

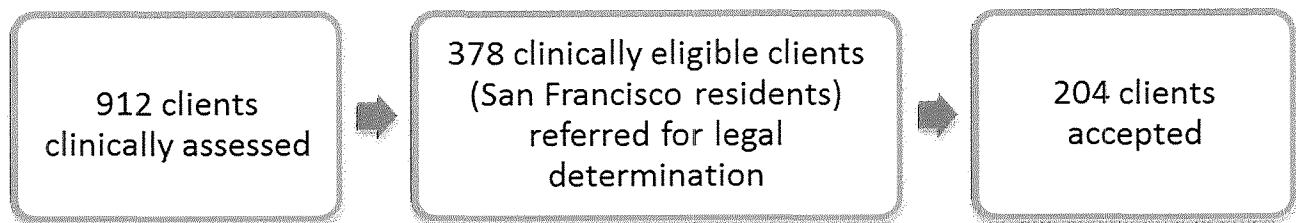


SAN FRANCISCO COLLABORATIVE COURTS

San Francisco Behavioral Health Court*

- Approximately 130 Clients are currently receiving services from the BHC Team

Client snapshot: Jan 1, 2016 – Dec. 31, 2018



New Clients (n=204)

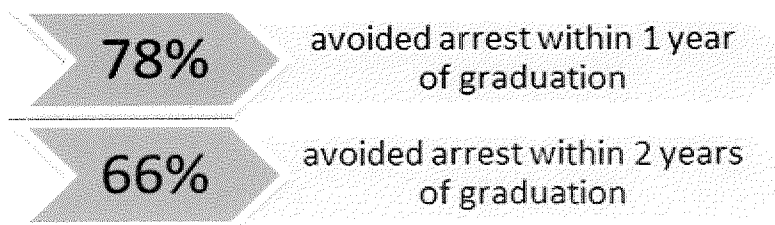
- 48% reported they were homeless, living on the street, or in a shelter prior to arrest.
- 74% reported a history of homelessness.
- 56% had a Primary Diagnosis of Schizophrenia, 16% Psychotic disorder, Bipolar 14%.
- 81% had a Co-Occurring Substance Abuse Disorder

Graduating Clients (n=97)**

- 44% were homeless prior to arrest
- 82% had independent housing at exit
- 16% were in Residential Treatment at exit
- Median time in program 747 days

58% Graduation Rate
from 2008 to 2018

Re-Arrests in San Francisco County***



*Felony and Misdemeanor cases

**Includes clients who graduated the program and those who successfully completed terms of Probation.

***Includes 2016 and 2017 Graduating clients (58)

Mental Health Diversion in San Francisco County
August 1, 2018 through April 1, 2019

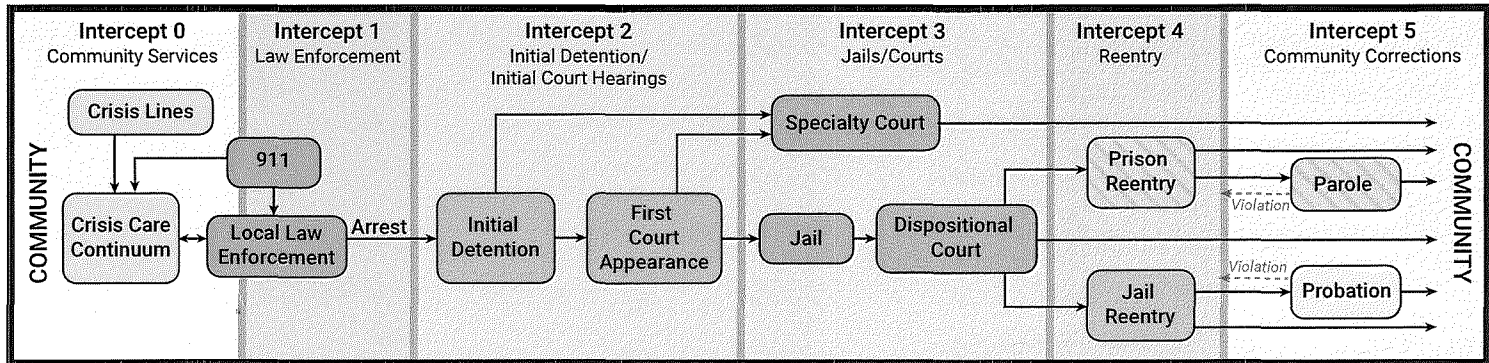
- 166 Referred
- 50 Pending
- 50 Denied
- 35 Accepted
- 28 Withdrawn by defense
- 1 Terminated
- 1 Successful Completion

THE SEQUENTIAL INTERCEPT MODEL

Advancing Community-Based Solutions for Justice-Involved People with Mental and Substance Use Disorders



The Sequential Intercept Model



Key Issues at Each Intercept

Intercept 0

Mobile crisis outreach teams and co-responders. Behavioral health practitioners who can respond to people experiencing a behavioral health crisis or co-respond to a police encounter.

Emergency Department diversion. Emergency department (ED) diversion can consist of a triage service, embedded mobile crisis, or a peer specialist who provides support to people in crisis.

Police-friendly crisis services. Police officers can bring people in crisis to locations other than jail or the ED, such as stabilization units, walk-in services, or respite.

Intercept 1

Dispatcher training. Dispatchers can identify behavioral health crisis situations and pass that information along so that Crisis Intervention Team officers can respond to the call.

Specialized police responses. Police officers can learn how to interact with individuals experiencing a behavioral health crisis and build partnerships between law enforcement and the community.

Intervening with super-utilizers and providing follow-up after the crisis. Police officers, crisis services, and hospitals can reduce super-utilizers of 911 and ED services through specialized responses.

Intercept 2

Screening for mental and substance use disorders. Brief screens can be administered universally by non-clinical staff at jail booking, police holding cells, court lock ups, and prior to the first court appearance.

Data matching initiatives between the jail and community-based behavioral health providers.

Pretrial supervision and diversion services to reduce episodes of incarceration. Risk-based pre-trial services can reduce incarceration of defendants with low risk of criminal behavior or failure to appear in court.

Intercept 3

Treatment courts for high-risk/high-need individuals. Treatment courts or specialized dockets can be developed, examples of which include adult drug courts, mental health courts, and veterans treatment courts.

Jail-based programming and health care services. Jail health care providers are constitutionally required to provide behavioral health and medical services to detainees needing treatment.

Collaboration with the Veterans Justice Outreach specialist from the Veterans Health Administration.

Intercept 4

Transition planning by the jail or in-reach providers. Transition planning improves reentry outcomes by organizing services around an individual's needs in advance of release.

Medication and prescription access upon release from jail or prison. Inmates should be provided with a minimum of 30 days medication at release and have prescriptions in hand upon release.

Warm hand-offs from corrections to providers increases engagement in services. Case managers that pick an individual up and transport them directly to services will increase positive outcomes.

Intercept 5

Specialized community supervision caseloads of people with mental disorders.

Medication-assisted treatment for substance use disorders. Medication-assisted treatment approaches can reduce relapse episodes and overdoses among individuals returning from detention.

Access to recovery supports, benefits, housing, and competitive employment. Housing and employment are as important to justice-involved individuals as access to behavioral health services. Removing criminal justice-specific barriers to access is critical.

Implementing Intercept 0

Crisis Response

Crisis response models provide short-term help to individuals who are experiencing behavioral health crisis and can divert individuals from the criminal justice system. Crisis response models include:

- Certified Community Behavioral Health Clinics
- Crisis Care Teams
- Crisis Response Centers
- Mobile Crisis Teams

Police Strategies

Proactive police response with disadvantaged and vulnerable populations are a unique method of diverting individuals from the criminal justice system. Proactive police response models include:

- Crisis Intervention Teams
- Homeless Outreach Teams
- Serial Inebriate Programs
- Systemwide Mental Assessment Response Team

Sequential Intercept Model as a Strategic Planning Tool

The **Sequential Intercept Model** is most effective when used as a community strategic planning tool to assess available resources, determine gaps in services, and plan for community change. These activities are best accomplished by a team of stakeholders that cross over multiple systems, including mental health, substance use, law enforcement, pretrial services, courts, jails, community corrections, housing, health, social services, people with lived experiences, family members, and many others. Employed as a strategic planning tool, communities can use the **Sequential Intercept Model** to:

1. Develop a comprehensive picture of how people with mental and substance use disorders flow through the criminal justice system along six distinct intercept points: (0) Community Services, (1) Law Enforcement, (2) Initial Detention and Initial Court Hearings, (3) Jails and Courts, (4) Reentry, and (5) Community Corrections
2. Identify gaps, resources, and opportunities at each intercept for adults with mental and substance use disorders
3. Develop priorities for action designed to improve system and service level responses for adults with mental and substance use disorders

Policy Research Associates

We are a national leader in behavioral health services research and its application to social change. Since 1987, we have assisted over 200 communities nationwide through a broad range of services to guide policy and practice.

We conduct meaningful, quality work through evaluation and research, technical assistance and training, and facilitation and event planning to improve the lives of people who are disadvantaged. We strive to make an impact in the field and promote a positive work environment.

345 Delaware Ave
Delmar, NY 12054
p. (518) 439-7415
e. pra@prainc.com
www.prainc.com



@_PolicyResearch



/PolicyResearchAssociates/

History and Impact of the Sequential Intercept Model

The Sequential Intercept Model (SIM) was developed over several years in the early 2000s by Mark Munetz, MD and Patricia A. Griffin, PhD, along with Henry J. Steadman, PhD, of Policy Research Associates, Inc. The SIM was developed as a conceptual model to inform community-based responses to the involvement of people with mental and substance use disorders in the criminal justice system.

After years of refinement and testing, several versions of the model emerged. The "linear" depiction of the model found in this publication was first conceptualized by Dr. Steadman of PRA in 2004¹ through his leadership of a National Institute of Mental Health-funded Small Business Innovative Research (SBIR) grant awarded to PRA. The linear SIM model was first published by PRA in 2005² through its contract to operate the GAINS Center on behalf of the Substance Abuse and Mental Health Services Administration (SAMHSA). The "filter" and "revolving door" versions of the model were formally introduced in a 2006 article in the peer-reviewed journal *Psychiatric Services* authored by Drs. Munetz and Griffin³. A full history of the development of the SIM can be found in the book *The Sequential Intercept Model and Criminal Justice: Promoting Community Alternatives for Individuals with Serious Mental Illness*⁴.

With funding from the National Institute of Mental Health, PRA developed the linear version of the SIM as an applied strategic planning tool to improve cross-system collaborations to reduce involvement in the justice system by people with mental and substance use disorders. Through this grant, PRA, working with Dr. Griffin and others, produced an interactive, facilitated workshop based on the linear version of the SIM to assist cities and counties in determining how people with mental and substance use disorders flow from the community into the criminal justice system and eventually return to the community.

During the mapping process, the community stakeholders are introduced to evidence-based practices and emerging best practices from around the country. The culmination of the mapping process is the creation of a local strategic plan based on the gaps, resources, and priorities identified by community stakeholders.

Since its development, the use of the SIM as a strategic planning tool has grown tremendously. In the 21st Century Cures Act⁵, the 114th Congress of the United States of America identified the SIM, specifically the mapping workshop, as a means for promoting community-based strategies to reduce the justice system involvement of people with mental disorders. SAMHSA has supported community-based strategies to improve public health and public safety outcomes for justice-involved people with mental and substance use disorders through SIM Mapping Workshop national solicitations and by providing SIM workshops as technical assistance to its criminal justice and behavioral health grant programs. In addition, the Bureau of Justice Assistance has supported the SIM Mapping Workshop by including it as a priority for the Justice and Mental Health Collaboration Program grants.

With the advent of Intercept 0, the SIM continues to increase its utility as a strategic planning tool for communities who want to address the justice involvement of people with mental and substance use disorders⁶.

1. Steadman, H.J. (2007). NIMH SBIR Adult Cross-Training Curriculum (AXT) Project – Phase II Final Report. Delmar, NY: Policy Research Associates. (Technical report submitted to NIMH on 3/27/07.)
2. National GAINS Center. (2005). Developing a comprehensive state plan for mental health and criminal justice collaboration. Delmar, NY: Author.
3. Munetz, M.R., & Griffin, P.A. (2006). Use of the sequential intercept model as an approach to decriminalization of people with serious mental illness. *Psychiatric Services*, 57, 544-549. DOI: 10.1176/ps.2006.57.4.544
4. Griffin, P.A., Heilbrun, K., Mulvey, E.P., DeMatteo, D., & Schubert, C.A. (Eds.). (2015). *The sequential intercept model and criminal justice: Promoting community alternatives for individuals with serious mental illness*. New York: Oxford University Press. DOI: 10.1093/medpsych/9780199826759.001.0001
5. 21st Century Cures Act, Pub. L. 114-255, Title XIV, Subtitle B, Section 14021, codified as amended at 41 U.S.C. 3797aa, Title I, Section 2991
6. Abreu, D., Parker, T.W., Noether, C.D., Steadman, H.J., & Case, B. (2017). Revising the paradigm for jail diversion for people with mental and substance use disorders: Intercept 0. *Behavioral Sciences & the Law*, 35, 380-395. DOI: 10.1002/bsl.2300

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

Craig Haney, Ph.D., J.D.
Professor of Psychology, University of California, Santa Cruz

Jennifer K. Johnson, J.D.
Co-Founder of San Francisco Behavioral Health Court

Kathleen Lacey, LCSW
Director, UCSF Citywide Case Management Forensic Program

Michael Romano, J.D.
Director, Stanford Law School Justice Advocacy Project

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).

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.

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)

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 is well-positioned to pioneer these important changes.

Table of Contents

I. Introduction: San Francisco's Mental Health Crisis.....	1
II. Current Mental Health Support and Treatment Landscape in San Francisco	1
Law Enforcement has Few Options for Individuals in Mental Health Crisis	2
Individuals with Mental Health Disorders Languish in Jail Waiting for Treatment	2
Defendants Found Incompetent Wait Months for Placement in a Hospital	2
Individuals with Mental Health Disorders released from Jail Custody have Few Options	3
III. Jails Are Not Designed for Mental Health Treatment.....	3
IV. Local Data Support the Need for the Behavioral Health Justice Center.....	4
V. A Center Designed to Ensure a Continuum of Care	7
Level 1: Emergency Mental Health Reception Center and Respite Beds	7
Level 2: Short-term Transitional Housing	9
Level 3: Long-term Residential Dual Diagnosis Treatment	10
Level 4: Secure Inpatient Transitional Care Unit	10
VI. Additional Features of the Behavioral Health Justice Center	10
Inpatient Competency Restoration Program	10
Multidisciplinary Care Coordinator	11
Peer Mentor Center	11
Partnership with the Community and Services Center (CASC)	11
Primary Care Services	11
Family Center	11
Courtrooms, Classrooms, and Interview Rooms	12
VII. Administration and Oversight	12
VIII. Case Studies Supporting a More Holistic Approach to Mental Health and Criminal Justice	12
Miami Dade County, Florida	12
Bexar County, Texas	13
Memphis, Tennessee	13
IX. National Public Policy Trends Support the Creation of a Behavioral Health Justice Center	13
The Sequential Intercept Model (SIM)	13
The Criminal Justice/Mental Health Consensus Project	13
The Essential System of Care	13
X. Conclusion	14

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 (SFPDH), 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 Care³⁵

- 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 Project³⁸

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 Care³⁹

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.

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

² San Francisco Police Department, Crime Analysis Unit, *Response to Request for Information*, March 3, 2016.

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.

⁵ Presentation by the San Francisco Department of Public Health to the *Workgroup to Re-Envision the Jail Replacement Project*, April 8, 2016.

⁶ Data obtained from Superior Court of San Francisco, Department 50.

⁷ *Trueblood v. State Dept. of Social and Health Services*, “Findings of Fact and Conclusions of Law,” p.2 (April 2, 2015, the Honorable Marsha J. Pechman, Chief United States District Judge.

⁸ As one relatively recent survey of correctional treatment services put it, “[s]imply stated, prison environments are not conducive to optimal mental health functioning.” Bewley, M., & Morgan, R. (2011). A national survey of mental illness services available to offenders with mental illness: Who is doing what? *Law and Human Behavior*, 35, 351-363, at p. 352. See, also: Haney, C. (2006). *Reforming Punishment: Psychological Limits to the Pains of Imprisonment*. Washington, DC: American Psychological Association; Human Rights Watch (2003). *Ill-Equipped: Prisons and Offenders with Mental Illness* [available at: www.hrw.org/reports/2003/usa1003/usa1003.pdf]; National Research Council, *The Growth of Incarceration in the United States: Exploring Causes and Consequences*. Committee on Causes and Consequences of High Rates of Incarceration, J. Travis, B. Western, and S. Redburn (Editors). Committee on Law and Justice, Division of Behavioral and Social Sciences and Education. Washington, DC: The National Academies Press (2014).

⁹ For example, see: Kaba, F., Lewis, A., Glowa-Kollisch, S., Hadler, J., Lee, D., et al. (2014). Solitary confinement and risk of self-harm among jail inmates, *American Journal of Public Health*, 104, 442-447; Marcus, P., & Alcabes, P. (1993). Characteristics of suicides by inmates in an urban jail, *Hospital & Community Psychiatry*, 44, 256-261.

¹⁰ For example, see: James, D., & Glaze, L. (2006, September). *Mental Health Problems of Prison and Jail Inmates*. Bureau of Justice Statistics Report. NJC 213600. Washington, DC: Department of Justice; and O’Keefe, M., & Schnell, M. (2007). Offenders with mental illness in the correctional system, *Journal of Offender Rehabilitation*, 45, 81-104 (2007).

¹¹ For example, see: Blitz, C., Wolff, N., & Shi, J. (2008). Physical victimization in prison: The role of mental illness, *International Journal of Law and Psychiatry*, 3, 385-393; Wolff, N., Blitz, C., & Shi, J. (2007). Rates of sexual victimization in prison for inmates with and without mental disorders, *Psychiatric Services*, 58, 1087-1094.

-
- ¹² For example, see: Doty, et al., Self-injurious behaviors in corrections: Informal social control and institutional responses in a state prison system, *Victims & Offenders*, 7, 30-52; Erickson, P., & Erickson, S. (2008). *Crime, Punishment, and Mental Illness: Law and Social Sciences in Conflict*. Piscataway, NJ: Rutgers University Press; Martin, S. (2006). Staff use of force in U.S. confinement settings: Lawful control tactics versus corporal punishment, *Social Justice*, 33, 182-190; and Peters, et al. (2015). Co-occurring substance abuse and mental disorders in the criminal justice system: A new frontier of clinical practice and research, *Psychiatric Rehabilitation Journal*, 38, 1-6.
- ¹³ Office of the Controller County Jail Needs Assessment, October 2013, p. 17; Office of the Controller Update to the Jail Population Forecast, June 2016, p.5.
- ¹⁴ *Policy Analysis Report*, p. 5.
- ¹⁵ San Francisco Police Department, Crime Analysis Unit, *Response to Request for Information*, March 3, 2016.
- ¹⁶ *Policy Analysis Report*, p.8.
- ¹⁷ Dilley, James W., ZSFG Department of Psychiatry Presentation, August 14, 2012.
- ¹⁸ American College of Emergency Physicians, Emergency Medicine Practice Committee, *Care of the Psychiatric Patient in the Emergency Department: A Review of the Literature*, October 2014.
- ¹⁹ *Policy Analysis Report*, p.6.
- ²⁰ *Ibid*, p. 9
- ²¹ *Ibid*, p.13
- ²² <http://www.nimh.nih.gov/health/statistics/prevalence/any-mental-illness-ami-among-us-adults.shtml>
- ²³ *Policy Analysis Report*, p.12.
- ²⁴ National Institute of Mental Health, *Serious Mental Illness (SMI) Among US Adults*, <http://www.nimh.nih.gov/health/statistics/prevalence/serious-mental-illness-smi-among-us-adults.shtml>
- ²⁵ San Francisco Sheriff's Department *Mentally Ill Offender Crime Reduction Grant* proposal to the Board of State and Community Corrections, March 2015.
- ²⁶ San Francisco Sheriff's Department *Mentally Ill Offender Crime Reduction Grant* proposal to the Board of State and Community Corrections, March 2015.
- ²⁷ San Francisco Sheriff's Department Data and Policy Analysis Report, p.13.
- ²⁸ *Policy Analysis Report*, pp.13-15.
- ²⁹ *Ibid*, pp. 11-13, 16.
- ³⁰ *Policy Analysis Report*, p. 16.
- ³¹ *Ibid*, p.11.
- ³² McNeil, D. E., and Binder, R. L. (2007). *Effectiveness of a mental health court in reducing criminal recidivism and violence*. American Journal of Psychiatry, 164, 1395–1403.
- ³³ *Ending an American Tragedy*, p. 6-8.
- ³⁴ *Policy Analysis Report*, p.10.
- ³⁵ Memphis CIT Core Elements.
- ³⁶ California State Legislature, Senate Local Government Committee, *Governments Working Together: A Citizen's Guide to Joint Powers Agreements*, August 2007, p. 14.
- ³⁷ SAMHSA's GAINS Center for Behavioral Health and Justice Transformation, *Sequential Intercept Model*, Oxford University Press, 2006.
- ³⁸ Council of State Governments, *Criminal Justice/Mental Health Consensus Project*, June 2002.
- ³⁹ *Ending an American Tragedy*, pp. 6-8.
- ⁴⁰ McNeil, D., Binder, R., *Effectiveness of a Mental Health Court for Reducing Recidivism and Violence*, Am J Psychiatry 2007; 164:1395–1403; Steadman, H., et al., *The Effect of Mental Health Courts on Arrest and Jail Days*, Archives of General Psychiatry, October 2010; Lindberg, A., McKee, M., *Examining Program Costs and Outcomes of San Francisco's Behavioral Health Court*, May 2009.
-

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.

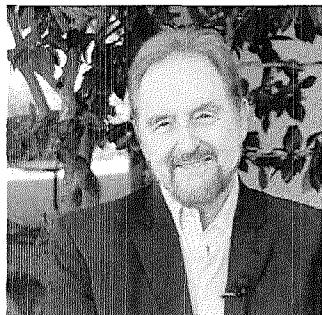
Peer Support: Forensic peer specialists can expand the continuum of services available to people with mental and substance use disorders and help them engage in treatment by bringing real-world experience with multiple service systems and an ability to relate one-on-one to people struggling to reclaim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

The Authors



Craig Haney,
Ph.D., J.D.

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.



Jennifer K.
Johnson,
J.D.

Jennifer Johnson is a Senior Trial Attorney at the Office of the Public Defender

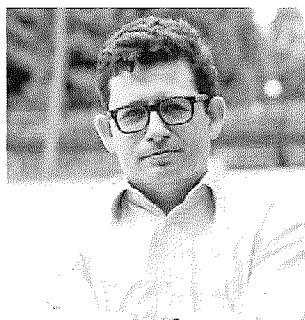
in San Francisco and one of the founders of San Francisco Superior Court’s Behavioral Health Court. She is actively involved in helping shape public policy at the intersection of mental health and criminal justice at the local, state and national levels. She is an expert for SAMHSA’s GAINS Center for Behavioral Health and Justice Transformation and was a member of the National Leadership Forum on Behavioral Health and Criminal Justice Services. Jennifer co-founded Johnson Woods Education with neuropsychiatrist George Woods, M.D. In 2012, they partnered with Thomson Reuters Corporation to create a national continuing education program on mental health for lawyers in all practice areas. She teaches a regular course at the San Francisco Police Department’s Crisis Intervention Training program and she is a lecturer at the University of California, Boalt Hall School of Law.



Kathleen Lacey,
LCSW

Kathleen Connolly Lacey, LCSW, is the Director of University of California San Francisco's Citywide Case Management Forensic Program

which provides assertive community treatment to 250 criminal justice-involved individuals with mental illness in the community. She was instrumental in implementing San Francisco's successful response to the state of California's first Mentally Ill Offender Crime Reduction Grant. A founding member of San Francisco's Behavioral Health Court, she provides clinical expertise to the courts and the community. With over 20 years of experience working in the criminal justice system and 15 years focused on the needs of individuals with serious mental disorders, she has expanded the focus of treatment to include: an emphasis on cultural and gender specific services; a comprehensive Dialectical Behavior Therapy program; a Full Service Partnership Program through San Francisco's Mental Health Services Act funds; a comprehensive Supported Employment program; mental health services for the San Francisco Sheriff Department's No Violence Alliance Program and the Adult Probation Department; and the recent creation of a Misdemeanor Behavioral Health Court in SF. She graduated from Gonzaga University in 1989 with a Bachelor of Arts Degree in Philosophy and Speech Communications; received her Masters in Social Welfare from the University of California, Berkeley in 1997 and has practiced as a Licensed Clinical Social Worker since 2001.



Michael
Romano,
J.D.

Michael Romano is the director and co-founder of the Stanford Justice Advocacy Project (formerly Three

Strikes Project) and a Lecturer in Law at Stanford Law School. He has been recognized as one of the top lawyers in California and has published several scholarly and popular press articles on criminal law and sentencing in the United States. He has successfully represented over one hundred individual clients in state and federal courts serving life sentences for nonviolent crimes. As counsel for the NAACP Legal Defense and Educational Fund, Mr. Romano co-authored successful statewide California ballot measures, the Three Strikes Reform Act of 2012 ("Proposition 36") and Safe Neighborhoods and Schools Act of 2014 ("Proposition 47"). He currently works in conjunction with the White House in support of the administration's initiative on executive clemency and advises the U.S. Department of Justice on issues involving prisoner reentry. Mr. Romano has won awards for his scholarship and advocacy improving the criminal justice system, and his work has been profiled in *The New York Times Magazine*, *Rolling Stone*, *The Economist*, and other outlets. Mr. Romano also maintains a small criminal appeals, post-conviction, and civil rights law practice in San Francisco. He graduated with honors from Stanford Law School; he was a John Knight Fellow and received a Masters in the Study of Law at Yale Law School; and he clerked for U.S. Court of Appeals Judge Richard Tallman.



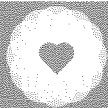
San Francisco
Health Network

SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

BEHAVIORAL HEALTH SERVICES FOR THE JUSTICE-INVOLVED POPULATION

**Serving the Needs of Criminal Justice-Involved
Patients with Mental Health and Substance Use
disorders**

Tanya Mera, LCSW
Director, Jail Health Behavioral Health and Reentry Services
San Francisco Department of Public Health

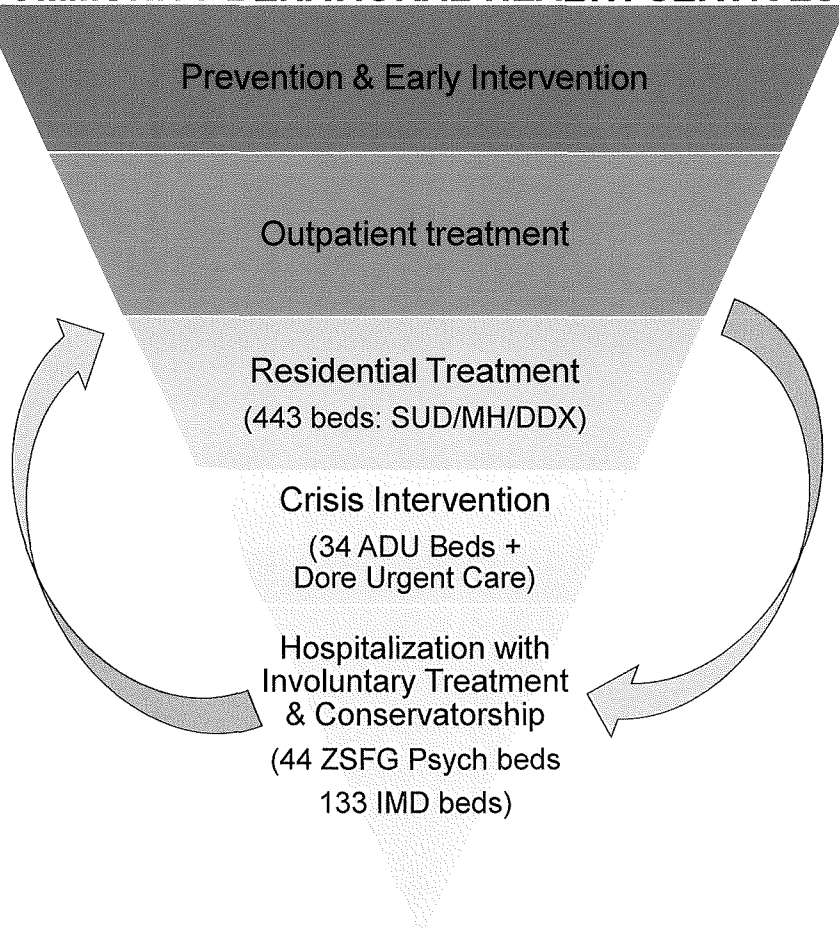


San Francisco
Health Network

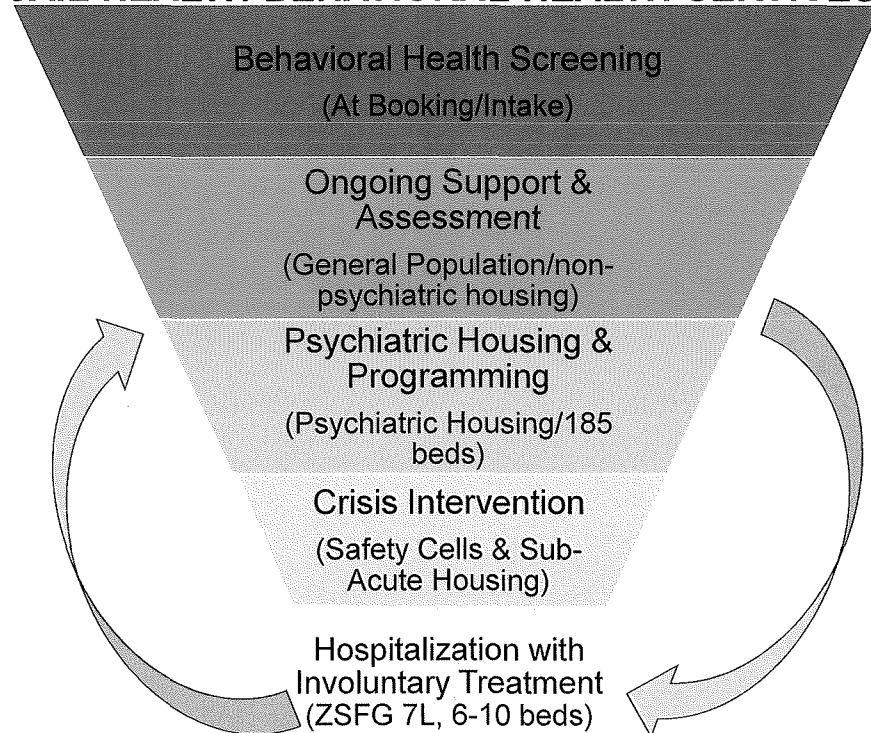
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

DPH BEHAVIORAL HEALTH CARE SYSTEMS

COMMUNITY BEHAVIORAL HEALTH SERVICES



JAIL HEALTH BEHAVIORAL HEALTH SERVICES



*Linkage to community
treatment occurs at all
levels and can include
conservatorship *



San Francisco
Health Network

SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

Jail Access to Community Treatment

- Outpatient Treatment: No wait
- Intensive Case Management/FSP: >2 months
- Acute Diversion Unit: 16 days
- Residential (MH/Dual Dx): 84 days
- Residential (SUD): 28 days
- Locked Psychiatric Facility: 2 weeks-12 months



Cross-Agency Initiatives

- Health Commission Resolution on Incarceration
- Multidisciplinary Jail Treatment Teams (SFSD & JHS)
- Mental Health Diversion grant application
- SB 1045
- AB 1557
- MacArthur Foundation Safety and Justice Challenge Grant



San Francisco
Health Network

SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

DPH Investments and Initiatives 2016-2019

Low Barrier Medications for Addiction Treatment

Pilot program to provide addiction treatment with few barriers.

Nov

Street Medicine and Shelter Health

Team expanded to provide additional outreach and medical services for people exp. homelessness.

July

2016

2017

2018

2019

Medical Respite

Added 31 beds to provide post-hospital recuperative care and sobering services for people too sick for shelters or the street.

Dec

Low Barrier Medications for Addiction Treatment

Expanded pilot program to include 10 staff providing addiction treatment.

July

Mar

San Francisco Healing Center

40 beds added for behavioral health residential treatment.

Jan

HSOC

Interagency coordinated response to street behavior and people experiencing homelessness.

Improved Linkages

Adding peer counselors and social workers to PES and Hummingbird.

May

Recovery Residences

Opening 72 new transitional housing beds for people exiting substance use treatment programs.

July

Feb

Hummingbird Place

Increased capacity to 29 stabilization beds to care for clients with behavioral health issues.

Health Fairs

First health fair dedicated to harm reduction services, health promotion, and care targeted to people experiencing homelessness.

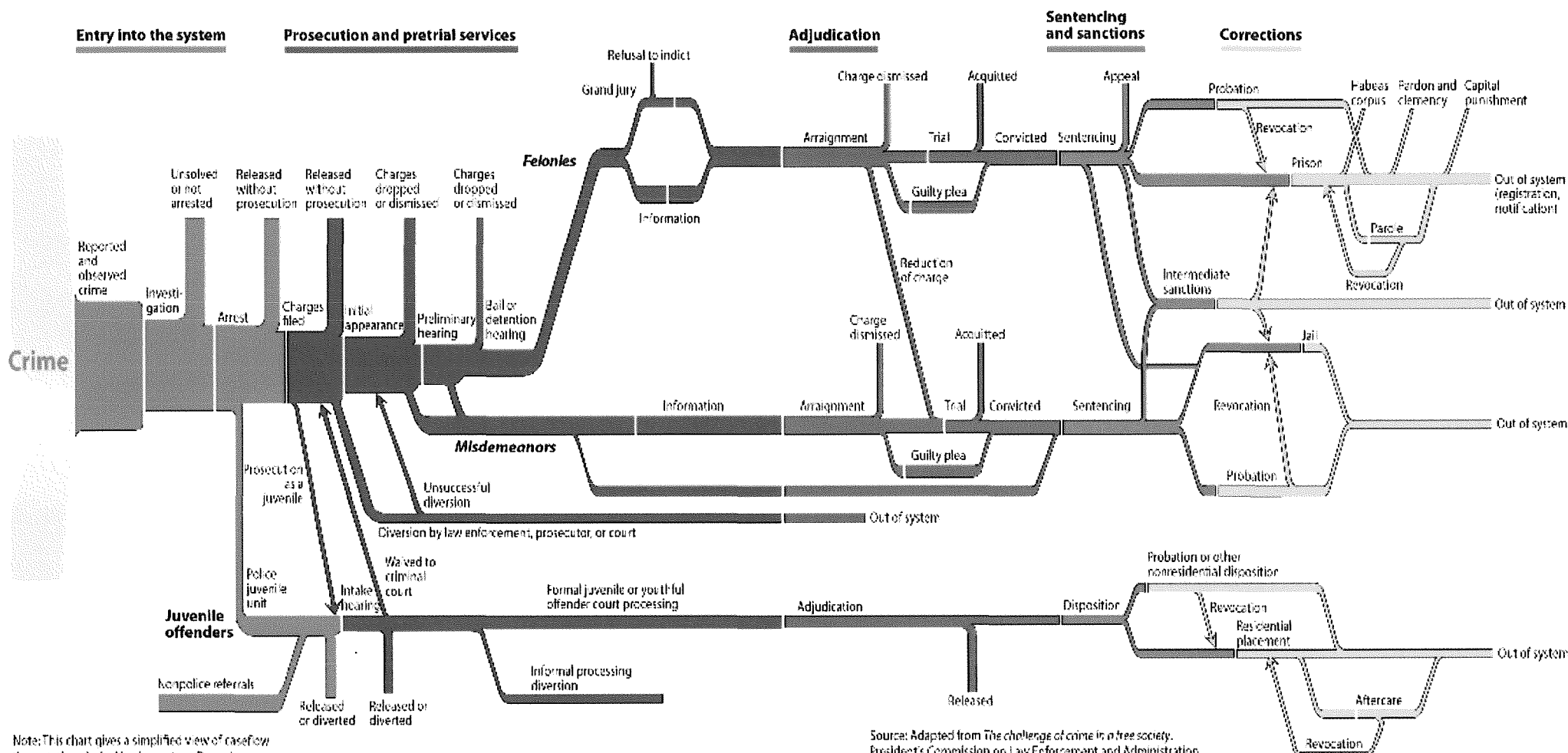
Dec

Aug

Hummingbird Place

15 beds opened to serve as navigation center for clients with behavioral health issues.

What is the sequence of events in the criminal justice system?



Note: This chart gives a simplified view of caseload through the criminal justice system. Procedures vary among jurisdictions. The weights of the lines are not intended to show actual size of caseloads.

Source: Adapted from *The challenge of crime in a free society*. President's Commission on Law Enforcement and Administration of Justice, 1967. This revision, a result of the Symposium on the 30th Anniversary of the President's Commission, was prepared by the Bureau of Justice Statistics in 1997.



George Gascón
District Attorney

April 11, 2019

The Honorable Rafael Mandelman
1 Dr Carlton B. Goodlett Place
City Hall, Room 244
San Francisco, Ca. 94102

Dear Supervisor Mandelman,

Thank you for calling a hearing regarding Behavior Health Court and its role in addressing the needs of individuals in the criminal justice system that have significant behavioral health needs. The various departments working at this intersection are approaching the work with energy and ingenuity, and I am optimistic that together we can make progress on this complex topic. My letter today is intended to lay out a variety of ideas that can improve outcomes. As the Chief Law enforcement official for the City and County of San Francisco, a primary concern is that the absence of sufficient and effective services for this population continues to result in police, the Sheriff, defense attorneys, the courts, and my office using the criminal justice system to respond to a public health crisis.

As you know, individuals with serious behavioral health needs are disproportionately represented in the criminal justice system. According to a 2016 report by the Budget and Legislative Analyst's (BLA) office, 17 percent of individuals in jail custody are diagnosed with a Serious Mental Illness, and over 36 percent of the 13,510 individuals booked into San Francisco County Jail were seen by Jail Behavioral Health Services.¹ Researchers have concluded that custodial settings exacerbate behavioral health conditions.² This means that the absence of both sufficient and appropriate services for this population makes them far more prone to re-offend upon release. We are therefore spending a tremendous amount of resources on inhumane and ineffective interventions that are not producing favorable outcomes.

The Department of Public Health (DPH) has made significant strides to increase its provision of behavioral health services. Nonetheless, individuals who are justice-involved are effectively deprioritized. In fact, according to the Workgroup to Re-envision the Jail, justice involved individuals awaiting service placement in San Francisco County Jail have had to wait five times longer than non-justice involved individuals.³ This fundamentally cripples our ability to effectuate positive outcomes as offenders often choose to plead guilty in order to get out of jail rather than wait in custody to be connected to services.

Below is an overview of some important initiatives as well as my thoughts on necessary next steps that will enable us to continue our progression on this critical issue.

Behavioral Health Court (BHC)

The mission of the Behavioral Health Court (BHC) is to enhance public safety and reduce recidivism of criminal defendants who suffer from serious mental illness by connecting them

¹ Board of Supervisors Budget and Legislative Analyst's Office, *Policy Analysis Report*, May 25, 2016, p.13

² Office of the Controller County Jail Needs Assessment, October 2013, p. 17; Office of the Controller Update to the Jail Population Forecast, June 2016, p.5.

³ Presentation by the San Francisco Department of Public Health to the *Workgroup to Re-Envision the Jail Replacement Project*, April 8, 2016.

with community treatment services. BHC participation reduces the probability of a new violent criminal charge by 55 percent in the 18 months after entering the program when compared to other in-custody individuals who suffer from mental illness. On average, each participant saves the criminal justice system over \$10,000 during the first year of BHC.

The absence of sufficient services for this population has been a significant challenge. In 2017, individuals in-custody awaiting placement in a residential behavioral health program regularly spent up to 90 additional days in jail simply waiting for a treatment bed in the community.

Law Enforcement Assisted Diversion (LEAD)

LEAD is an innovative pre-booking diversion program that refers repeat, low-level drug offenders to community-based health and social services as an alternative to jail and prosecution. This referral is made as soon as they come into contact with law enforcement. San Francisco's program is modeled after Seattle's, an evaluation of which revealed that participants were 58% less likely than people in the control group to be rearrested. The evaluation also found statistically significant reductions for the LEAD group compared to the control group in average yearly criminal justice and legal system utilization and associated costs.

San Francisco's LEAD program focuses on the Tenderloin and Mission districts where a significant percentage of the city's drug incidents occur. With the state grant funding ending in June, this important work needs to continue. LEAD working group partners submitted budget requests to ensure this work continues. I strongly encourage the Mayor and the Board to prioritize these budget requests, and to work with the LEAD working group to expand the eligibility criteria and relaunch the program citywide.

Mental Health Diversion

Last summer the Governor signed AB 1810 which provides a defendant charged with almost any type of misdemeanor or felony a pathway to diversion from prosecution if they can demonstrate that the offense was committed as a result of a treatable mental health disorder. AB 1810 may be used at the discretion of the superior court, and San Francisco's Superior Court has elected to do so. Since August 2018, 131 petitions have been filed – however, the Public Defender's Office has estimated that up to 40 percent of their office's caseload will be eligible for Mental Health Diversion (MHD). Using last year's filing numbers and estimating that the Public Defender handles approximately 60 percent of all cases, we project that their office may file as many as 1,800 MHD petitions annually. Adding in cases represented by private counsel, the total number of potential petitions could range from 1,800 to 3,000.

In order to ensure the objectives of AB 1810 are satisfied, city leaders should ensure there are sufficient and appropriate services to accommodate the anticipated increase in demand. Without a significant increase in available services for this population the court will either not be able to divert individuals suffering from mental illness, or we will face significant equity challenges as those with resources will be able to take advantage of this law while the economically disadvantaged will not.

MacArthur Foundation Grant

In October, The John D. and Catherine T. MacArthur Foundation awarded a \$2 million grant to my office in partnership with the Superior Court, Public Defender's Office, Sheriff and Adult Probation Department to reform the local criminal justice system. The funding supports the implementation of strategies that address the main drivers of local jail incarceration, including ineffective practices that take a particularly heavy toll on people with mental health and

substance abuse issues. The initiative is intended to help eliminate the need for a replacement jail facility.

This grant gives San Francisco access to expertise and technical assistance, and we need to take advantage of this opportunity by committing the local resources necessary to meet our collective goals. All of the partners to this grant have concluded that reducing case processing and the wait time for treatment is a key strategy, and we should therefore ensure sufficient resources are provided in order to realize this goal.

A Comprehensive Needs Assessment

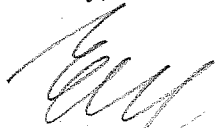
There is widespread agreement that San Francisco needs to do more to meet the demand for behavioral health services for the justice-involved population. However, San Francisco has never studied what services are needed, at what scale, where in the community these services should be located, and much more. Furthermore, these figures are not static; they will change over time. Therefore, it is essential that San Francisco conduct a robust needs assessment for justice-involved individuals with behavioral health needs, and that we continue to update it over time. We cannot meet the pressing and challenging needs of this 21st century public health epidemic without knowing its scope.

Thankfully, my partners at DPH and throughout the criminal justice system agree that this is an essential step, and we look forward to working with you to ensure that a needs and gap assessment is completed and that we have the results necessary to develop a coordinated system of services that can meet the needs of our justice-involved population.

In conclusion, I am grateful that the dialogue on this complex topic has advanced so considerably. Three years ago, the absence of a continuum of care for this population led me to convene four experts in this field who ultimately recommended that San Francisco construct a Behavioral Health Justice Center. In recognition of similar challenges, the Los Angeles County Board of Supervisors recently approved a plan to tear down the Men's Central Jail downtown and build a mental health treatment center in its place. It is my opinion that such an approach should be considered as the Board considers how to meet this challenge.

Ultimately, we must recognize the crucial role that the mental health system plays in ensuring public safety, and our approach to serving individuals who cycle between the streets, the hospitals and jails must change. What is clear is that we cannot solve our modern behavioral health challenges for the justice-involved population by adhering to the same playbook. We need a new approach, and I look forward to working with you and my partners in the criminal justice and public health systems to deliver the solutions that our community deserves.

Sincerely,



George Gascón
San Francisco District Attorney

CC: San Francisco Mayor London Breed
San Francisco Board of Supervisors
San Francisco Sheriff Vicki Hennessy
San Francisco Public Defender Manohar Raju
San Francisco Chief of Police William Scott
San Francisco Director of Public Health Dr. Grant Colfax