Justice That Heals:
Promoting Behavioral Health, Safeguarding the Public, and Ending Our Overreliance on Jails

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Executive Summary

Despite a significant drop in San Francisco's jail population and exemplary advancements in county-run community-based supervision, individuals with serious mental illness continue to be disproportionately represented in the criminal justice system. Between 35 and 40 percent of individuals detained in San Francisco jail receive care from Jail Behavioral Health Services and 15 percent are treated for a serious mental illness. These individuals are presenting with more severe mental illnesses and more acute symptoms than ever before.

Research shows that incarcerating those with mental illness is counterproductive to their rehabilitation, making it more difficult for them to successfully reenter free society. As a result, incarcerating people with mental illness undermines long-term community safety by increasing recidivism. To address the growing population of individuals with mental illness who enter a criminal justice system that exacerbates their conditions and increases their likelihood to recidivate, this concept paper outlines a series of recommendations for enhanced care coordination and service delivery in a centralized service center: The Behavioral Health Justice Center (BHJC).

OUR MENTAL HEALTH CRISIS BY THE NUMBERS

- **64%** of jail inmates across the country have mental health problems
- **35-40%** of individuals detained in SF county jail receive care from Jail Behavioral Health Services
- **120-day** average wait for a mental health bed through Behavioral Health Court (BHC)

The proposed BHJC ensures public safety by providing mental health services designed to interrupt the cycle of homelessness, addiction, and criminal activity. Central to the concept is a system of interconnected components that creates a continuum of mental health care services. The BHJC will provide, for the first time, a purposeful, coordinated system of care with different levels of service and appropriate treatment options for individuals with mental illness in the justice system. The BHJC has four tiers of service and treatment to address four distinct levels of need. Participation at all four levels will be voluntary.

Level 1: Emergency Mental Health Reception Center and Respite Beds. A 24-hour venue for police to bring individuals experiencing a mental health episode for an initial mental health assessment.

Level 2: Short-term (2-3 week) Transitional Housing and on-site residential treatment.

Level 3: Long-term Residential Dual Diagnosis Treatment. Longer-term intensive residential psychiatric care and substance abuse treatment in an unlocked setting.

Level 4: Secure Inpatient Transitional Care Unit. Short-term, voluntary inpatient treatment for persons with mental illness transitioning to community-based residential treatment programs.

The proposed BHJC is a collaborative, independently administered, interagency center designed to 1) bridge the current divide between the criminal justice system and community-based treatment programs for mentally ill individuals, and 2) ensure diversion at the earliest possible opportunity. The co-location of these services across the continuum will promote a seamless system of care for individuals with mental illness that will help them exit the criminal justice system.

The creation of the BHJC may require legislative and regulatory steps to be taken that, at a minimum, ensure that the individuals who access services through the Center maintain all rights and privileges traditionally afforded in a custodial setting. As a nation, we have recently entered a long-overdue era in which there is unprecedented bipartisan collaboration designed to achieve both criminal justice *and* mental health reform. As a national leader in the effort to reform both of these systems, San Francisco and is well-positioned to pioneer these important changes.

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I. Introduction: San Francisco's Mental Health Crisis

This paper outlines a concept for a Behavioral Health Justice Center (BHJC) in order to address the growing problem of a criminal justice system that is ill-suited to meet the needs of people with mental illness. As discussed in more detail below, this concept is based on the best available evidence in the field and builds on models of similar successful programs around the country. It has been refined with San Francisco-specific data and includes features tailored to our community. The BHJC is a new facility that combines public safety and mental health services designed to interrupt the cycle of mental illness, homelessness, addiction, and criminal activity. At the crux of the concept is a system of interconnected components that creates a seamless continuum of services and care. It is a new approach to improving public safety and enhancing individual outcomes for some of the most vulnerable people in San Francisco.

The San Francisco County Jail is the Largest Mental Health Facility in the County.

Although the number of individuals in the San Francisco jail has decreased steadily in recent years, the concentration of inmates suffering from serious mental illness is on the rise. At any given time, between 35 and 40 percent of San Francisco jail inmates are under the care of Jail Behavioral Health Services and being treated for mental illness. Incarcerated individuals are presenting with more severe mental illnesses and more acute symptoms than ever before. According to the San Francisco Department of Public Health (SFDPH), persons with mental illness are incarcerated 160 percent longer than individuals in the general population.[1]

The BHJC proposed here is an alternative to a jail. It is not a new jail with improved mental health services. The BHJC is an entirely different response to the problem of mental illness and criminal justice in San Francisco. The BHJC will provide, for the first time, a coordinated and seamless system of care with different levels of services and appropriate treatment options for people with serious mental illness in the justice system.

The BHJC proposed here would be a multi-level, tiered system of care founded on well-researched, proven interventions. The best available evidence shows that, if properly designed and implemented, this approach can significantly improve the health outcomes of those with serious mental illness involved in the criminal justice system, reduce crime rates within the city, reduce the need for jail beds and save money.

II. Current Mental Health Support & Treatment Landscape in San Francisco

San Francisco is ill-prepared to care for and treat those with mental health disorders in the justice system. Incarcerating individuals with mental illness in county jails impedes their treatment and rehabilitation, makes it more difficult for them to successfully reenter free society, and undermines long-term community safety by increasing recidivism. The BHJC will

help alleviate these complex problems by ending the criminalization of persons with mental illness which results in unnecessary and lengthy stays in county jail.

Law Enforcement has Few Options for People in Mental Health Crisis

In the three-month period between December 2015 and February 2016, the police department received a total of 5,013 calls involving people in mental health crisis.[2] In fact, the San Francisco Chronicle has reported that 80 percent of calls to police involve individuals with mental illness. San Francisco has limited options for law enforcement who encounter persons in the throes of a mental health crisis. When a person commits a minor crime and also suffers from mental illness, officers do not have a workable avenue or option for diverting people out of the criminal justice system. Police often take people in crisis to Psychiatric Emergency Services (PES) at Zuckerberg San Francisco General Hospital (ZSFG). PES is frequently so overwhelmed that doctors are forced to redirect patients to other hospitals ("condition red") for assessment and treatment. In fiscal year 2014-15, PES was on condition red for a total of 63 days.[3] If space is available in PES, the police officer may wait hours while that patient is processed and finally admitted. Frequently, patients are discharged back to the street within hours of arriving at PES.

Individuals with Mental Health Disorders Languish in Jail Waiting for Treatment

A vast majority of justice-involved persons with serious mental illness have a co-occurring substance use disorder. The most widely accepted, evidence-based practice for treating such individuals is Integrated Dual Diagnosis Treatment, which treats both mental health and substance abuse disorders simultaneously and in the same setting.[4] While San Francisco does have an integrated community behavioral health system, it does not include residential dual diagnosis programs dedicated to people in the justice system. Persons who are being held in jail in San Francisco currently wait an average of 120 days for a bed in a community-based residential treatment program after they are deemed clinically stable and appropriate for placement. Non-criminal justice-involved individuals in the mental health system are prioritized for placement and often displace jail inmates on waiting lists for community treatment beds resulting in a wait that is 5 times longer for jail inmates.[5] As a result, only those offenders who commit more serious crimes will be in custody long enough to receive a referral to an inpatient treatment facility.

Defendants Found Incompetent Wait Months for Placement in a Hospital

Persons with mental illness in the San Francisco County Jail who have been found incompetent to stand trial on felony charges wait an average of 4 to 6 months in jail before being transferred to an available bed in the state mental hospital.[6] Last year, a United States District Court in the state of Washington ruled that a delay of more than 7 days between a finding of incompetency to stand trial and the commencement of competency restoration services is unconstitutional.[7] Clearly, San Francisco is vulnerable to a similar constitutional challenge to its treatment of felony offenders found incompetent to stand trial.

Individuals with Mental Health Disorders Released from Jail Custody Have Few Options

Regardless of whether individuals receive adequate care while incarcerated, all jail inmates are eventually released and returned to their communities. Individuals suffering from mental illnesses are regularly released without adequate reentry plans, programs, or connections to community programs to continue mental health treatment. In some cases, individuals are released without adequate medication or prescriptions. Failure to adequately prepare for community reentry and continuation of mental health services can exacerbate psychiatric conditions and increase the likelihood of addiction, homelessness, and recidivism.

III. Jails Are Not Designed For Mental Health Treatment

Correctional facilities are fundamentally places of punishment and control, not treatment and rehabilitation. By necessity, security within a jail or prison is paramount, making it difficult to create and maintain an effective system of mental health care. By virtue of their very nature—from their architectural design to the manner in which they are routinely operated—jails and prisons tend to exacerbate mental illness.[8] Adding treatment services to traditional jail facilities will never adequately address this inherent problem.

Many studies have shown that prisoners with mental illness are especially vulnerable to a wide range of potential harms in correctional facilities. This vulnerability is reflected in the fact that they are not only more likely to engage in suicidal and self-harming behavior,[9] but also more likely to incur disciplinary infractions,[10] more likely to be victimized by other prisoners,[11] and more likely to be the targets of use of force by correctional staff.[12] They often find themselves mired in a cycle of disciplinary infractions, imposed sanctions that include isolation or solitary confinement, and further deterioration of their mental health, leading to the increased likelihood of future infractions. This downward spiral exacerbates mental illness, hampers rehabilitation, and increases recidivism.

The harms suffered by prisoners with mental illness in traditional jail and prison settings serve to underscore the extraordinarily difficult challenge of providing mental health treatment and care inside jails and prisons. Correctional settings begin with and operate on the assumption that the containment, constraint, and control of the prisoner population are of primary importance. Therapeutic settings, on the other hand, begin with the assumption that the fostering of trust, delivery of individualized services, and responsiveness to the needs of the patients are paramount.

For these reasons, the difference between a "mental health jail" and the BHJC that is proposed here is far more than mere semantics. Rather than a jail facility where mental health treatment is also provided, a behavioral health center is primarily a treatment site that also properly ensures the safety of the staff and patients who are housed there, as well as the community at

large. This core difference should extend to the construction of the BHJC itself, the atmosphere that is created inside, and the primary mission and mindset of the staff hired.

Unlike a jail, the BHJC can serve as a critically important component in a well-designed system of behavioral health care in the larger community. It can help facilitate the overall mission of the community's comprehensive system of mental health care.

IV. Local Data Support the Need for the BHJC

According to the 2013 Jail Needs Assessment by the San Francisco Controller, county jail inmates face increasingly serious mental health needs. Only 78 beds in the county jail are designed for individuals with mental health or medical needs. The Controller Needs Assessment also noted that county jail facilities lack adequate, appropriate treatment space for individuals with mental illness: "[N]o dedicated space exists for mental health services. As a result, psychiatric groups are conducted in holding cells, and when interview rooms are in use, psychiatric staff must interview inmates in the jail hallway."[13]

In June 2016, the San Francisco Budget and Legislative Analyst's Office on Jail Population, Costs, and Alternatives released a report with similar findings. According to the LAO report, 17 percent of jail inmates were diagnosed with Serious Mental Illness. Given the lack of appropriate housing in the jail, the report found that "[o]n November 15, 2015, there were 240 inmates diagnosed with a Serious Mental Illness—resulting in a shortage of 204 appropriate beds for those inmates."[14]

The data below (FY 2014-15 unless otherwise noted) show that providing effective treatment to offenders with mental illness in a behavioral health center can improve public safety outcomes and reduce costs:

Law Enforcement and Lack of Crisis Services

- The San Francisco Police Department receives approximately 20,000 calls for individuals in mental health crisis every year.[15]
- San Francisco's Psychiatric Emergency Services was unable to accept any new patients for a total of 63 days in 2015 due to lack of capacity.[16]
- Between 2008 and 2011, the number of acute psychiatric beds in Zuckerberg San Francisco General Hospital (ZSFG) was reduced from 87 to 22.[17]
- Health policy experts recommend that the minimum number of psychiatric beds per 100,000 persons should be 50.[18] San Francisco's total number of psychiatric beds (acute, non-acute, private pay and uninsured) is 153.[19] With a population of 837,442, San Francisco is at a deficit of 266 psychiatric beds to meet minimum quality standards for its size.
- The Dore Urgent Care Clinic is a medically-staffed 12-bed short term psychiatric crisis residential clinic. 18 percent of its admissions are referred by the SFPD.[20]

Arrest, Initial Detention, Pre-Trial Diversion

- Over 36 percent of the 13,510 individuals booked into SF County Jail were seen by Jail Behavioral Health Services (JBHS),[21] compared to the approximately 18 percent prevalence rate of any mental illness in the general American adult population.[22]
- Over 14 percent of individuals booked met the criteria for a Serious Mental Illness (SMI)[23] while only 4.2 percent of American adults were diagnosed with a SMI.[24]
- A snapshot of incarcerated individuals with misdemeanor charges on March 4, 2015, indicated that 61 percent of all individuals charged with misdemeanors had at least one contact with JBHS and 40.7 percent were receiving ongoing JBHS services.[25]
- An analysis of the 80 persons referred by the court for potential pretrial release during January and February 2015, and subsequently denied release, revealed that over 60% of them had at least one contact with JBHS, and that 35% were receiving ongoing JBHS services.[26]

Jail: A Profile of Incarcerated Individuals and Access to Care

While the overall numbers of incarcerated individuals seen by JBHS have gone down 8 percent since 2010, over the same period, the number of JBHS service contacts has gone up by 34 percent and the number of contacts per individual has gone up by 46 percent.[27] This suggests that the population of incarcerated individuals has increasingly severe mental health problems with correspondingly more intensive needs.

Of the almost 5,000 incarcerated individuals seen by JBHS between November 2014 and November 2015:[28]

- 59 percent had previously received DPH behavioral health services.
- 57 percent had been homeless at some point in their lives.
- 31 percent had been homeless in the last year.
- 288 were among DPH's top five percent of Urgent/Emergent utilizers.
- 40 percent had at least one Urgent/Emergent contact within DPH.
- Only 4 percent had currently open mental health intensive case management and 10 percent currently had open mental health non-intensive case management.
- 38 percent were African American.

Of over 13,500 individuals incarcerated in FY 2014-15:[29]

- 14.5 percent were diagnosed with a serious mental illness.
- Only 6.4 percent of individuals saw a psychiatrist.
- Only 5.9 percent of individuals received psychiatric medication (a decrease of 61 percent since 2013).[30]
- JBHS employs only 1.4 Full-Time Equivalent Psychiatrists.
- Only one-half of one percent (77) was housed in psychiatric housing units.

Of the 77 incarcerated individuals housed in psychiatric housing:[31]

- 100 percent were charged with at least one felony.
- 50.6 percent faced between 5 and 9 charges.
- The most common felony charge was Assault with Force Likely to Commit Great Bodily Injury.

Behavioral Health Court

Since 2003, San Francisco has treated defendants with mental illness in a specialized program designed to identify people who are in the criminal justice system because of untreated mental illness. The specialized problem-solving court serves individuals with serious mental illness by redirecting them to evidence-based treatment. Individuals participating in San Francisco's Behavioral Health Court have improved public safety outcomes:

- After 18 months, 26 percent of BHC participants were less likely to be charged with a new offense.
- 55 percent were less likely to be charged with a new violent offense.
- At the same time, the length of jail time for Behavioral Health Court participants was reduced by 36.8 percent.[32]

The Cost to the Community: Misdemeanor Behavioral Health Court

Misdemeanor Behavioral Health Court (MBHC) is a new San Francisco collaborative court designed to serve misdemeanants with complex mental health needs. The goal of the court is to identify and engage participants with severe mental illness in community services by providing them with case management and access to mental health services. The program grew out of a need to better engage misdemeanants with mental illness whose short jail stays made it difficult to enroll them in the existing Behavioral Health Court. Representatives from the Court, the Sheriff's Department, the Public Defender, the District Attorney and UCSF/Citywide Forensics collaborated to create MBHC.

Between June 2015 and December 2015, 18 individuals were enrolled in Misdemeanor Behavioral Health Court. Fifteen of the 18 individuals were homeless upon entry into the program. A review of the incarceration and mental health history for these 18 individuals reveals that in the 12 months prior to their enrollment in MBHC, they had a combined total of:

- 3,022 jail bed days, 168 days average per client.
- 72 psychiatric emergency room visits.
- 127 inpatient psychiatric hospitalization days.

Because misdemeanor clients cycle rapidly and repeatedly through the jail, the short time they spend in jail is not likely captured in the data from the Budget Legislative Analyst's Office. The approximate cost to the city for these 18 individuals was more than $800,000 in the 12 months prior to entering MBHC. That conservative estimate does not include the cost of law enforcement, transportation, or the cost of prosecuting and defending these 18 individuals.

V. A Center Designed to Ensure a Continuum of Care

The BHJC is designed to provide a continuum of care for people with serious mental illness who are involved in the criminal justice system and also to serve as a hub for effective mental health services within the community.

The BHJC has four tiers of service and treatment designed to address four distinct levels of need. At each level of care, the BHJC will adhere to evidence-based practices including: forensic intensive case management, supportive housing, integrated dual diagnosis treatment, access to appropriate medication, medication management, peer support, forensic assertive community treatment, supported employment, cognitive behavioral therapy, gender-based mental health treatment, and trauma-informed care.[33] (See glossary for more information about these practices.) All programming housed in the BHJC would expand, not replace, existing services.

Co-locating services and agencies within the BHJC will provide a built-in safety net for persons transitioning from the jail to community-based treatment. As a multi-agency center, the BHJC will also ensure that each program within the center is held accountable for quality mental health treatment and tracking outcomes.

The creation of the BHJC may require legislative and regulatory steps to be taken that, at a minimum, ensure that individuals who access services through the center maintain all rights and privileges afforded to them in a traditional custodial setting. As a national leader in criminal justice and behavioral health reform, San Francisco is well-positioned to pioneer these important changes.

Level 1: Emergency Mental Health Reception Center and Respite Beds

Level 1 will provide a 24-hour venue for local law enforcement to bring individuals experiencing a mental health episode (who do not meet the criteria for a 5150) for an initial mental health assessment. On-site mental health assessment services will give police an accessible and streamlined alternative to detention, result in early identification of mental illness, and ensure better outcomes for the individual and for the community. This unit will also screen for mental health, physical health, and substance abuse needs. Individuals will receive emergency care and have access to short-term respite beds. The unit will also have a 24-hour mental health clinician on staff to respond to police calls for assistance. Specialized clinical assessment will reduce the time between identification of mental illness and connection to appropriate services.

Along with serving as a drop-off center for police, individuals may self-present to the assessment center or be referred by the collaborative courts, probation, local hospitals, community-based organizations, and family members. From Level 1, individuals may be referred to a higher level of care within the BHJC (levels 2-3), to a short-term respite bed, or to social services in the community. This Level will also serve as the center point for case coordination, community collaboration, and linkage to community programs. By diverting people from

custody at the front door and providing a necessary support system, this level will reduce the number of people booked into the jail, and reduce the likelihood of rearrest.

Crisis Intervention Team: Using Memphis as a Model

Nationwide, communities struggle to train law enforcement to respond appropriately to people in mental health crisis. In 2011, the San Francisco Police Department began implementing a new 40-hour Crisis Intervention Team (CIT) training for officers based on the nationally-recognized Memphis Model.

Since 2011, more than 500 officers have received the new training.[34] In addition, the department has committed to training all new recruits coming out of the Police Academy. While training is an essential starting point, training alone is not enough. Without additional support from the city and from the community mental health system, San Francisco will not be able to implement an effective program.

According to the Memphis Model of CIT, an "Emergency Mental Health Receiving Facility" is an essential core element of the program.

The founders of the Memphis program specifically outline the elements of such a facility:

Specialized Mental Health Emergency Care[35]

- Single Source of Entry (or well-coordinated multiple sources)
- On Demand Access: Twenty-Four Hours/Seven Days A Week Availability
- No Clinical Barriers to Care
- Minimal Law Enforcement Turnaround Time
- Access to Wide Range of Disposition Options
- Community Interface (Feedback and Problem Solving Capacity)

The BHJC is designed with the Memphis Model of CIT in mind to provide these core components of service in a single location.

Pre-Booking Diversion: San Francisco's New Initiative

San Francisco law enforcement feeds a person with mental illness directly into the criminal justice system on minor charges because the city lacks a pre-booking diversion program for low-level offenders in mental health crisis. Given this reality, the City is actively working to launch a police-based diversion program called Assistance Before Law Enforcement (ABLE).

This initiative is based on Seattle's successful Law Enforcement Assisted Diversion (LEAD) model, in which police are given discretion to connect individuals to services as a diversion from prosecution.

As San Francisco implements ABLE, a critical component will be an appropriately staffed and resourced center that can engage with individuals at the moment of diversion and begin connecting them to the services they need. The Emergency Mental Health Reception Center is an ideal site for this purpose.

From the BHJC, individuals could be diverted to:

- Level 1 - Short-term respite bed
- Level 2 - Short-term transitional housing
- Level 3 – Long-term residential dual diagnosis treatment bed
- Zuckerberg San Francisco General Hospital
- UCSF Center for Geriatric Care
- Misdemeanor Behavioral Health Court
- The Women's Resource Center
- Community Assessment and Services Center (CASC)
- Court Accountable Homeless Services (CAHS)
- The No Violence Alliance Project (NOVA)
- San Francisco Sobering Center
- Pretrial Diversion Services
- Supervised Pretrial Release (SPR)
- Sheriff's Department Community Services (70 Oak Grove)
- The Navigation Center
- Hummingbird Place Peer Respite
- Medical Detoxification Bed
- Community-based mental health services
- Community-based substance abuse services
- San Francisco shelter bed

Level 2: Short-term Transitional Housing

Level 2 will provide short-term (2-3 week) on-site residential treatment. This level will also assist with transition to community treatment services and linkage to community programs, education, and employment support for individuals transitioning from jail to community-based treatment. Individuals with mental illness wait months in the county jail for placement in a residential treatment program and often opt out of comprehensive mental health treatment in the community because of the inordinately long wait. The ability to move people to a less restrictive level of care when they are psychiatrically stable will help maintain an effective treatment plan, provide a smooth and safe transition to the community, free up the higher levels of care for others in need of those limited resources, and reduce jail bed usage.

Level 3: Long-term Residential Dual Diagnosis Treatment

Level 3 will provide longer-term intensive residential psychiatric care and substance abuse treatment in an unlocked setting. The city of San Francisco does not have enough residential dual diagnosis treatment beds to meet the needs of the community, and hospital patients are prioritized for care over individuals in county jail. The unit will serve as a step-down from the secure inpatient unit (Level 4) or as a step-up from a lower level of care (Levels 1 or 2). Individuals may be assigned to this unit directly from the county jail if clinically appropriate, thus reducing length of stay for this population. From this residential treatment program, individuals will remain on a waitlist for a bed in a community-based treatment program that serves both the forensic and non-forensic populations.

Level 4: Secure Inpatient Transitional Care Unit

Level 4 will provide secure, short-term, inpatient treatment to persons with mental illness who are transitioning to placement in community-based residential treatment programs. Moving patients with serious mental illness from the county jail to a hospital-like setting will decrease the overall jail population and create a safer atmosphere for deputies and jail staff. It will also increase the likelihood of success once that person is transferred to a residential treatment bed. Persons who would otherwise be waiting in the county jail without appropriate treatment services may voluntarily transfer to this unit. It is explicitly designed and intended for use as a transitional facility for persons awaiting transfer to residential treatment elsewhere or to another appropriate placement.

With consent of the parties in the criminal case, and based upon a clinical determination by mental health professionals, a judge may authorize voluntary transfer to the BHJC. The secure unit is not a replacement for the jail, but rather an appropriate venue for successful transition in one direction—from the jail to mental health treatment. The locked unit cannot be accessed except via voluntary transfer from the county jail. Clients in other levels of treatment in the BHJC or the community will not be sent to the secure floor. In addition, individuals will not be sentenced to serve jail time in the BHJC. Moving individuals with mental illness from the county jail to the BHJC not only ensures the needs of this population are better met, it will also free up traditional county jail beds, further reducing the need for a new jail.

VI. Additional Features of the BHJC

Inpatient Competency Restoration Program

Individuals found incompetent to stand trial on felony charges languish in jail for up to six months without treatment waiting for transfer to a state hospital. Having a local competency restoration program would permit clinicians to begin the restoration process immediately after the competency finding, and would ensure that the county is not violating the constitutional rights of those who have been found incompetent to stand trial.

Multidisciplinary Care Coordinator

To address the lack of communication and coordination between agencies that interact with the criminal justice system, the BHJC should employ a Multidisciplinary Care Coordinator to span the different administrative structures, funding mechanisms, and treatment approaches of the community behavioral health and criminal justice systems. By employing a single person or entity to oversee both systems, San Francisco will be able to close gaps and ensure accountability for outcomes across the mental health care continuum.

Peer Mentor Coordinator

San Francisco Collaborative Courts recently received a grant to implement a peer mentor program for all clients participating in problem solving courts. The Mentoring and Peer Support (MAPS) Project is designed to enhance behavioral health and wellness outcomes among substance using men and women under Court jurisdiction who have diagnoses of severe and persistent mental illness. A centralized Peer Mentor Center will facilitate better communication between clients and mentors and result in better outcomes.

Partnership with the Community Assessment and Services Center (CASC)

Along with providing direct service onsite, the BHJC will be a referral source to numerous other treatment providers in the community, including a direct relationship with the Adult Probation Department's CASC Center. The BHJC will refer individuals between the two programs depending on individual needs of the participants.

Primary Care Services

Along with untreated mental illness, many of the individuals in jail and in the community have untreated medical needs that impair functioning. At this location, each person would be screened by medical providers and directed to appropriate medical services in the community.

Family Center

Family members and caregivers of people with mental illnesses often play a large role in helping and supporting them. The San Francisco Collaborative Courts have a strong relationship with National Alliance for Mental Illness (NAMI) and rely upon its members for education and training. By working with NAMI, the BHJC can include family members in the criminal justice process from the beginning, resulting in better outcomes for the family and for the person in crisis.

Courtrooms, Classrooms, and Interview Rooms

The BHJC can also house courtrooms designed for problem-solving courts that do not have the need for accommodating a jury. Placing collaborative courts in a separate location from traditional criminal courts will enhance the stakeholders' ability to work together and foster the non-adversarial atmosphere necessary for a problem-solving court.

VII. Administration and Oversight

The BHJC proposed here is a collaborative interagency center designed to (1) bridge a divide between the criminal justice system and community-based treatment programs for mentally ill individuals, and (2) ensure diversion from the criminal justice system at the earliest possible opportunity. The center should therefore be administered by an independent organization with oversight and support from a joint authority of medical, mental health, and criminal justice agencies.

One possible model would be the creation of a Joint Powers Authority pursuant to the Joint Exercise of Powers Act. The term "joint powers" describes government agencies that have agreed to combine their resources and power to work on common problems. Joint Powers Agreements (JPAs) are commonly used in construction projects, including the building of mental health facilities. According to the state Senate Local Government Committee, "Agencies create JPAs to deliver more cost-effective services, eliminate duplicative efforts, and consolidate services into a single agency."[36]

VIII. Case Studies Support a More Holistic Approach to Mental Health and Criminal Justice

Although the Behavioral Health Justice Center proposed here is a novel approach specific to the needs of San Francisco, several cities and counties across the country have designed programs similar to this concept.

Miami Dade County, Florida

Pursuant to a voter-approved bond measure in 2004, the county is in the process of renovating a former state mental hospital to create a 200-bed "Mental Health Diversion Facility" designed as a complete continuum of care for people with mental illness in the criminal justice system. The facility is expected to open in 2016 with 168 residential treatment beds for stays up to 90 days and 32 shorter-term crisis beds. The facility will also have a number of outpatient or day services, a courtroom for defendants with mental illnesses and eligible for diversion programs, and a primary health care unit. Services will be coordinated through case managers with probation officer involvement as needed. The facility is designed for both pretrial and post-conviction defendants, as well as people charged and convicted of felonies and misdemeanors.

The Mental Health Diversion Facility is designed to be part of a larger continuum of services for people with mental illness in the criminal justice system in Miami. Other components include Crisis Intervention Team training for police and school personnel, as well as the Eleventh Judicial Circuit Criminal Mental Health Project (CMHP), which includes pre- and post-arrest mental health diversion programs. Since implementation, the CMHP program has seen a drop in recidivism rates for people involved. Recidivism rates for people accused of misdemeanors dropped from 75% to 20%, and people accused of felonies have a recidivism rate of only 6%.

Bexar County, Texas

Since 2002, the Center for Health Care Services has provided services to people with mental illness who would otherwise end up in the criminal justice system, diverting approximately 7,000 people annually from jails and prisons to psychiatric services and community-based clinics. The center has a 48-hour inpatient psychiatric unit, sobering and detox centers, outpatient primary care and psychiatric services, a 90-day recovery program, housing for people with mental illnesses, and job training and a program to help people transition to supported housing.

Central to the model are partnerships between the Center for Health Care Services with local law enforcement, fire and emergency response teams, and community organizations to identify 46 distinct intervention points for people with mental illness. The center is estimated to save the county $10 million annually, and the State Legislature has appropriated funds to expand the model to other counties.

Memphis, Tennessee

The Memphis Police Department created the Crisis Intervention Team, which has become a national model to train law enforcement to recognize and respond to individuals with serious mental illness. The program is designed to train officers on how to deescalate scenarios and humanely assist people in crisis, as well as to work with local mental health services to increase referrals to appropriate mental health care. Ultimately, the program is designed to divert people with mental illness to treatment and away from jails and prisons. Jurisdictions with CIT training saw an 80% reduction in injuries to police officers responding to mental health calls and people with mental illness who interfaced with an officer with CIT training were less likely to be rearrested than a typical interaction. These jurisdictions were able to transport people with mental illness to a treatment facility, rather than jail, 49% of the time.

IX. National Public Policy Trends Support the Creation of a BHJC

For decades San Francisco has been guided by well-respected national policymakers in the development of programs at the intersection of mental health and criminal justice. Here we highlight three seminal policy documents that should be applied in the creation of the BHJC.

The Sequential Intercept Model (SIM)[37]

Developed by SAMHSA's GAINS Center for Behavioral Health and Justice Transformation, the Sequential Intercept Model (SIM) identifies five "intercepts" where people with mental illness engage with the criminal justice system: law enforcement; initial detention/initial court; jails/courts; reentry; and community corrections. Notably, San Francisco's Work Group to Re-Envision the Jail is using the SIM to guide its development of justice and behavioral health system reforms.

The proposed BHJC is grounded in the Sequential Intercept Model. It would allow the community to develop a robust pre-booking diversion program to redirect people out of the system at the initial interaction with the police and ensure that individuals at later intercepts have timely access to the levels of care they need. For the first time, the City would be able to provide linkage to services at all five intercepts in a single location with a coordinated approach.

The Criminal Justice/Mental Health Consensus Project[38]

In 2002, the Council for State Governments published a landmark document advancing 47 policy recommendations to help communities improve their response to people with mental health issues in the criminal justice system. Commonly known as *The Consensus Project*, the policy ideas were central in shaping Behavioral Health Court and other collaborative programs in the Superior Court of San Francisco.

The document makes recommendations at all points along the criminal justice continuum; pre arrest, post-arrest, pre-trial, post-conviction, and includes policies on training, outreach and evaluation. While the community has done a remarkable job of implementing many of these policies, progress has been piecemeal. The criminal justice system's response to people with mental illness remains fragmented. The BHJC will advance the core principles of The Consensus Project by centralizing services in a single location and co-locating services to facilitate better communication, improve outcomes, and insure accountability.

The Essential System of Care[39]

In September of 2009, the National Leadership Forum on Behavioral Health/Criminal Justice Services (NLF) released a report on the growing crisis of people with mental illness in jails and prisons. A key recommendation in the NLF report is *The Essential System of Care*. In that single recommendation, the NLF outlines eight evidence based practices that every community needs to implement to begin reversing the damage from decades of failed public policy. These practices include forensic intensive case management, supportive housing, peer support, accessible and appropriate medication, integrated dual diagnosis treatment, supported employment, forensic assertive community treatment, and cognitive behavior interventions targeted to risk factors.

San Francisco has implemented *all eight* of these practices in its Behavioral Health Court. The court has become a national model and shown measurable improvements for participants and for the safety of the public.[40] However, Behavioral Health Court serves a small population of San Franciscans and the intervention happens only when people are well entrenched in the criminal justice system. The BHJC, on the other hand, will build on the success of the court and expand the reach of the community to engage people all along the criminal justice continuum with research-based treatment interventions. The BHJC will dramatically increase the number of people we can connect to quality treatment and do so at an earlier point in time.

X. CONCLUSION

Any long-term sustainable approach to public safety—in San Francisco or elsewhere—must confront and address the role of mental illness and addiction. Traditional approaches—in particular, our jails and prisons—are almost singularly ill-suited for this task. In fact, relying on them for a purpose for which they were never intended has proven highly counterproductive. It creates and worsens many more problems than it solves. San Francisco already has taken a decisive step in rejecting state funds to build more traditional jail beds. By investing in a Behavioral Health Justice Center, San Francisco would be one of the first communities in the nation to take a second, equally bold step toward creating a justice system that promotes the well-being and safety of all of our community members.

With nearly half of California's jail and prison population suffering from mental illness, it is obvious that the status quo is failing and it is time to set a more strategic course. The Behavioral Health Justice Center will create a seamless continuum of care in San Francisco and will help make treatment and rehabilitation of individuals with mental illness in our justice system more effective, more efficient, and more just.

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[1] Presentation by SFDPH to the *Workgroup to Re-Envision the Jail Replacement Project* on 4/8/2016.

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[3] Board of Supervisors Budget and Legislative Analyst's Office, *Policy Analysis Report*, May 25, 2016, p.8.

[4] National Leadership Forum on Behavioral Health/Criminal Justice Services, *Ending an American Tragedy: Addressing the Needs of Justice Involved People with Mental Illnesses and Co-Occurring Disorders*, September 2009, p.7.

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Glossary of Terms

Cognitive Behavioral Therapy (CBT): CBT teaches individuals in treatment to recognize and stop negative patterns of thinking and behavior. For instance, cognitive-behavioral therapy might help a person be aware of the stressors, situations, and feelings that lead to substance use so that the person can avoid them or act differently when they occur.

Gender-Based Mental Health Treatment: mental health treatment that incorporates the influence of gender differences in the prevalence, course and burden of mental illnesses.

Forensic Assertive Community Treatment (FACT): FACT is a treatment model that addresses a significant gap in our service delivery systems by targeting the interface between mental health and criminal justice services. FACT provides assertive outreach and comprehensive services. FACT adds legal leverage in the form of judicial monitoring to comprehensive, high intensity, mobile, psychiatric treatment. Treatment is provided by a team of professionals with services determined by an individual's needs for as long as required.

Forensic Intensive Case Management (FICM): case management designed for justice-involved people with multiple and complex needs that features services provided when and where they are needed. FICM focuses on brokering rather than providing services directly.

Integrated Dual Diagnosis Treatment: treatment for mental and substance use disorders simultaneously and in the same setting.

Peer Support: Forensic peer specialists can expand the continuum of services available to people with mental and substance use disorders and help them engage in treatment by bringing real-world experience with multiple service systems and an ability to relate one-on-one to people struggling to reclaim their lives.

Supported Employment: an evidence-based practice that helps people with mental illnesses find and keep meaningful jobs in the community. Employment specialists closely coordinate with rehabilitation and clinical treatment practitioners, creating a comprehensive treatment program and providing ongoing support as needed. Jobs exist in the open labor market, pay at least minimum wage, and are in work settings that include people who are not disabled.

Supportive Housing: permanent, affordable housing linked to a broad range of supportive services, including treatment for mental and substance use disorders.

Trauma-Informed Care: a trauma-informed approach is one that (1) Realizes the widespread impact of trauma and understands potential paths for recovery; (2) Recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; (3) Responds by fully integrating knowledge about trauma into policies, procedures, and practices; and (4) Seeks to actively resist re-traumatization.

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Craig Haney is Distinguished Professor of Psychology, Director of the Program in Legal Studies, and the UC Presidential Chair, 2015-2018 at the University of California, Santa Cruz. Haney holds Ph.D. and J.D. degrees from Stanford University, and served as one of the principal researchers on the highly publicized "Stanford Prison Experiment" in 1971. He has been studying the psychological effects of living and working in prison environments since then, and many of his analyses of those issues appear in his widely praised book, Reforming Punishment: Psychological Limits to the Pains of Imprisonment, published by the American Psychological Association in 2006, and nominated for a National Book Award. Professor Haney has served as an expert witness in several landmark cases addressing the constitutional rights of prisoners, including Toussaint v. McCarthy (1983), Madrid v. Gomez (1995), Coleman v. Gomez (1995), and Ruiz v. Johnson (1999), and Brown v. Plata (2011). In 2012, he was appointed to a National Academy of Sciences Committee studying the causes and consequences of mass incarceration in the United States and also testified at an historic hearing before the U.S. Senate examining the nature and effects of solitary confinement. In 2014, Professor Haney was selected as the University's Distinguished Faculty Research Lecturer.

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