmdale were also combined to increase volume.

health disorders at the Inmate Reception Center had been the subject of several recent lawsuits, reflecting a pressing need to create off-ramps to treatment. Indeed, on the day we conducted an observation of the Inmate Reception Center in April 2024, the medical staff was so overwhelmed by mental health assessments that the facility was effectively closed, causing detained individuals to linger in local station jails.

Planning 2024

Site Selection 2024 The migration of the booking forms from paper to the Automated Booking System played a pivotal role in guiding the selection of new IBD implementation stations. Between 2020 and mid-2023, 5,252 individuals were flagged as potentially eligible for IBD based on mental health screening at the point of booking, and 60% (n = 3,152) went on to be processed at the Inmate Reception Center.[9] This demonstrated an ongoing need for IBD and enabled MET to identify stations that could generate high volume. However, compared to the original 2020 pilot, rather than relying on stations that already had buy-in

[9] Email communication between Principal Investigator and IBD point of contact dated 9/5/23.

from leadership or acknowledged the need for a targeted intervention, MET had to conduct direct outreach to the IBD implementation stations listed in Table 3.1.

Staffing 2024 MET teams and RAMP staff could no longer support IBD operations given the ever-increasing mental health calls for service and hiring challenges at LASD and the Department of Mental Health. In a significant departure from the original model, IBD would be supported by a MET sergeant overseeing three MET deputies (herein referred to as the IBD sergeant and IBD deputies) in carrying out the assessment and case management. One deputy would support North Patrol while two deputies in the south would each have a designated station and share coverage of the fourth station. A clinical supervisor from the Department of Mental Health would support the program by 1) verifying mental health history for the IBD deputies during the assessment via their triage desk staffing and 2) providing treatment linkages for IBD participants. See Appenidx C and Chapter 2, Figure 2.2 for differences in staffing and processes from 2020 to 2024.

In selecting the three deputies, the IBD sergeant considered who had both demonstrated success in diverting people in the field and the interpersonal skills to engage with a variety of parties, including watch commanders, lieutenants, station jail staff, detectives, and individuals with mental health disorders. The IBD deputies were given two weeks' notice that they would be pulled from their MET team to support IBD. In addition to training on IBD protocols, they received basic investigative training to understand the mechanisms for holding a case or filing charges if someone was noncompliant. This strategic move also ensured that IBD deputies could speak knowledgeably to detectives concerned that holding a case would impact their investigation.

Training 2024 The training approach was largely the same as the 2020 pilot. The IBD sergeant spent late 2023 visiting implementation stations to explain the upcoming pilot to station administrators. Then, IBD staff worked with station administrators to convene three targeted briefings at each station to raise awareness and allow staff to ask questions. The IBD deputies briefed patrol deputies, while the IBD sergeant briefed the watch commanders and detectives separately. All implementation stations were onboarded by January 2024.

Additional Changes to the IBD Model 2024 The feedback from station staff during these briefings informed two additional changes to the original IBD model: 1) victims needed to agree to the diversion, and 2) if a person completed IBD but was re-arrested within the statute of limitations, the diverted charge could be filed alongside the new charge (Appendix C).

The rationale for these changes was rooted in the bail reform implemented in the county in October 2023. The Pre-Arraignment Release Protocols (see Appendix A) broadened the COVID-19 era policies by eliminating cash bail for most misdemeanors and certain non-violent felonies (Sloan et al. 2024). Instead, most individuals are cited and released or assigned non-financial conditions of release rather than being booked at a station. Once again, IBD was impacted—these changes meant that most cases never touch a booking facility; those that do likely face charges that render them ineligible for the program.

Implementation 2024

IBD was relaunched on February 12, 2024. MET's approach to implementation focused on saturating each station with information about IBD during the first three months. To do so, IBD deputies maintained a physical presence at each station during their shifts to reinforce briefing messaging and encourage one-on-one engagement with those who inform diversion decisions. Like the 2020 pilot, MET focused on gaining buy-in for the program from the bottom up, rather than imposing a top-down mandate.

This implementation approach allowed the IBD deputies to observe individuals in custody directly. As with the 2020 pilot, IBD staff noticed fewer notifications than expected being made to the triage desk and theorized it had to do with the nature of the behavioral health screener. The five questions that trigger a mental health flag are only useful if (1) patrol deputies and station jail staff complete them with fidelity and (2) the arrested individual willingly discloses. For example, an individual might not flag during the initial booking, but they could decompensate as they await transfer to the Inmate Reception Center, which can take up to 48 hours. Given their specialized training, the IBD deputies could not only divert people via IBD but identify those who required a 72-hour emergency hospitalization (known in California as a 5150 hold) before they made it to the Inmate Reception Center and then potentially onto the Twin Towers Correctional Facility.

Within the first two weeks of implementation, 18 of the 19 individuals screened for IBD were not diverted. IBD deputies estimated that assessments took two to four hours due to required navigation across multiple decision-makers. MET used a spreadsheet to document the outcome of each case screened for IBD, including the presence of disqualifying charges, 5150 holds, or specific parties opposing the diversion. At this point in implementation, the most common reason was the individual declining the program and opting for charges to be filed (n = 6). These challenges will be expanded upon in Chapter 5.

After the first month of the 2024 pilot, there were only two program enrollees. At the same time, the implementation stations shifted. East Los Angeles dropped out of the pilot, prompting MET to approach Compton and Century stations in the Central Patrol region, based on their potential case volume and use of the same booking facility. However, Century opted not to move forward.[10] In North Patrol, Palmdale shifted from a control station to an implementation station to increase IBD volume. IBD deputies also screened the reports of cases cited in the field and conducted outreach using the contact information on the citation. However, most referrals still stemmed from the presence of IBD deputies in the booking stations.

The IBD deputies screened 96 individuals for the program and enrolled only six over the ten-month period. We will expand upon this in Chapter 4, but the most common reasons for disqualification were charge exclusion (n = 31), 5150 hold (n = 26), and the individual refusing services (n = 20). IBD deputies conducted follow-ups for the individuals placed on 5150 holds to see if they would be interested in the program following their hold. However, most declined or could not knowingly and willingly opt into the program.

Due to the lack of program enrollment, the IBD deputies were pulled back into their regular MET team assignments. They maintained contact with their respective stations if there was a lull in MET calls for service. The number of IBD assessments decreased, with the majority originating from Industry and Lakewood. By the end of 2024, the program was only active in these two stations, with no additional assessments conducted. In early 2025, the IBD sergeant was transferred out of MET and the program once again became dormant.

The IBD sergeant engaged with a judge and prosecutor involved in court-based mental health diversion programs throughout planning and implementation. The goal was to align IBD's criteria with what was being applied by the courts under PC § 1001.36 and to distill lessons learned from more established programs. MET ultimately wanted to explore opportunities for court-based programs to refer cases to IBD, similar to what occurred during the 2020 pilot. However, a formal partnership did not materialize prior to the IBD sergeant's departure.

Case Management 2024 Once an individual enrolled in the program, a clinical supervisor from the Department of Mental Health coordinated their referral to an outpatient treatment facility. IBD deputies secured the participant's release from the station, arranged additional resources (e.g., public transportation vouchers), assessed social support (e.g., family), and

[10] The station had recently been involved in a juvenile diversion program where instances of program participants' re-arrest gave them pause about engaging in a new diversion program.

clarified next steps. During the first two weeks of the program, IBD deputies communicated regularly with participants about program requirements. They ensured a formal connection to the service provider, given one of the lessons learned from the court-based diversion programs is that a warm handoff is required to build trust and facilitate treatment engagement. IBD deputies secured medical releases to ensure they could receive updates on treatment compliance without encountering HIPAA challenges later in the process.

While community-based providers developed and executed a treatment plan, IBD deputies maintained regular check-ins with the six participants via text messages, phone calls, and home visits. Deputies described these check-ins as informal and focused on identifying how they could support the participant. One IBD deputy described how they used these opportunities to build a relationship with participants. “I’m a cop, but I’m not here to arrest you. I’m here to help you; if you ever need to call me, call me. If you have any questions, you need a ride to your appointment—if I can get you there, I will get you there.” Another IBD deputy highlighted that even given instances of non-compliance, participants were given opportunities to reengage rather than facing immediate termination. “I feel having a deputy checking in on you has a different weight . . . If you’re not answering the phone and I can’t find you, I will go look at the places that you like to hang out to see where you’re at to make sure that you’re okay and check-in.”

Throughout this process, IBD deputies updated the detective assigned to the case. Once the participant completed 45 to 90 days of the program, IBD deputies filed their report with the detective. Treatment providers could recommend that an individual stay engaged in treatment for longer, but they would no longer be monitored by the IBD program.

Chapter 4

Descriptive Analysis of IBD and Comparison Cases

To develop a better understanding of the IBD program, we leverage several administrative data sources to examine cases during the 2024 IBD pilot period. We explore the composition and outcomes associated with cases screened by MET in IBD implementation stations compared to cases drawn from similar stations in the same patrol district[11] that generated a mental health flag during booking.

As noted in Chapter 1, this project was originally conceptualized as an evaluation that would enable us to estimate the causal effect of the IBD program. However, given the limited scale of the pilot, we cannot speak to program efficacy. Instead, we present descriptive analysis where we describe how key variables are associated with one another to gain insight into the population reached by IBD.

Data Sources and Study Sample

As described in Chapter 1, our analysis uses data linked across three data sources: (1) the IBD tracker maintained by MET to log cases screened for the program; (2) the MET database, which contains the universe of cases with MET contact; and (3) administrative jail data sources (AJIS and the Inmate Report Tracking System) that contain jail bookings and custodial violations. We examine data pulled from the MET database from 2019 to 2025 and from AJIS from February 2021 to April 2025, allowing for calculations of prior jail bookings or MET contact for three years prior to the 2024 rollout.

Altogether, the sample includes 420 cases (102 IBD screened cases and 318 comparison cases). Most of these cases originated from either North (34%) or East (30%) Patrol districts, with fewer cases coming from Central (20%) or South (16%) Patrol districts.[12] The distribution of cases screened for IBD was similar to the overall distribution.[13] However, our

[11] A patrol district is a larger organizational unit that contains multiple stations.

[12] Comparison stations that had a low volume of cases were excluded for privacy reasons.

[13] Most of the screened cases were concentrated in the North Patrol (n = 30), followed by South (n = 27), Central (n = 25), and East (n = 20) Patrol districts.

approach will yield different analysis-specific sample compositions, which we describe in more detail throughout this chapter.

Data Limitations

In terms of missing data, demographic information is missing for about 3% of cases at similar rates for the IBD screened and comparison cases. Charge information is missing for 9% of cases (11% for comparison cases and 5% for IBD screened cases). A larger data limitation is that 16% of cases in the sample are missing an associated jail booking. We cannot distinguish whether the cases were never booked or the data is missing. This is primarily concentrated in the cases screened for IBD (33%) relative to comparison cases (10%). In consultation with MET, we identified several potential explanations for the missing booking number. First, if a case was screened by IBD deputies and placed on a 5150 hold (n=26), station jail staff may have halted the booking process as the individual was diverted from the station to a hospital for a 72-hour emergency hold. Second, the missing data could be driven by manual data entry errors at the MET triage desk during remote consultation with station jail staff. Finally, there may be instances in which station jail staff connected with the MET triage desk before a booking number was assigned.

This leads to one key limitation: it is not possible to calculate prior or future jail bookings for cases without a booking number. Additionally, these cases are less likely to have information on their offense severity (i.e., felony or misdemeanor). To determine the top charge for cases with multiple charges, we use California's Department of Justice hierarchy ranking.[14] For charges missing their offense severity that can be charged as either a felony or a misdemeanor, we assign the charge's misdemeanor hierarchy ranking.

Descriptive Comparison of IBD Screened Cases and Comparison Cases

We begin with an exploration of those cases screened by IBD deputies relative to those identified with a mental health flag in comparison stations. As depicted in Table 4.1, the two groups of cases share similar demographics but differ in terms of the top charge using the hierarchy ranking. Roughly two-thirds of individuals for these cases are males, and the average age is 36. Both groups are predominantly Black and Hispanic, with a quarter or less

[14] California's DOJ provides a hierarch ranking number where lower numbers indicate a higher level of seriousness. These rankings can be found here.

of cases involving white individuals. IBD screened cases are more likely to involve assault (25% vs 11%) and public order offense (22% vs 13%) charges, while comparison cases are more likely to include domestic violence (19% versus 8%) and property offenses (8% versus 4%) charges.

Table 4.1. Demographic and Instant Case Characteristics, IBD Screened and Comparison Group

	All Cases	Comparison Group	IBD Screened	IBD Participants	IBD Disqualified
N	420	318	102	6	96
Demographics					
Sex[1]					
Male	68%	68%	69%	67%	69%
Female	29%	29%	31%	33%	31%
Average Age	36.1	36.1	36.1	35.2	36.1
Race[2]					
Black	23%	21%	31%	0%	33%
Hispanic	44%	45%	41%	50%	41%
White	24%	24%	22%	0%	23%
Other	6%	6%	6%	50%	3%
Instant Case Characteristics					
Missing Booking	16%	10%	33%	33%	33%
Top Charge Severity[3]					
Felony	46%	49%	35%	17%	37%
Misdemeanor	37%	40%	31%	50%	30%
Top Charge Type[4]					
Domestic Violence	16%	19%	8%	0%	8%
Assault	15%	11%	25%	17%	25%
Public Order	15%	13%	22%	33%	21%
Property	7%	8%	4%	0%	4%
Burglary	4%	4%	4%	0%	4%
Controlled Substance	4%	4%	5%	0%	5%
DUI/Suspended License	4%	4%	4%	0%	4%
Robbery	3%	3%	3%	0%	3%
Weapons	2%	3%	0%	0%	0%
Murder/Manslaughter	1%	2%	0%	0%	0%
Sex Offense	1%	2%	0%	0%	0%
Other	11%	10%	15%	33%	14%

[1] Sex is missing for 2.6% of all individuals.

[2] Race is missing for 3.1% of all individuals.

[3] Charge severity is missing for 15.7% of all individuals.

[4] Charge type is missing or unknown for 16.7% of all individuals.

[5] Demographic information is missing for about 3% of cases at similar rates for the IBD screened and comparison cases. Charge information is missing for 9% of cases (11% for comparison cases and 5% for IBD screened cases).

When restricting the sample to those cases with jail bookings where it is possible to calculate three-year criminal history measures (Tables 4.2, 4.4), both groups have at least one prior felony booking in approximately 40% of cases and at least one prior misdemeanor booking in a little under half of cases. Comparison cases have an average of 3.1 prior jail bookings, compared to 2.4 jail bookings for IBD-screened cases. They also have similar rates of prior MET contact, around 30%. In short, both groups are quite similar except for differences in the top charge.

Table 4.2. Criminal and MET History and Recidivism, IBD Screened and Comparison Group

	All Cases	Comparison Group	IBD Screened	IBD Participants	IBD Disqualified
N	351	284	67	4	63
Prior Criminal History[1]					
Average Prior Bookings	3.0	3.1	2.4	0	2.6
Any Prior Booking	59%	59%	63%	0%	67%
Felony Prior Booking	38%	38%	40%	0%	43%
Misdemeanor Prior Booking	47%	47%	49%	0%	52%
Prior MET Contact[1]					
Average Prior MET Contacts	0.7	0.7	0.6	0.5	0.6
Had Prior MET Contact	29%	30%	28%	25%	29%
Recidivism					
Subsequent MET Contact[2]	10%	9%	15%	0%	16%
Custodial Violation (Physical)	7%	7%	6%	0%	6%
Future Jail Booking					
3 Months	22%	22%	22%	0%	23%
6 Months	33%	32%	38%	25%	38%

[1] 3 years
[2] 3 months

IBD Screening, Participation, and Disqualification

Next, we focus on the subset of cases screened by IBD deputies. As discussed in Chapter 3, only six individuals participated in IBD, with most of the 102 screened individuals disqualified from the program. As depicted in Table 4.3, almost a third of screened individuals were disqualified due to the nature of their offense. Over a quarter of cases were determined by the IBD deputies to be in an altered mental state and placed under an involuntary hold requiring a psychiatric evaluation (5150 hold). Approximately 2 out of 5

cases were disqualified due to patient,[15] detective, watch commander, or victim refusal. Although the sample is limited due to the missing jail booking data, Table 4.4 provides some insight into past and future legal system contact, with a few trends of note:

- **Participants versus Disqualified Individuals** IBD participants had no prior jail bookings, while disqualified individuals had prior bookings. Participants were more likely to be charged with misdemeanor offenses (versus felonies), indicating that the population entering the IBD program may have been lower risk of recidivating (Table 4.4).

- **5150 Hold Disqualification** The majority of IBD screened cases disqualified due to 5150 holds were missing jail bookings (89%). The lack of a booking number suggests that the IBD screening process may have resulted in some individuals with mental health disorders avoiding jail booking altogether, instead being transferred to a mental health facility (Table 4.3).

- **Detective Refusals** Although detective refusals were limited (n = 13), hindering our ability to draw concrete conclusions, they occurred most frequently in felony cases and assaults. Nearly two-thirds of these cases had a prior booking, suggesting that criminal history may have factored into the decision (Table 4.3 & 4.4).

- **Patient Refusals** Patient refusals most frequently occurred in misdemeanor cases. Over three-quarters of patients who refused to participate in IBD had a jail booking within the past three years and about a third had prior MET contact (Table 4.4).

[15] MET teams refer to the individuals they screen for mental health as patients. To reflect consistency with MET's data tracking system, we will use that term in this chapter to reflect individuals who declined to engage in diversion.

Table 4.3. IBD Ineligible Cases: Offense Exclusions and 5150 Holds Drive IBD Disqualification

	5150	Detective Refusal	Victim Refusal	Patient Refusal	Watch Commander Refusal	Offense Exclusion
N	26	13	3	20	3	31
Demographics						
Sex[1]						
Male	62%	85%	100%	50%	67%	77%
Female	39%	15%	0%	50%	33%	23%
Average Age	35.2	38.0	31.3	37.3	36.0	37.3
Race[2]						
Black	31%	46%	33%	35%	0%	29%
Hispanic	54%	31%	33%	25%	100%	42%
White	12%	15%	33%	35%	0%	29%
Other	4%	8%	0%	5%	0%	0%
Instant Case Characteristics						
Missing Booking	89%	0%	33%	15%	0%	13%
Top Charge Severity[3]						
Felony	8%	77%	33%	35%	100%	42%
Misdemeanor	4%	23%	33%	50%	0%	45%
Top Charge Type[4]						
Domestic Violence	0%	0%	0%	0%	0%	26%
Assault	27%	39%	67%	30%	33%	13%
Public Order	42%	15%	0%	35%	0%	0%
Property	4%	8%	33%	0%	0%	3%
Burglary	4%	0%	0%	15%	0%	0%
Controlled Substance	0%	15%	0%	5%	67%	0%
DUI/Suspended License	0%	0%	0%	0%	0%	13%
Robbery	0%	8%	0%	0%	0%	7%
Weapons	0%	0%	0%	0%	0%	0%
Murder/Manslaughter	0%	0%	0%	0%	0%	0%
Sex Offense	0%	0%	0%	0%	0%	0%
Other	8%	15%	0%	5%	0%	29%

[1] Sex is missing for 0% of IBD screened individuals. Sex may does not equal 100% due to rounding.

[2] Race is missing for 0% of IBD screened individuals. Race may does not equal 100% due to rounding.

[3] Charge severity is missing for 33.3% of IBD screened individuals.

[4] Charge type is missing or unknown for 10.8% of IBD screened individuals.

Table 4.4. IBD Ineligible Cases: Comparison of Prior History and Recidivism by Disqualifier

	5150	Detective Refusal	Victim Refusal	Patient Refusal	Watch Commander Refusal	Offense Exclusion
N	3	13	2	17	3	26
Prior Criminal History[1]						
Average Prior Bookings	0.3	3.3	1.5	2.6	3	2.4
Any Prior Booking	33%	62%	50%	77%	100%	62%
Felony Prior Booking	0%	46%	50%	35%	100%	42%
Misdemeanor Prior Booking	33%	46%	50%	71%	33%	46%
Prior MET Contact[1]						
Average Prior MET Contacts	1	0.4	0	0.8	0.3	0.6
Had Prior MET Contact	33%	31%	0%	29%	33%	27%
Recidivism						
Subsequent MET Contact[2]	33%	8%	50%	18%	0%	15%
Custodial Violation (Physical)	0%	8%	0%	0%	33%	8%
Future Jail Booking						
3 Months	33%	23%	50%	29%	0%	21%
6 Months	67%	46%	50%	47%	50%	25%

[1] 3 years
[2] 3 months

Jail Booking and Recidivism Analysis

Outcomes and Control Variables

Next, we examine how those screened for IBD and the comparison group vary across two sets of dichotomous outcomes (both coded as (0/1) indicators):

- **Jail Bookings** We examine whether an incident had an associated jail booking. Lack of a booking serves as a proxy for diversion away from the main jail facilities (understanding that the data quality limits the accuracy of this measure as the data may simply be missing). For those booked, we also examine the length of the jail stay.

- **Future Contact/Violations** We examine whether individuals had (a) a subsequent contact with MET within three months of their release date; (b) custodial violations for physical or fighting-related infractions during the jail stay; (c) future jail bookings within 3 or 6 months of their release date.

In all such exploratory analyses, we include a treatment variable (screened for IBD versus not screened) and control variables, including demographics (sex, race, and a categorical age

variable); charge severity and type; prior history within the past three years (any felony booking, any misdemeanor booking, any prior MET contact); and patrol district.

Across the analyses, the sample size and control variables vary due to data limitations noted earlier. For individuals with multiple cases, we retain their earliest case. For those with a case in both groups, we retain the IBD screened case (cases appearing in the comparison sample prior to the IBD screened case are considered criminal history; cases after the IBD screened case are considered future contact). For analyses on future contact, we restrict the sample to cases with booking numbers and release dates. Additionally, we limit the samples to those with at least 90 or 180 days from their release date to April 29, 2025, to provide ample follow-up time and prevent data censoring. The 90-day windows align with the case management and supervision that IBD participants would have received had they opted into the program (45-90 days). For custodial violations, we restrict the sample to cases with jail bookings.

Analytic Approach

Our analytic approach involves using two sets of regression models to estimate the association between IBD screening and the outcomes noted above.

OLS Regression This approach *partially* accounts for differences in case composition between the IBD-screened and comparison groups. This is carried out by including the treatment and control variables in a regression model to account for their associations with one another while estimating the outcome. One benefit is that this approach retains the full sample. However, the approach does not account for unobserved differences between the two groups.

Propensity Score Matching Plus OLS Regression Propensity score matching attempts to refine the treatment and comparison samples by applying an algorithm to ensure the two groups are balanced across observed characteristics *before* running an OLS regression. We apply nearest neighbor 1:1 matching using the control described above. If a proper match is not available for the IBD screened case, it is dropped from the analysis. Consequently, the samples for the matching analysis are generally smaller. This approach is most effective when there are an extensive number of control variables to match on to minimize the differences in case characteristics where we have data on between the two groups, which might be related to outcomes. In the current study, we have a limited number of control variables available. While this technique can reduce confounding, it is possible

that there continue to be unobserved differences between the two groups that bias the estimates.

We present the findings of the OLS regression first and treat the matching analysis as a secondary check to estimate whether individuals had (a) a subsequent contact with MET within three months of their release date; (b) custodial violations for physical or fighting-related infractions during the jail stay; (c) future jail bookings within 3 months or 6 months of their release date. Missing values for demographics and charges are included as covariates that are controlled for or matched on. The matched process yielded a balanced sample with minimal differences on observed covariates between the cases screened by IBD and comparison cases. With nearest neighbor matching, the standardized mean difference for overall distance between the two groups is 0.14 for the jail booking analysis and 0.09 for the future MET contact/recidivism analysis, with no standardized difference for any covariate rising above the 0.20 threshold (Austin, 2008). Across both approaches, there may still be unobserved confounders or differences between the two groups. As such, we interpret these results as associations rather than causal effects. Please see Appendix E and F for more details on sample balance.

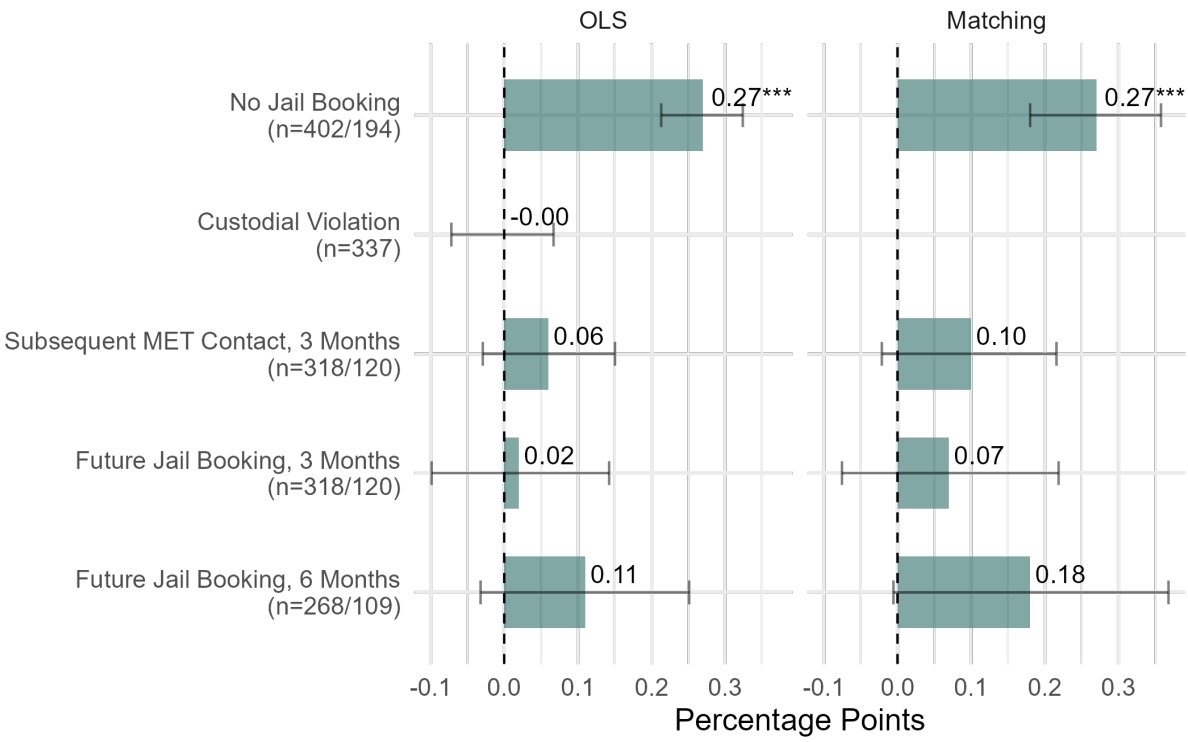
Findings

The OLS estimates (Appendix G and H) show that IBD screening is associated with a 26.9 percentage point increase in remaining out of jail. The remaining estimates show non-significant differences. The results with the matched sample are similar with non-significant differences in future recidivism but a significantly lower likelihood of being booked into jail. General takeaways from our analysis include:

- Controlling for different case attributes, IBD screened cases are less likely to be booked into jail (Figure 4.1). We base this on the observation that IBD diverted a number of individuals from jail to a hospital for a 5150 hold. Therefore, a missing jail booking is treated as a proxy for diversion in our data sample.
- Those screened for IBD were no more (or less) likely to have a new jail booking within the three- or six-month follow-up periods. This finding was consistent across both approaches (OLS and matching).
- Among those booked, length of time in jail was similar for those screened for IBD and the comparison group (Figure 4.2).
- Those screened for IBD and the comparison group show no significant differences in violations for infractions involving fighting while detained. However, these types of infractions are infrequent, and the lack of statistical significance could be a product of

the outcome variable being a rare occurrence. The low frequency of this outcome makes it impossible to examine this outcome in the matched analysis.

Figure 4.1. IBD Screening is Associated with Diversion from Jail



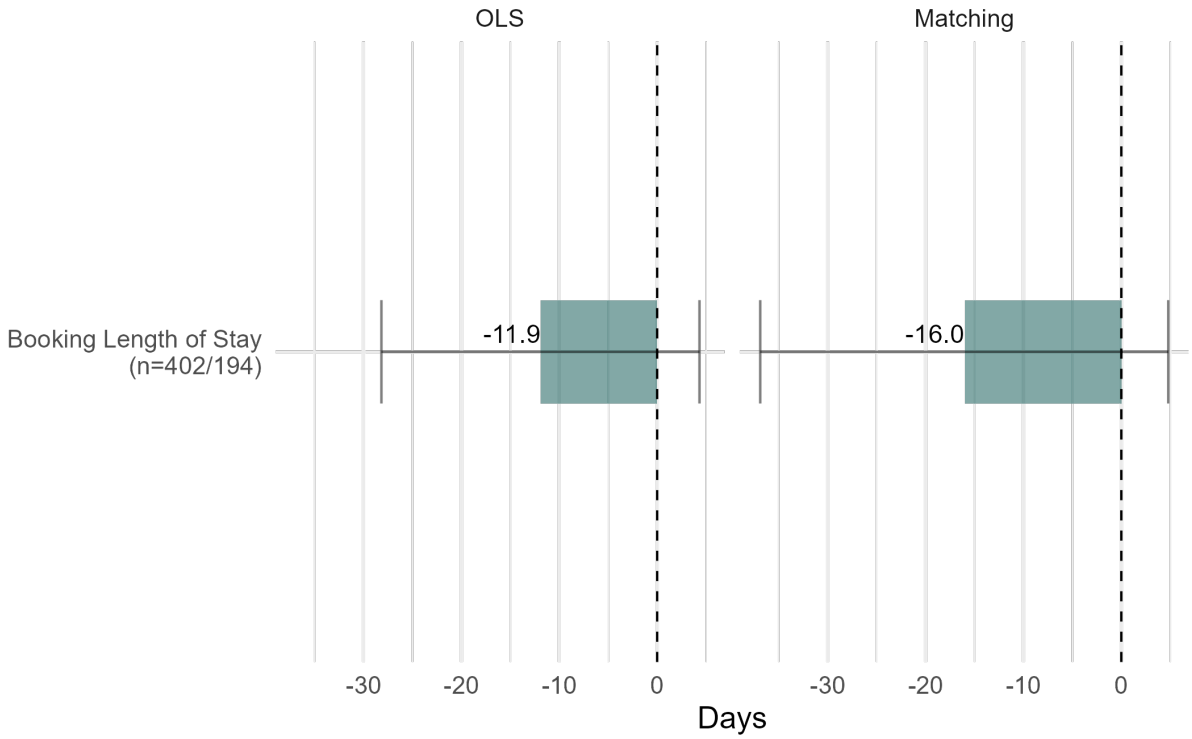
Note: Custodial violations are restricted to major infractions involving fighting. Due to the low frequency of this event, the matching process drops cases in the IBD group that have these types of custodial violations leading to no estimates for the matching analysis. For the jail booking regressions, we assume that missing jail booking data is a proxy for diversion away from jail.

With the low IBD participation rates and eligibility criteria restricting the program to those with essentially no prior history and low-level offenses, it is not surprising that our analyses suggest no reductions in recidivism. Moreover, given the three-year lookback criminal history (see Table 4.2), the individuals in the sample were being booked an average of one time per year, so the recidivism period of only up to six-months may not have been sufficient time to expect to see many new bookings for most in the sample.

Yet, IBD screening did appear to alter the trajectory of cases and identify where a 5150 hold may be more appropriate than jail detention. In this sense, the 2024 IBD pilot may be seen as a net benefit if it accurately screens individuals with mental health disorders and continues to nudge them towards more appropriate venues. The lack of IBD participants makes it unclear whether the program conditions are more effective than the status quo, especially given

substantial differences in case composition and the potential unobserved differences that were flagged during interviews. However, it is also possible that the high rate of missing jail bookings for cases with a 5150 hold were due to actual missing data. Under this interpretation, we would likely observe no differences in jail booking rates. In addition, cases without jail booking data were dropped from the recidivism analysis due to the lack of recidivism data; if these cases screened by IBD with 5150 holds have higher risk levels, the regressions are potentially underestimating the differences in recidivism between the two groups, assuming the comparison group has the same case composition.

Figure 4.2. Length of Stay is Similar for Both Groups



Chapter 5
Strengths and Challenges

In this chapter, we present the strengths and challenges that interviewees identified during the 2020 and 2024 IBD pilot periods. We discuss these in relation to both LA County context and the existent research on specialized police responses to mental health disorders. We will expand upon these observations in lessons learned from implementation in Chapter 6.

Strengths

MET's Commitment to Innovation

In response to challenges—many beyond LASD control—MET has adapted dynamic programming. As described in Chapter 2, MET has steadily grown since the unit's inception as a co-responder pilot program in 1991. Interviewees described how this has coincided with ever increasing crisis calls for service and stagnant staffing of both law enforcement and clinical staff. Nevertheless, interviewees expressed that the unit is committed to exploring opportunities to improve their response to individuals in crisis.

IBD operates as part of a broader vision for improving responses for those with mental health disorders. Interviewees articulated that even though MET teams, RAMP, and IBD are all serving different populations, the activities complement one another. For example, interviewees noted that IBD could benefit RAMP in a preventive capacity by providing service linkages to individuals at a point where their symptoms and alleged crimes have yet to escalate to the point of needing RAMP's more intensive approach. In contrast, an arrest is the triggering event for IBD, whereas interviewees noted that many MET calls for service rarely result in an arrest. As one interviewee noted, the different programmatic components require different decision making on the part of MET deputies, but their specialized training positions them to consider whether there is a nexus between an individual's mental health disorder and the alleged crime. "You have to determine whether or not mental health played a factor in what happened and that's interpretive, right? Because I can't say for 100% certainty that [the mental health disorder is] why, but I can say what it sounded like and what it seemed like and how they present in the jail."

The approach developed as one mechanism for identifying mental health indicators early on. The value of the MET triage desk gathering information on mental

health needs at the point of system entry should not be understated. As noted in Chapters 2 and 3, MET recognized an opportunity during LASD's shift to electronic booking forms and worked with programmers to require station jail staff to contact the MET triage desk if someone flagged for mental health at the point of booking to initiate a MET response. This forward thinking enabled MET to identify individuals during the earliest stage of case processing, which has the potential to inform subsequent decision making related to diversion opportunities.

Designated IBD Staffing

IBD deputies embedded in stations made crucial connections for keeping programming top-of-mind. Under the original IBD model, MET teams were envisioned as responding to IBD calls for service. However, MET staffing shortages during the 2024 relaunch meant that the program was overseen by a sergeant and implemented by three deputies embedded in implementation stations. Interviewees expressed that embedding the IBD deputies within their respective stations was key to identifying potential cases, building trust with station staff, and maintaining awareness of the program. The engagement efforts of the sergeant and IBD deputies created opportunities to regularly reinforce messaging during briefings tailored to specific audiences (e.g., deputies, watch commanders, detectives) and allowed for one-on-one interactions, which helped IBD deputies to understand station staff concerns. Station jail staff and watch commanders in IBD implementation stations spoke at length about the IBD deputies being the reason why they knew of the program. Some maintained that the program would not continue without the IBD deputies present at the station.

IBD deputies benefited from specialized training. Related, the IBD staffing structure allowed MET to provide additional training for the IBD deputies, which would be a challenge if staffing was decentralized. The IBD deputies received basic investigator training, which taught them about diversion referral considerations detectives would have. "Knowing what you have to deal with helps me help you deal with it." One interviewee felt it was a starting point to clarifying roles and responsibilities. "The detective still has to investigate the whole case …We're not detectives. We are MET deputies … Detectives are not trained in mental health either. So, we all have our specialties."

Understanding of Program Goals

LASD staff consistently understood the goals of IBD. Regardless of rank or assignment, LASD staff saw the program as an opportunity to provide an alternative to pretrial detention by linking individuals with a mental health disorder to community-based

treatment. Many spoke of IBD as an "option" or an "opportunity" for the individual to get connected to services that address the needs that brought them into contact with the criminal legal system.

Shared Belief that IBD has Potential

IBD can benefit individuals with mental health needs at a critical early stage.

Interviewees expressed the value of IBD as an early diversion model that minimized the collateral consequences of a conviction and did not involve the same intensive services or supervision associated with court-based diversion programs. One interviewee emphasized the value of the sequential intercept model and having different options across the case continuum to tailor diversion to the individual.[16] "I think that there are sometimes some people that respond well to court supervision . . . I don't think it's a model we should grow any more than necessary. And I think if there's a way to link someone to services and keep them out of jail and keep them out of court altogether, I think that is a huge win."

IBD can benefit communities. Some interviewees described how treatment rather than pretrial detention can potentially increase public safety. For example, IBD was described as a resource for family members who want to see their loved ones get treatment instead of going to jail. Others described how jails are ill-equipped to provide care and that such approaches ultimately undermine the safety and wellness of deputies and patients. "Like in all reality you shouldn't have deputies monitoring mentally ill people. It should be a hospital. . . not jail cells and locked up—that just makes it worse . . . You shouldn't have deputies because we're cops and that's when you get [use of] force and you get all these things."

IBD can benefit law enforcement. Interviewees also identified benefits for law enforcement, including potentially lessening workloads, increasing morale and officer safety, and minimizing the potential for the use of force.

[16] The sequential intercept model maps how individuals with mental health disorders move through the legal system and opportunities for off-ramps from jail and prison. The model defines several intercept points (preventive community services, law enforcement, initial appearance, jails/courts, reentry, community corrections) to allow jurisdictions to better understand the interventions and resources available across the system (Steadman et al., 2009).

Challenges

MET Resources

IBD could benefit from additional investment in staffing and infrastructure.

Although MET has expanded their programming over time, MET staff were clear that the unit's primary function is to respond to crisis calls for service and that is where the resources are concentrated. If IBD is to expand beyond a pilot, MET will need additional resources to ensure they do not undermine existing operations. "We know how to deal with crisis, right? I don't think we have the personnel or resources to really deal with IBD type of cases." One interviewee discussed how RAMP provides a strong foundation for building out IBD case management, but it must be done in such a manner that it would not compromise existing RAMP operations. Others described how MET has outgrown the in-house database that the triage desk relies upon and needs something more robust to enable data-driven decision-making.

IBD needs to build on and expand existing relationships with service providers. MET has a long history of close collaboration with the Department of Mental Health and can access their vast network of providers for immediate service linkages. However, interviewees cautioned that MET would need to invest in building relationships with appropriate community-based providers who can support patients after IBD disengages with them. "We can't go continuously [providing services] … because we are here for the short-term, we are not for the long term."

Addressing Other Common Needs

Unhoused individuals are uniquely challenging to engage. The IBD deputies spoke of the willingness of detectives to refer cases involving unhoused individuals. However, this population presented unique challenges—such as maintaining communication with someone who is transient—that deputies were unable to resolve during implementation.

There is a need for immediate service linkages for those with complex or multi-pronged needs. IBD deputies also noted the challenges in creating immediate service linkages for unhoused individuals with co-occurring mental health and substance use needs. Interviewees contrasted these challenges with the court-based programming provided by the Office of Diversion and Reentry Housing program, which releases their unhoused participants with co-occurring disorders directly from jail to supportive housing. Interviewees noted that there must be careful consideration of resources and service networks for unhoused individuals or these individuals are unlikely to be successful. "If you're

unhoused, we need to have a house for you. Otherwise, there's really no point, because it's going to be a lot of failures and it's not their fault. You're not giving them the tools."

Residual Impacts of the COVID-19 Pandemic

The pandemic saw an increase in the severity of mental health crises, which is ongoing. Interviewees noted that pandemic-related disruptions to the behavioral health system were still impacting operations today. More specifically, they described how MET teams are engaging in the field with individuals who present with more severe mental illness than they did prior to the pandemic. "Something happened, and people are different than they were before COVID, and they're all meeting multiple criteria."

Increasing clinical needs are exacerbated by struggles to find and retain qualified clinical staff. The proliferation of hybrid outpatient treatment in the wake of the pandemic was identified as a factor impacting the Department of Mental Health's ability to hire clinicians. Some interviewees noted that clinicians now have more employment options that are less intense compared to working alongside law enforcement to provide crisis stabilization in the field. "It takes a certain type of individual to be a part of this team and commit to the cause of working with law enforcement." The Department of Mental Health has started to involve social work graduate students in MET's work to fill gaps and recruit new staff, but it will take time for these new strategies to yield a solution to the shortage of clinicians.

Implications of a Changing Policy Landscape

Increased use of cite and release means fewer eligible individuals booked. When IBD was originally developed, MET felt the real challenge would be providing a response to what they envisioned as a large volume of cases. However, the changes to the LA County bail schedule over the life of the project meant that many low-level charges originally envisioned as ideal targets for IBD were no longer subject to custodial booking. "There's potentially a whole population that's falling between the cracks because they're being cited out." While the increased use of citation does accomplish the goal of keeping those with mental health disorders out of jail, it does signal the need for an earlier intercept to fulfill the goal of treatment linkage.

Cases subject to custodial booking have shifted. Our descriptive analysis revealed that the most common disqualifier for IBD was charge ineligibility. Although disqualifications based on the opposition of watch commanders or detectives were less common, they frequently occurred in felony cases and specific offenses (assault and

burglary), likely those considered "too serious" for booking diversion. Additionally, most of these cases had a prior booking within the past three years, suggesting that even though IBD did not include criminal history as an explicit disqualifier, it may be shaping discretion. If MET were to scale up the program, they would need to examine the universe of cases moving through the stations and potentially reconsider the eligibility criteria.

Clarifying the Theory of Change

IBD yielded more emergency hospitalizations than diversion referrals. Only six individuals entered the IBD program, but IBD deputies diverted approximately four times that number from the station to hospitals via 5150 holds. We infer, based on the lack of a corresponding booking number, these cases were completely diverted away from the criminal legal system. The literature notes that emergency hospitalization is not always a solution to establishing long-term care linkages (Watson, Owens, et al. 2021; Watson et al. 2019). However, in this context, the 5150 holds accomplished one of IBD's goals—ensuring individuals were not transferred to the Inmate Reception Center to potentially be hospitalized in Twin Towers. This finding highlights a possible need to reconsider IBD's underlying theory of change. That is, instead of solely serving as a diversion program linking people away from jail and toward community-based services, IBD might be reconceptualized only as an extension of the crisis intervention work carried out in the field by MET teams or it could serve dual purposes. For example, one interviewee from an IBD station stated that they "look at IBD as another MET team helping us out."

Engagement in Diversion

A considerable number of people declined IBD. One challenge we heard from interviewees concerned the high rate of individuals refusing to enter the program and opting instead for charges to be filed. Our analysis shows that these refusals occurred most often in misdemeanor cases where the criminal histories were characterized by higher rates of prior misdemeanor (versus felony) bookings. About a third of these cases also had a prior contact with MET and approximately 18% had a subsequent MET contact within three months of IBD screening. Thus, the refusals are most frequent in instances involving low-level charges—the types of cases that IBD was originally designed to intercept. Although we lack details on the specific context associated with these cases or their dispositions, these individuals may know that the low-level nature of their charges could likely result in time served or cases being dismissed, creating less incentive to engage in diversion.

The intercept point may be too early for people to consider services. Some interviewees expressed that IBD's intercept point may be too early in the criminal legal process to get people to consider opting into a voluntary program, suggesting that there was more incentive for individuals to participate in court-based diversion programs because the legal leverage is higher at that stage, and they have consulted with an attorney. However, representatives from court-based diversion programs noted they are not immune from refusals, and it depends on the individual and case context. Thus, any of these diversion programs must reconcile with the reality that individuals may not be ready to engage in treatment, especially treatment offered via the criminal legal system, regardless of the legal benefits. "But there is a certain group of clients, I think less the ones that are not willing to do diversion. It's really more the ones who are not interested in treatment."

Lack of a Top-Down Directive

MET championed the program. IBD was a pilot program developed and implemented by MET—essentially an outside unit coming into select stations to promote an alternative to traditional policing practices.

> Obviously with our [pilot], we walked in, 'Hey, we're IBD. We want to divert your cases.' Well, [LASD station staff said] 'We don't know. We know nothing about you. We're, you know, leery of taking a perfectly good case and saying, here, take this, and then let's see what happens after all the work's been done.'

As described in Chapter 3, the initial pilot relied on MET working with a supportive chief in East Patrol. However, there were challenges that parallelled what we heard from interviewees during the 2024 relaunch that underscore the lack of a formalized policy endorsed by LASD leadership. "In order for [IBD] to function, it should have started with more collaboration with upper management in each station in order for it to be successful."

Securing buy-in from detectives proved challenging. One area where this challenge was most apparent was in working with detectives who were asked to hold IBD cases until the individual completed the program. This was particularly challenging in cases that involved non-family member victims because of concerns over losing witnesses and evidence. "If we hold [IBD cases] for two, three months while we're trying to help the individual, that case is sitting on their [the detective] desk. Then let's say the individual at the third month doesn't comply with everything. Now, [detectives] have to start fresh with the case."

The diversion process was labor intensive and time consuming. This lack of a top-down directive likely contributed to the time-consuming process associated with screening cases for IBD. The IBD deputies estimated it took them two to four hours on average to resolve an IBD call. In addition to addressing all the concerns of LASD staff, it took time to locate victims and discuss diversion as an option with them. As one interviewee noted, the decision-making process involved many steps, and if even one party disagreed, the process stops.

Culture Change

Alternatives to traditional policing take time to grow. Multiple interviewees noted that change does not happen overnight, particularly when an alternative approach to standard policing practice is introduced. As one interviewee noted, LASD patrol accepts MET as mental health experts, but it took years for the unit to establish that trust and credibility. Another interviewee noted that culture change takes time. "It's a cultural shift . . . I know there's one way of doing things and I have more control, versus now I'm relying on IBD to come in."

Culture varies by station. Additionally, interviewees described how the IBD implementation stations each had their own unique culture and noted stark differences between the north and south county. These differences included behavioral health resources, demographics, crime rates, and staff engagement with MET in a non-IBD capacity.

Chapter 6

Lessons Learned from Implementation

We conclude our implementation evaluation with a discussion of the lessons learned from the IBD pilot program. We also reflect upon our core findings to inform the potential expansion of IBD in LA County or other law enforcement agencies' adaptation of a booking diversion model.

Pilot Projects Do Not Always Go According to Plan

Programs can yield unexpected outcomes. IBD was originally envisioned as creating an off-ramp from jail to community-based services for a broad population of cases where there was a nexus between the alleged crime and an individual's mental health disorder. However, this goal was never fully realized due to significant shifts in the population driven by the COVID-19 pandemic and bail reform. In practice, the utility of IBD as a diversion program was extremely limited, having only diverted six cases characterized by lower-level charges, limited criminal histories, and situations involving familial support. While it is commendable to want to extend help in these cases, if IBD is focused on this limited population, it will not realize its larger goal of reducing the jail mental health population. However, where the program succeeded was the increased identification of individuals experiencing a mental health crisis prior to their transfer to the Inmate Reception Center—and transfer of these individuals to hospitals in lieu of booking—which undoubtedly has serious implications for the jail population.

Research is always evolving. As noted in Chapter 1, this study originally included a robust outcome evaluation that would allow us to estimate the effect of IBD on key outcomes. However, as IBD implementation was impacted, so was our ability to conduct a rigorous test of the IBD model. While we have produced an in-depth account of how the program shifted across five years and the characteristics of the cases screened relative to comparison cases, we caution that the quantitative findings presented in Chapter 4 do not represent a test of whether IBD "worked." Instead, they are a starting point to consider if IBD is ever to be scaled up across the county.

Design the Program Around the Target Population

Apply a data-driven approach to developing programming. At the time IBD was initially developed, LASD had not yet implemented the data infrastructure that would benefit

the 2024 relaunch (i.e., shifting from paper to electronic booking forms) and MET made assumptions about the nature and scope of the population based on their experiences responding to crisis calls. When asked to reflect one year later upon whether there was still a need for IBD, interviewees agreed that there was, but the appropriate population was much smaller than they expected—individuals with low-level charges and limited criminal histories where the alleged crime involved a family member. If the program is to be sustained, MET should examine the available data to determine how many cases flagging for IBD reflect that population to inform scalability and resource allocation.

If eligibility is expanded, planners should consider how to secure legal stakeholder buy-in. Some interviewees still felt there was potential for IBD to impact more serious cases, but opinions on how to do so varied. During our initial site visit, one interviewee described the eligible charges as "narrow" and felt that having the prosecutor involved might facilitate diversion of more serious cases because it could assuage liability concerns for LASD staff. "If that [IBD participant] went and committed like some serious crime, it'd fall back on the sheriff's department. That's why they're more hesitant…they don't want to get in trouble." However, when we probed for the value of including prosecutors in IBD diversion decisions one year later, interviewees felt it would unnecessarily complicate decision making. Instead, they felt that reimagining the role of the IBD deputies as akin to "detectives dealing with all mental health related cases" would create opportunities to consider the nuances associated with more serious cases. "Every case is different. I think all should be looked at and then decided upon … Just because you have said charge doesn't mean that you deserve to be overlooked because one bad decision while in crisis can get you some pretty serious charges."

Examine whether IBD is responsive to the target population. If MET moves forward with applying IBD only in low-level cases with limited criminal histories, interviewees suggested considering whether the services provided and duration of requirements are responsive to the needs of the target population or overly onerous. For example, one interviewee noted that many low-level charges are likely to be eligible for judicial diversion, which can be granted over a prosecutor's objection and largely requires the individual remain arrest free for six months. "And so, I think that that's part of the problem. If you're aiming too low and you're making your requirements too high, there's just better [options for charged individuals] out there." Conversely, the IBD deputies spoke of family members contacting them after an individual completed the program asking for further help. "A lot of my patients during the program, they did well. Super great. But two months later when I'm no longer monitoring, I would get a call from dad, 'Hey, my son is

drinking again. He's acting aggressive again.'" The IBD deputies spoke about how all they could do in these situations is refer the family to RAMP. However, as noted above, if MET had the resources to build more robust relationships with community-based providers, there could be the potential to ensure greater continuity in treatment services or non-law enforcement-based options for service linkages.

MET Deputies Embedded in Stations Yielded Benefits

IBD deputies facilitated relationship building. Overall, LASD staff were supportive of having the IBD deputies in their stations during the pilot. Since they were in a designated role, the IBD deputies had the time to build relationships and be in regular communication with station staff. In particular, the IBD deputies noted two valuable lessons learned: (1) provide regular updates (e.g., weekly emails) to detectives on how participants are progressing to establish trust and ensure a transparent process and (2) take the time to build a relationship with community-based providers. To the latter point, even though participants had signed medical release forms, providers were unaware of the program and wary of sharing information over the phone. This necessitated the IBD deputies going to the clinic in-person to present their credentials and provide an overview of the program which paved the way for future information sharing.

IBD deputies served as an extension of the MET teams. The IBD deputies discussed that when there was a lull in screening, they would step in to perform other MET duties. "I stepped in as a MET deputy to help them because I didn't have IBD things to deal with . . . So we were helpful to our stations—more than just IBD." However, when they were pulled back to the MET teams and supported IBD stations only during lulls in crisis calls, the deputies reported it was a challenge to perform IBD tasks as crisis calls are prioritized. "You have that working relationship where they know they can count on you, versus as a side gig where it's like, they might come, they might not. So having that in-house presence makes a big difference. So you can't be half in, half out. You're either there every day or you're not." Even though IBD had challenges enrolling participants, carrying out MET duties at the station level is likely what led to the large number of cases diverted from the station to the hospital for a 5150 hold. Interviewees noted that station jail staff were particularly appreciative of the IBD deputies, as they could conduct mental health assessments on the spot rather than calling the MET triage desk and waiting for a MET team to be dispatched. From an efficiency standpoint, having an IBD deputy in the station could ensure that a MET team remains available to respond to calls for service.

IBD deputies facilitated information sharing for non IBD participants. Not only did IBD deputies describe how they helped station staff, but they also noted their engagement efforts with individuals who did not enter the program. One IBD deputy expressed that this type of engagement made people feel like their concerns were being heard and that it ultimately was a positive reflection on MET:

> There are other cases that we helped that weren't IBD, right? Getting people—instead of being released—getting them to a homeless shelter, to the hospital, talking . . . We talked to random people in jails. If they had questions about things, we answered them, referred them to different programs that they could do on their own.

The West Hollywood MET team was an exemplar of designated staffing. When asked how to sustain IBD, interviewees described that since the target population is so limited and scattered across the county, MET would need to have a designated team of IBD deputies assigned to each of LASD's fourteen stations to identify cases and build trust with station staff. Interviewees cited the West Hollywood MET team as an example of what this could look like—the City of West Hollywood contracts with MET directly and that team only responds to calls for service within the city, whereas other MET teams provide countywide coverage. Interviewees noted that this makes the West Hollywood team more knowledgeable about what is happening in that region and creates community engagement and service outreach opportunities when they are not responding to crisis calls.

> [West Hollywood MET] go out and do homeless outreach—they know who's in their area. They go to special events, they set up booths, they do the MET things . . . They're more involved because they're there . . . And you can do multiple things, because there's no ETA [to respond to a MET call for service].

More specific to IBD, the embedded MET deputies could create opportunities to engage local service providers, build trust with station staff, and, if it were to be made formal policy, assume investigative responsibilities from detectives for IBD cases. However, interviewees were clear that if an investigative component were ever assigned to IBD deputies, there would have to be regionalization, given the size of the county.

> You're in Pico Rivera on a case and then you've got another case over in Walnut and then you've got another case in Carson . . . from an investigative standpoint, that's a lot of travel to follow up on your cases in a timely manner versus having a station where everything's here.

The Messenger Matters

Include a larger role for clinicians in IBD. If MET is to sustain IBD as a diversion program, some interviewees felt that involving a clinician at the station level could be beneficial. One interviewee noted that even though MET deputies are not uniformed officers, potential participants are still reluctant to accept services from law enforcement. Although interviewees acknowledged that resources are also constrained for the Department of Mental Health, having at least one social worker involved could be beneficial in coordinating information, making linkages, and working with the IBD deputies to engage potential participants. "The MET team is a co-response model, and it's a deputy and a clinician. IBD is not. There's no clinician involved, and sometimes that civilian [responder] can get further than we can." When asked to reflect upon what they would have done differently during the pilot, one interviewee explicitly mentioned that they would have involved a clinician in the pilot. They noted that as well trained as the MET deputies are, "it always helps to be partnered up with the clinicians." In contrast, the IBD deputies themselves felt that the support they had from clinicians throughout the pilot (accessing Department of Mental Health records via the triage desk, helping with service linkages) was helpful but that an onsite clinician would not have helped in those instances where someone refused the program. As discussed in Chapter 1, co-response models can take many different forms (e.g., the current MET team configuration of a clinician and deputy responding together or the IBD configuration where specially trained deputies receive remote support from a clinician). As MET reconsiders the target population and goals of the program, they will need to weigh resource allocation.

Consider the Intercept Point and Upstream Coordination

Keep the program at the point of booking. When asked to consider the problems associated with program enrollment and the limited target population, some interviewees felt that the intercept point was appropriate and all that would be needed to increase caseload is to roll out IBD to more LASD stations or smaller law enforcement agencies with administrative jail staff who rely on MET services. "A lot of cities have extra specialized staff in their jails that we just don't have." For example, one interviewee noted that the data infrastructure put into place during 2020 could help inform a revised approach to the program, rather than the designated station staff. "We have so many stations calling for a MET number … We wouldn't be able to drive to every station … It would have to be a phone call [to MET triage] first and then if it seems like it would qualify, [MET] would then respond." Some interviewees noted that moving the program to the Inmate Reception Center could address concerns over MET's resources and centralize booking diversion decisions.

Still, they flagged that both resources at the facility and decision-making (e.g., how custody staff would engage with station staff) must be considered.

Consider expanding to post-booking referrals. Others discussed how it would be valuable to explore post-booking referrals where prosecutors and/or the courts could refer cases back to IBD if they were eligible pre-filing. "Prosecutors would say, 'No, we need to back up two steps and go a different direction with that one.'"

Coordinate with later stage diversion programs. One consideration is *how* and *where* the mental health indicators being captured early by MET could be shared to inform the availability of subsequent off-ramps. For example, LASD's custody division and the Office of Diversion and Reentry Housing program already work together to share information to identify appropriate cases for diversion. However, the Rapid Diversion Program serves clients who may be detained or out of custody. Hypothetically, if someone refused IBD, passing information about that declined diversion offer to the Rapid Diversion Program could prime that team to try and engage the individual at arraignment. One interviewee felt this could also work with cases that failed IBD and had their charges filed.

> I think that there is room because even in an alert like, "Hey, we tried with this client, we didn't do it, but letting you know." Like not as a punishment to this client, but the opposite . . . to really have that second chance with the program.

A Top-Down Approach is Required for Station Buy-In

IBD should be formalized in LASD policy. IBD was described as an "experiment" that was generally viewed favorably, but it was never formally endorsed by command staff. Therefore, it became MET's responsibility to shepherd the program. If IBD were to expand, interviewees were clear that a formalized policy change would need to occur (articulating the eligibility criteria, roles, and responsibilities) and the messaging would need to come from the top down to secure the needed buy-in from stations.

> You need to communicate to your line staff that this program is available, [to explain] "If you're going to have someone that you arrest and they identify with mental illness, these are the charges that you can divert … You don't have to do anything other than identify, notify, and then the IBD team will do the rest."

When asked if a firm policy should be supplemented by the targeted briefings like those MET did in 2020 and 2024, interviewees stressed that the program just needed to be formal

policy that line staff were told to follow. “You need it to come from the captain to the watch commander to say, ‘hey, station, this is what we do,’ and then they would tell their people in briefing versus [two plainclothes IBD deputies].”

Top-Down Directives Need to Be Supplemented with Education

Repetition of information is essential. One interviewee noted that even when there are top-down directives, programs like IBD are still likely to encounter the same types of problems due to the challenges associated with culture change. This interviewee felt that education needs to come well in advance of any formal directive to make sure station staff understand how the program functions. Although MET attempted to saturate the IBD pilot stations prior to the relaunch, the lack of a directive may have made that information less salient. While the few patrol deputies we interviewed during the initial site visit had heard of IBD and generally understood the program goals, they also indicated a need for more training on eligibility criteria. Additionally, there appeared to be confusion about whether IBD required a different booking process or if patrol must file a different form. One interviewee emphasized that briefings are important for raising awareness, but debriefing is the best way to train and build staff experience. “You debrief, and you get everybody’s perspective, and everybody’s on the same page. That’s the best way to get this out.” Several interviewees emphasized that the frequency of such efforts is critical to program success “Patrol deputies need at least three months of that education … training once a week or reminders once a week.”

Consider additional informational aids to reinforce educational efforts. The station staff we interviewed also shared that it would be helpful to have supplemental tools like a checklist or visual aids. This would help maintain awareness of the program and ensure the criteria and process were laid out for all to consider. The MET and Department of Mental Health staff we interviewed also expressed value in videos, brochures, and monthly emails to raise awareness among station staff that IBD “is another tool on your belt.”

Celebrating program successes may encourage culture shift. Interviewees emphasized that a core component of education needs to be celebrating program successes, broadly defined. For example, the Rapid Diversion Program organizes public graduation ceremonies for their participants where they invite staff, prosecutors, and judges to demonstrate real-world program impacts. Although IBD was limited in the number of participants they reached, it is still possible to celebrate and capture the work that IBD deputies did with the stations and participants. “There has to be a repeated message because the culture is not going to change overnight. . . That narrative has to be brought out every

time we have a success in connecting [a person to services] and that has to be on a constant basis so people have reinforcement." Interviewees expressed that celebrating these victories signals to station staff that they are a part of a success story that not only impacted an individual participant but also made an impact in their community. As a result, program staff will slowly start to shift culture and secure buy-in for an alternative way of police work.

Conclusion

The IBD pilot provides a framework for booking diversion programs that address mental health needs. The example provided by this pilot highlights key challenges that other jurisdictions may face, such as logistical and geographic restrictions; insufficient mental health resources, services, and/or personnel; cultural pushback; the absence of high-level stakeholder buy-in; and changes in the underlying population. Given the limited number of staff and the additional time required to respond to mental health calls for service in the field, it can be logistically impossible for co-response teams to meet every call, especially in a geographically large area like LA County. Moreover, not every crisis call for service will involve an arrest. IBD represents an opportunity to intercept those individuals where there is a nexus between their mental health disorder and the alleged crime who may benefit from a lighter touch and service linkages.

IBD's evolving approach to booking diversion has been heavily shaped by the challenges to implementation. With the decentralized nature of patrol stations and their varied cultures, the consistent presence of IBD deputies potentially offered additional MET supports beyond IBD operations. The findings from our interviews highlight that this approach of designating staff to the IBD program helped foster program trust through regular communication and interaction. More specifically, embedding MET deputies at the station level successfully identified many people who required emergency hospitalization before they entered the central jail system. Although this was not originally conceptualized as an IBD goal, it is an unintended outcome that has the potential to influence the jail mental health population.

At the same time, MET must consider the next stage of IBD's evolution as a diversion program, given the lessons learned from the pilot and careful consideration of the target population and program activities. For booking diversion programs like IBD to be viable, they need to serve as an alternative to existing options that are proportional to the severity of mental health issues and the potential sanctions. One key challenge is ensuring that IBD does not lead to net-widening or the drawing of cases that would have previously been dismissed into more onerous conditions. IBD's design mitigates net-widening risk by providing

multiple release valves, such as allowing screened individuals to opt out of participation. IBD deputies also understand the breadth of mental health resources available and strive to refer people to those programs that will adequately support participants, reserving more serious cases for RAMP or other more intensive alternatives.

It is also crucial to understand where the booking diversion program is situated within case processing. For booking diversion programs focused on mental health, it can take longer for the necessary information to be gathered to help the relevant players (e.g., judge, defense, prosecutor) make informed decisions. Consequently, a booking diversion program's efficacy should be assessed not only by its programming, but also by its ability to share information with stakeholders. Even though IBD only enrolled a tiny fraction of screened cases, such a strategy may provide critical information on mental health cases to downstream system stakeholders. These downstream players can use the information to appropriately triage responses to these difficult cases.

When changes to enforcement or case processing occur through policy changes or unexpected events, booking diversion programs may need to revisit their theory of change, redesign program conditions, reassess their eligibility criteria, and/or consider linking cases to more appropriate options. IBD experienced this first during the COVID-19 pandemic as emergency protocols placed restrictions on the type of cases that could be booked into jail; these changes were later expanded and formalized under LA County bail reform. Nevertheless, IBD continued to serve as an early screener for potential 5150 cases, creating off-ramps from the jail to hospitals. As IBD contemplates changes to eligibility criteria and programming conditions, it is identifying where it has comparative benefits over other diversion programs in the county. Such advantages may include enacting IBD programming as originally envisioned, formally expanding the reach of MET teams from the field to the booking station to address crises, and/or reimagining the role of the IBD deputies as a conduit for MET's engagement efforts with community, service providers, and station staff.

When asked to reflect upon their experiences with the pilot, the IBD deputies spoke of it positively and noted how the assignment was a welcomed change from constantly responding to crisis calls. Thus, there is an additional advantage for MET specifically, as IBD could reflect a professional development opportunity for MET deputies and an alternative assignment that could mitigate against burnout. "I was grateful that I had the opportunity to be an IBD deputy because it was very rewarding when you're helping people . . . We got very good feedback from the hospitals, from family, from the watch commander, from the jailers."

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Appendix A. Timeline of Events Relevant to IBD Implementation

The following outlines LA County's jail reform efforts and the broader factors influencing IBD's implementation study.

- **August 2015** The U.S. Department of Justice puts the LA County jail system under mandatory federal monitoring due to conditions including lack of mental health care, suicides, and use of excessive force (U.S. Department of Justice 2015).

- **September 2015** The LA County Board of Supervisors establishes the Office of Diversion and Reentry to develop and implement county-wide criminal justice diversion for persons with mental health disorders and/or substance use disorders, to provide reentry support services based on the individual's needs and reduce youth involvement with the justice system (Ochoa et al. 2021).

- **February 2018** The Los Angeles County Sheriff Civilian Oversight Commission, established in 2016 to enhance transparency and accountability of the LASD, recommends expanding MET teams from 23 to 60, implementing department-wide de-escalation training with a mental health focus, strengthening collaboration with mental health partners and stakeholders, and integrating MET and mental health-focused de-escalation training as key components of use-of-force reduction strategies and constitutional policing (Los Angeles County Civilian Oversight Commission 2025).

- **June 2018** California Assembly Bill 1810 is passed (codified as PC § 1001.36), establishing the pretrial Mental Health Diversion program. This program allows judges to divert individuals whose mental health disorder contributed to their offense, with required court-monitored treatment. Diversion may be granted for specific misdemeanor and felony charges. Successful completion can lead to dropped or reduced charges.

- **February 2019** The LA County Board of Supervisors passes a motion to develop an Alternatives to Incarceration (ATI) workgroup under the *Care First, Jails Last Initiative*, recognizing that jail is not always suitable for people, particularly those with mental health or substance use disorders who may benefit more from supportive services, rehabilitation, and community-based care. ATI aims to develop alternatives, coordinate services, reduce incarceration, and support rehabilitation (Los Angeles County Alternatives to Incarceration Workgroup 2020).

- **June 2019** The LA County Public Defender's Office launches a pilot of the Rapid Diversion Program, a court-based, pre-plea diversion initiative for individuals with mental health or substance use disorders. Eligible individuals are redirected from the court system to treatment services and assigned a case manager for ongoing support. Upon completing the program, their case is dismissed or their charges are reduced. The program is designed and implemented during District Attorney Jackie Lacey's term in office, where she takes a moderately progressive stance on prosecution (Los Angeles County Justice Care and Opportunities Department 2025b).

- **September 2019** After repeatedly raising concerns about Sheriff Alex Villanueva's spending, the LA County Board of Supervisors freezes LASD's budget due to a $63 million shortfall caused by the sheriff's financial decisions, particularly on overtime costs and resistance to budget cuts. In the budget for fiscal year 2020-21, the Board cuts over $145 million from LASD, fueling existing tensions between Villanueva and the Board (Fremon 2020; Stiles and Tchekmedyian 2019).

- **January 2020** LASD's MET team launches the IBD Program Pilot.

- **March 2020** LA County Department of Public Health issues its first stay-at-home order during the COVID-19 pandemic which will ultimately impact criminal legal and behavioral health system functions (County of Los Angeles Department of Public Health 2020).

  In response to the need to minimize the spread of COVID-19, the LA Superior Court implements an Emergency Bail Schedule to reduce the jail population. This policy allows for the immediate release of individuals after arrest, setting bail at zero dollars. The policy applies to non-violent misdemeanors and certain lower-level felonies but excludes repeat offenders, violent or serious felonies, and certain misdemeanors (Sloan et al. 2024).

  Los Angeles County voters pass Measure R, strengthening the power of the Sheriff Civilian Oversight Commission, which allows them to investigate misconduct using subpoenas; requires the Commission to develop a plan to reduce the jail population; and reinvests cost savings into mental health treatment and other community-based services (Tchekmedyian 2020).

- **May 2020** The death of George Floyd leads to calls from local activists and community groups for the reallocation of law enforcement funds to programs aimed towards helping those in need and prevention services (e.g., job training, education, gang intervention and prevention for youth; Marcellin and Doyle 2020; Smith and Zahniser 2021).

- **September 2020** The LA County Board of Supervisors approves the creation of a Jail Population Review Council, consisting of county officials and community stakeholders. To keep the jail population from increasing to pre-COVID-19 numbers, the council is tasked with overseeing efforts to reduce incarceration rates in Los Angeles County. Its responsibilities include analyzing jail booking, population, and release data from the sheriff's department and implementing Alternatives to Incarceration workgroup recommendations that promote racial equity in jail population reduction (Walker 2020).

- **November 2020** Following the protests that began in May and partly facilitated by LASD's budget cuts, Measure J is passed by voters in November 2020**.** It requires LA County to reallocate 10% of its general funds—approximately $360 million—to social services such as housing, mental health treatment, and jail diversion programs. After a legal challenge in 2021, which delayed its full implementation, Measure J is upheld in July 2023, allowing the initiative to proceed with its funding requirements (Cosgrove 2023).

  George Gascón is elected as the LA District Attorney, running on a progressive criminal justice reform platform. However, that same month, California voters reject Proposition 25, which sought to eliminate cash bail across the state (Booker 2020; The California Legislative Analyst's Office 2020).

- **January 2021** LA County Department of Health officially lifts its stay-at-home order imposed due to the COVID-19 pandemic (County of Los Angeles Department of Public Health 2021).

- **March 2021** California Supreme Court upholds 2018 decision of *In re Humphrey*, determining it is unconstitutional to detain someone pretrial solely because they cannot afford bail. With this ruling, California courts must consider an individual's ability pay, as well as non-monetary alternatives such as electronic monitoring and community supervision when setting bail (*In re Humphrey* 2021).

- **June 2021** The Alternatives to Incarceration Office begins piloting the ATI Pre-File Diversion Program in one LA police district and one Sheriff's station. The goal of the program is to divert individuals with a mental health disorder, those who are unhoused, and those with a substance use disorder before their charges are filed and to link them to mental health and social services and housing. Only misdemeanors and non-violent/non-serious felonies are eligible (Los Angeles County Chief Executive Office 2021).

- **July 2022** Regular bail schedule is resumed, marking the end of the emergency "zero bail" policy in place during the COVID-19 pandemic (Sloan et al. 2024).

- **September 2022** The ACLU National Prison Project and ACLU of California file an emergency motion (*Rutherford v. Villanueva*) to get a federal judge to order LA County to address the inhumane conditions at the Inmate Reception Center. In response, a federal judge issues a temporary restraining order, directing LA County and Sheriff Villanueva to limit custody at the facility to a maximum of 24 hours and to improve conditions to meet minimum legal standards (American Civil Liberties Union 2025).

- **November 2022** The LA County Board of Supervisors establishes the Justice, Care, and Opportunities Department (JCOD) under the *Care First, Jails Last Initiative*. The department is created to promote collaboration and transparency while addressing systemic issues such as homelessness, poverty, mental health disorders, and substance use disorders. By centralizing various programs, including the Office of Diversion and Reentry, Alternatives to Incarceration, and the Jail Closure Implementation Team, which will later be moved into the Chief Executive Office and renamed the Community Safety Implementation Team), JCOD aims to streamline efforts in supporting vulnerable, justice-involved populations (Los Angeles County Justice Care and Opportunities Department 2025a).

  In a rebuke to Sheriff Villanueva, who has ongoing tension with the LA County Board of Supervisors, opposition to oversight, and has denounced calls for criminal justice reform, Robert Luna is elected LA County Sheriff on a platform emphasizing transparency, accountability, and cooperation with the LA Board of Supervisors (Associated Press, 2022).

- **February 2023** The ACLU files *Rutherford v. Luna* to hold LA County, the Board of Supervisors, and Sheriff Luna in contempt of court because conditions at the Inmate Reception Center have not improved since the September 2022 filing. The ACLU of

Southern California also submits grievances on behalf of incarcerated individuals, citing numerous concerns, including access to mattresses, recreation, food, menstrual products, medical and mental health care, showers, overcrowding, and classification (American Civil Liberties Union of Southern California 2023b).

- **May 2023** *Urquidi v. City of Los Angeles* is filed against the County and City of LA, the LASD, and LAPD, and the Chief of the LAPD. A preliminary injunction bars the LAPD and LASD from detaining individuals who would have been released under the emergency bail schedule. The lawsuit reinstates the county's emergency bail schedule for indigent individuals. The case is ongoing (Sloan et al. 2024).

- **June 2023** The ACLU reaches a settlement with the LA County Board of Supervisors and Sheriff Luna in *Rutherford v. Luna* to create 1,925 community beds as alternatives to jailing people with a mental health disorder in the Inmate Reception Center. In addition, the settlement includes measures to limit the time incarcerated persons are held in the jail, tethered to the clinic front bench, holding cell, and/or clinic cage. Finally, the settlement creates sanitary conditions and access to medical and mental health care (American Civil Liberties Union of Southern California 2023a).

- **October 2023** LA County implements Pre-Arraignment Release Protocols (PARP), eliminating cash bail for most misdemeanors and certain non-violent felonies. Instead, individuals are cited and released or assigned non-financial conditions such as electronic monitoring or home supervision. Those deemed a heightened public safety or flight risk are referred to a magistrate judge for review, who determines whether they should be held in custody pending arraignment (Sloan et al. 2024).

- **December 2023** Twenty-nine cities sue to block the new bail policy**,** but an LA County Superior Court judge rejects the lawsuit, allowing the reforms to remain in place (Henry and Schwebke 2023).

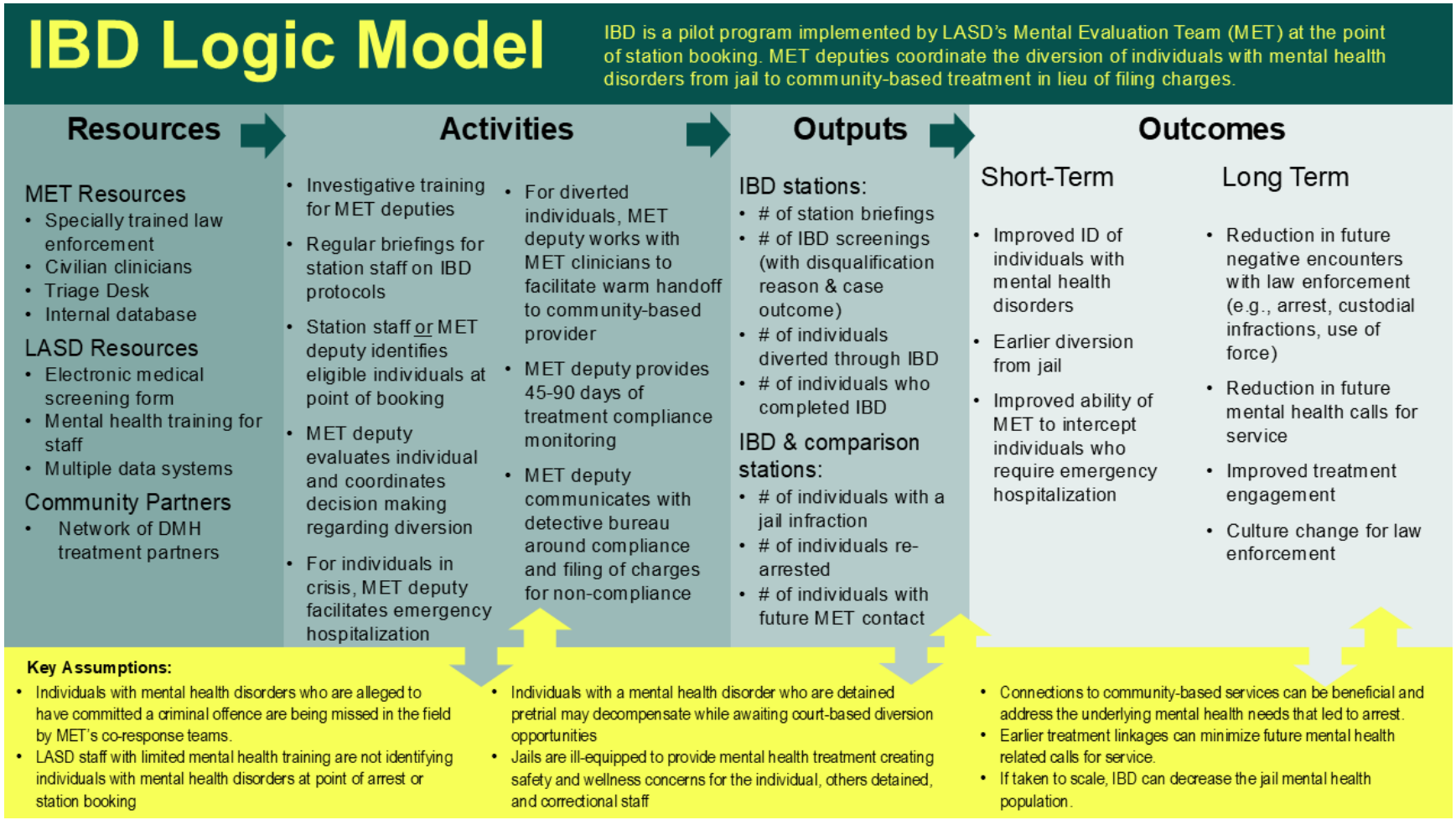
- **February 2024** LASD's MET team begins the relaunch of the IBD program**,** expanding to four patrol stations.

- **November 2024** Prop 36 passes, rescinding significant portions of Prop 47, restoring previously reclassified misdemeanors to felony offenses, creating a pathway to longer jail and prison sentences and enabling courts to impose mandated treatment for certain felony offenses (Staudt 2024).

- **December 2024** LA County District Attorney Hochman is elected on a moderate-to-conservative approach**,** marking a shift from the progressive policies of the former administration (Ding 2024).

- **September 2025** California Attorney General Bonta files a lawsuit against LA County, LASD, and County Correctional Health Services over unconstitutional and inhumane conditions in the jails. The attorney general notes that while Sheriff Luna has advanced significant reforms to patrol operations, there has been little progress in address the conditions in the county jails (California Office of the Attorney General 2025).

Appendix B. Logic Model



Appendix C. Comparison of 2020 and 2024 IBD Pilot

	2020	2024	Context for Changes
Identification	Station jailer flags individuals for a mental health disorder during medical screening	IBD deputies are embedded in stations to identify individuals with a mental health disorder	Medical screening not being completed with fidelity; individuals' non-disclosure
Response	MET team dispatched by the MET Triage Desk to coordinate diversion	IBD deputy assigned to the station will coordinate diversion	MET teams could not respond to mental health calls for service and IBD related calls due to staffing shortage
Exclusionary Criteria	(1) Specific mental health disorders *(e.g., antisocial personality disorder, borderline personality disorder, pedophilia)* (2) Felony charges subject to a prison sentence (3) Specific felonies excluded except through agreement with DA *(DUI causing injury, CA "manslaughter" offenses, child pornography, and CA gun crimes)*	(3) Expanded specific felonies *(same + sex crimes, domestic violence/stalking, arson, resisting arrest, and non-citable outstanding warrants)*	Specific felonies were updated to align with bail reform criteria
Parties who Inform Diversion Decisions	MET, arresting deputy, watch commander, detective bureau, arrested individual	Same, but with victim consent required	Bail reform created concerns among station staff that only those facing serious charges are now subject to custodial booking
Case Management	RAMP coordinates treatment linkages and provides intensive case management and supervision for 45-90 days	IBD deputies provide intensive case management and supervision for 45-90 days DMH staff member helps coordinate treatment linkage	RAMP did not have the resources to take on IBD cases
Responses to Non-Compliance	RAMP notifies detectives to file charges	Initial charges expire at the statute of limitations; If an IBD completer is arrested on new charges during the statute of limitations (misdemeanor: 1 year, felony: 3 years), initial arrest can be reactivated alongside the new charges	Bail reform created concerns among station staff that only those facing serious charges are now subject to custodial booking

Appendix D. Diversion Program Descriptions

Program[1]	Implementation	Diversion Model	Identification Process	Populations Served	Duration of Services
Intake Booking Diversion	2020 - 2022 2024	Pre-filing	Identified by an LASD deputy with specialized training at the point of booking	• Individuals with mild to moderate mental health needs • Individuals who require emergency hospitalization at the point of booking (5150) • Misdemeanors and low-level felonies • Individuals with limited criminal histories (LASD approval)	45-90 days
Justice, Care, and Opportunities Department - Alternatives to Incarceration	2021 - 2024	Pre-filing	Identified by a civilian clinician at the point of booking	• Individuals with mild to moderate mental health needs • Misdemeanors and low-level felonies • Individuals with limited criminal histories (requires law enforcement and prosecutor approval)	90-days for misdemeanors and 180-days for felonies
Office of Diversion and Reentry Housing	2015 - Present[2]	Post-filing	Identified by ODR and LASD custody staff during pretrial detention	• Individuals with high mental health needs (includes co-occurring substance use disorder) • Individuals who require supportive housing • Serious felonies (often violent) • Individuals with extensive criminal histories	Two years for diversion cases , but can be as much as five years if a diverted case is placed on probation
Rapid Diversion Program	2019 - Present	Post-filing	Identified at arraignment by a public defense attorney who will coordinate with a staff clinician	• Individuals with mild to moderate mental health needs • Misdemeanors and low-level felonies • Individuals with limited criminal histories (requires prosecutor approval)	One year for misdemeanors and two-years for felonies
Court-Based Diversion	2018 - Present	Post-filing	Identified by defense counsel assigned to the case	• Severity of mental health disorder varies • Severity of charges varies • Criminal history is unknown	One year for misdemeanors and two-years for felonies

Note: Content adapted from interviewees as well as Gilliam et al. (2022) and Brooks Holliday, Marsolais, and Matthews (2024).

[1] Our focus is limited to programs similar to IBD in the populations served and their application of PC § 1001.36. For example, ODR also facilitates LEAD (Let Everyone Advance with Dignity / Law Enforcement Assisted Diversion) and MET's RAMP team also facilitates court-based diversion. However, both serve specialized populations (e.g., high system utilizers, co-occurring disorders) and can provide services whether or not a crime has occurred.

[2] ODR Housing predates the creation of PC § 1001.36 as it also serves individuals sentenced to probation. Individuals who enter via pretrial diversion can be sentenced to probation if they are noncompliant, but it is rare.

Appendix E. Balance Tables B-C

	ALL CASES			MATCHED SAMPLES		
	IBD Screened	Comparison	Standardized Mean Difference	IBD Screened	Comparison	Standardized Mean Difference
Overall Distance	0.37	0.20	0.92	0.37	0.34	0.14
Female	0.32	0.29	0.07	0.32	0.27	0.11
Male	0.68	0.68	0.01	0.68	0.73	-0.11
Missing Sex	0.00	0.04	-0.22	0.00	0.00	0.00
Asian	0.03	0.01	0.14	0.03	0.02	0.06
Black	0.32	0.21	0.23	0.32	0.27	0.11
Hispanic	0.40	0.45	-0.09	0.40	0.48	-0.17
Missing Race	0.00	0.04	-0.24	0.00	0.00	0.00
Other Race	0.03	0.05	-0.12	0.03	0.01	0.12
White	0.22	0.24	-0.06	0.22	0.22	0.00
Age <18	0.08	0.01	0.25	0.08	0.04	0.15
Age 18-25	0.10	0.14	-0.14	0.10	0.09	0.03
Age 26-35	0.38	0.37	0.02	0.38	0.44	-0.13
Age 36-45	0.22	0.28	-0.16	0.22	0.23	-0.03
Age 45+	0.22	0.19	0.06	0.22	0.20	0.05
Offense Category - Arson	0.03	0.01	0.10	0.03	0.03	0.00
Offense Category - Assault	0.25	0.11	0.31	0.25	0.26	-0.02
Offense Category - Burglary	0.05	0.04	0.06	0.05	0.07	-0.09
Offense Category - Controlled Substance	0.04	0.04	0.01	0.04	0.04	0.00
Offense Category - Domestic Violence	0.07	0.19	-0.46	0.07	0.08	-0.04
Offense Category - DUI/Suspended License	0.04	0.04	0.03	0.04	0.03	0.05
Offense Category - Kidnapping/False Imprisonment/Stalking/Cruelty	0.02	0.03	-0.09	0.02	0.00	0.15
Offense Category - Missing	0.05	0.10	-0.23	0.05	0.02	0.14
Offense Category - Murder/Manslaughter	0.00	0.02	-0.15	0.00	0.00	0.00
Offense Category - Obstruction of Justice	0.06	0.02	0.18	0.06	0.06	0.00
Offense Category - Public Order	0.22	0.12	0.22	0.22	0.22	0.00
Offense Category - Robbery	0.02	0.03	-0.09	0.02	0.01	0.07
Offense Category - Sex	0.00	0.02	-0.15	0.00	0.00	0.00
Offense Category - Shoplift/Recieve Stolen Property/Fraud	0.02	0.03	-0.09	0.02	0.04	-0.15
Offense Category - Supervision	0.03	0.03	0.01	0.03	0.04	-0.06
Offense Category - Theft	0.02	0.05	-0.20	0.02	0.03	-0.07
Offense Category - Unknown	0.07	0.09	-0.05	0.07	0.06	0.04
Offense Category - Weapons	0.00	0.03	-0.19	0.00	0.00	0.00
Any Prior MET Contact	0.34	0.30	0.09	0.34	0.37	-0.07
Central Patrol District	0.25	0.19	0.14	0.25	0.24	0.02
East Patrol DIstrict	0.20	0.32	-0.32	0.20	0.21	-0.03
North Patrol District	0.30	0.35	-0.12	0.30	0.31	-0.02
South Patrol District	0.26	0.13	0.28	0.26	0.25	0.02
Count	97	305		97	97	

Appendix F. Balance Tables D - F

	ALL CASES			MATCHED SAMPLES		
	IBD Screened	Comparison	Standardized Mean Difference	IBD Screened	Comparison	Standardized Mean Difference
Overall Distance	0.33	0.16	0.90	0.33	0.31	0.09
Female	0.34	0.32	0.05	0.34	0.32	0.03
Male	0.66	0.68	-0.05	0.66	0.68	-0.03
Asian	0.05	0.01	0.19	0.05	0.03	0.08
Black	0.34	0.22	0.25	0.34	0.35	-0.03
Hispanic	0.34	0.46	-0.27	0.34	0.37	-0.07
Other Race	0.02	0.05	-0.28	0.02	0.00	0.13
White	0.26	0.25	0.01	0.26	0.24	0.04
Age <18	0.03	0.02	0.09	0.03	0.02	0.09
Age 18-25	0.11	0.14	-0.10	0.11	0.13	-0.05
Age 26-35	0.39	0.37	0.04	0.39	0.40	-0.03
Age 36-45	0.24	0.29	-0.12	0.24	0.23	0.04
Age 45+	0.23	0.18	0.11	0.23	0.23	0.00
Offense Category - Arson	0.02	0.02	0.00	0.02	0.02	0.00
Offense Category - Assault	0.24	0.13	0.26	0.24	0.27	-0.08
Offense Category - Burglary	0.06	0.04	0.09	0.06	0.08	-0.07
Offense Category - Controlled Substance	0.06	0.04	0.09	0.06	0.02	0.20
Offense Category - Domestic Violence	0.08	0.23	-0.54	0.08	0.08	0.00
Offense Category - DUI/Suspended License	0.06	0.04	0.09	0.06	0.05	0.07
Offense Category - Kidnapping/False Imprisonment/Stalking/Cruelty	0.02	0.04	-0.18	0.02	0.03	-0.13
Offense Category - Murder/Manslaughter	0.00	0.00	-0.07	0.00	0.00	0.00
Offense Category - Obstruction of Justice	0.10	0.02	0.25	0.10	0.08	0.05
Offense Category - Public Order	0.21	0.13	0.19	0.21	0.19	0.04
Offense Category - Robbery	0.03	0.04	-0.04	0.03	0.03	0.00
Offense Category - Sex	0.00	0.02	-0.16	0.00	0.00	0.00
Offense Category - Shoplift/Recieve Stolen Property/Fraud	0.02	0.04	-0.18	0.02	0.02	0.00
Offense Category - Supervision	0.05	0.03	0.10	0.05	0.08	-0.15
Offense Category - Theft	0.03	0.05	-0.13	0.03	0.02	0.09
Offense Category - Unknown	0.02	0.09	-0.59	0.02	0.03	-0.13
Offense Category - Weapons	0.00	0.03	-0.20	0.00	0.00	0.00
Offense Level - Felony	0.53	0.54	-0.02	0.53	0.61	-0.16
Offense Level - Misdemeanor	0.47	0.44	0.05	0.47	0.39	0.16
Offense Level - Other	0.00	0.02	-0.14	0.00	0.00	0.00
Any Prior Felony Booking	0.37	0.36	0.03	0.37	0.45	-0.17
Any Prior Misdemeanor Booking	0.47	0.45	0.03	0.47	0.45	0.03
Any Prior MET Contact	0.24	0.27	-0.06	0.24	0.15	0.23
Central Patrol District	0.18	0.20	-0.06	0.18	0.18	0.00
East Patrol DIstrict	0.23	0.32	-0.24	0.23	0.27	-0.12
North Patrol District	0.32	0.35	-0.06	0.32	0.26	0.14
South Patrol District	0.27	0.12	0.33	0.27	0.29	-0.04
Count	62	256		60	60	

Appendix G. OLS Regression Summary

	No Jail Booking	Booking Length of Stay	Subsequent MET Contact 3 Months	Custodial Violation	Future Jail Booking 3 Months	Future Jail Booking 6 Months
IBD Screened	0.269***	-11.927	0.061	-0.002	0.022	0.110
	(0.028)	(8.289)	(0.046)	(0.035)	(0.061)	(0.072)
Num.Obs.	402	402	318	337	318	268
R2	0.668	0.261	0.150	0.176	0.143	0.207
R2 Adj.	0.638	0.195	0.048	0.083	0.040	0.091
AIC	-35.8	4531.6	167.6	20.8	355.0	363.6
BIC	104.1	4671.5	303.0	158.3	490.5	492.9
Log.Lik.	52.880	-2230.822	-47.803	25.614	-141.522	-145.815
RMSE	0.21	62.20	0.28	0.22	0.38	0.42

*** p<0.001 **p<0.01 *p<0.05 + p<0.10

Note: Control variables were included in the model, but only main effects are presented.

Appendix H. Matching Regression Summary

	No Jail Booking	Booking Length of Stay	Subsequent MET Contact 3 Months	Future Jail Booking 3 Months	Future Jail Booking 6 Months
IBD Screened	0.269***	-16.050	0.097	0.072	0.181+
	(0.045)	(10.633)	(0.061)	(0.075)	(0.095)
Num.Obs.	194	194	120	120	109
R2	0.465	0.288	0.289	0.252	0.254
R2 Adj.	0.374	0.168	0.060	0.011	-0.020
AIC	122.6	2240.0	96.0	147.7	174.9
BIC	220.6	2338.0	182.4	234.2	258.4
Log.Lik.	-31.299	-1089.987	-17.016	-42.873	-56.473
RMSE	0.28	66.66	0.28	0.35	0.41

*** p<0.001 **p<0.01 *p<0.05 + p<0.10

Note: Control variables were not included in the model as matching was applied to the sample.

Appendix I. Project Artifacts

Findings from the study were shared with MET via an internal memo:

Tallon, J.A., & Jensen, E. (2024, September). Early Implementation Findings from the Intake Booking Diversion Program. Internal memo shared with MET leadership September 9, 2024.

In addition to this technical report, two practitioner briefs were developed:

Tallon, J.A., Nguyen, V., & Jensen, E. (2026, April). Early Mental Health Diversion in Los Angeles County: The Intake Booking Diversion Program Model. New York, NY: Center for Justice Innovation.

Tallon, J.A., Nguyen, V., & Jensen, E. (2026, April). Early Mental Health Diversion in Los Angeles County: Lessons Learned from the Intake Booking Diversion Program. New York, NY: Center for Justice Innovation.

All public written deliverables were disseminated via a multimedia strategy. Written deliverables were posted to the Center's website. In 2025, the Center's website logged an average of 28,085 visitors and 42,785 page views per month, and 16,907 copies of the Center's publications were downloaded. The number of policymakers and practitioners who received study products was enhanced through LinkedIn and social media updates that reach a combined total of 70,000 followers and at least one email newsletter which reached more than 20,000 professionals nationwide (and be forwarded to many others).

Findings from the study were also disseminated at the following national conferences:

Tallon, J.A., & Jensen, E. (2024, November). Early Implementation Findings from the Los Angeles County Sheriff's Department's Intake Booking Diversion Program. Paper presented at the 79th Annual Meeting of the American Society of Criminology, San Francisco, CA.

Tallon, J.A., Nguyen, V., & Jensen, E. (2025, November). A Descriptive Outcome Evaluation of the Los Angeles County Intake Booking Diversion Program. Paper presented at the 80th Annual Meeting of the American Society of Criminology, Washington, D.C.

The following datasets sets were archived at the National Archive of Criminal Justice Data:

- **MET Analytical File** Cleaned, analytical RDS file that is used to analyze IBD. The file contains information linked and cleaned from several LASD data sources. (n=402, # of variables = 69).

- **Interview Transcripts and Notes** Transcripts/notes from 18 stakeholder interviews with 26 interviewees at two times: 3-months into implementation and one-year later.

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