



Blueprint for Mental Health Reform

*A Strategic New Approach
Addressing the Intersection of
Mental Health, Homelessness
and Criminal Justice in San
Diego County*



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Message from District Attorney Summer Stephan



As District Attorney for San Diego County, I lead an office that delivers fair and equal justice for more than three million residents in the second-largest county in California. One of my key priorities is to improve the response of the criminal justice system when it comes into contact with people who suffer from mental illness, and/or substance abuse issues. For more than a year, the District Attorney's Office, along with hundreds of dedicated stakeholders, have worked together to create this **Blueprint for Mental Health Reform: A Strategic New Approach Addressing the Intersection of Mental Health, Homelessness and Criminal Justice in San Diego County** (The Blueprint). It has the very real potential to propel us forward as a region and deliver better outcomes for those facing mental health challenges in San Diego County.

This Blueprint identifies the gaps, needs, and concrete solutions that balance compassion and dignity with public safety and accountability. We are excited to share this Blueprint with the community we serve.

Addressing the critical issues surrounding mental health and criminal justice system is a complex and monumental task. The recommendations contained in this Blueprint are not intended to cast blame on any one party or agency for the crisis we face. Rather, the recommendations acknowledge the shared responsibility we have in creating a better, more humane way to serve individuals with mental illness when they find themselves entangled in the criminal justice system.

The issues we face in San Diego County cannot be solved or fixed by one agency alone. Rather, it will take a coordinated response to create a shared strategic plan for the entire county that leverages our resources. The recommendations in this report can serve as the basis of this strategic plan from the criminal justice perspective. This will not be easy as what we need is a sea change— a significant transformation of an outdated approach into a system that strives for public safety, fairness, and dignity.

In order to arrive at these recommendations, we first needed to analyze and understand the problem in depth. Our team at the District Attorney's Office studied available local data and best practices around the country. I created a new position within my Office— Deputy DA Rachel Solov is our Chief of Criminal Justice and Mental Health Reform Strategies. After we did our homework, we employed a three step process:

We brought together approximately 200 stakeholders with diverse community perspectives to identify the gaps for people with mental health and substance abuse issues within the criminal justice system. Next, we convened about 100 stakeholders focused on solutions to the gaps that were identified. Then, we delivered this Blueprint in a draft form and invited feedback. Now, we are making this blueprint publicly available in the spirit of the open and good government.

Thank you to everyone for the time and energy they devoted to this project. Now, we promise to translate your hard work into action.

Summer Stephan, San Diego County District Attorney

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Blueprint for Mental Health Reform:

A Strategic New Approach Addressing the Intersection of Mental Health, Homelessness and Criminal Justice in San Diego County

Executive Summary

Mental health and homelessness frequently intersect with the criminal justice system, and too often the outcomes fall short of helping people in our communities who face these challenges. To better map the intersection, define the problem and find solutions, District Attorney Summer Stephan led three key initiatives to shape a new approach:

- 1) A symposium that brought approximately 200 stakeholders and subject matter experts together to map the intersection of mental health, homelessness and criminal justice on April 30, 2018;
- 2) A second symposium of approximately 100 stakeholders and subject matter experts to work towards specific solutions on October 22, 2018; and now,
- 3) The Blueprint for Mental Health Reform, to report recommendations for significant changes in how we approach mental illness and criminal justice in San Diego County.¹

These initiatives identified opportunities for various stakeholders to work together to address the needs of individuals living with mental illness and co-occurring substance use disorders. Further, it allowed for the development of solutions to enhance systems of care for individuals living with mental illness, focused on those that intersect with criminal justice and public safety, and work toward common goals for the citizens we serve.

The resulting 10 recommendations included in this blueprint, which include sub-recommendations, fall into four general categories:

- 1) Mental Health Prevention and Intervention;**
- 2) Acute Crisis Response and Stabilization Management;**
- 3) Mental Health Diversion; and,**
- 4) Data, Outcomes and Information Sharing.**

Within these categories, stakeholders identified gaps and provided recommendations. For a complete Summary of Recommendations, please refer to

¹ For purposes of this report, reference to mental health includes mental illness, substance use disorders and co-occurring disorders.

Appendix A. Some gaps can be addressed with minor process changes, while others require widescale change and funding. Many of the recommendations will require examination of operations with fresh eyes, an open mind and without judgment or blame for where we are today. These recommendations should not be seen as criticism of any one agency or department, but rather as an opportunity to come together, work toward a common goal and effect great change for the people we serve.

Many of the recommendations build upon each other, and all will require a collaborative approach. The 10 recommendations are summarized as follows:

- 1) Develop a system of timely follow-up care to connect a person to appropriate services and levels of care after a mental health crisis involving law enforcement or other first responders. This can result in reducing subsequent law enforcement crisis calls that may escalate and turn deadly and can also result in safe and compassionate continuum of care that supports the health and safety of the individual in crisis, their family and community at large. Additionally, add PERT Clinicians trained in threat assessment and trauma to school law enforcement agencies as appropriate for imminent threats or emergencies and create a continuum of behavioral health responses for youth in non-emergency situations.**
- 2) Build regional Crisis Stabilization Centers, or Mental Health Urgent Care Centers, using a “no wrong doors” approach that can provide walk-in mental health and substance use disorder services, efficient law enforcement drop-offs when appropriate as a healthy and safe alternative to jail or emergency departments, and step-down care coordination with case management services.**
- 3) Support the creation and expansion of crisis/de-escalation training for law enforcement and 911 dispatchers countywide.**
- 4) Address barriers to obtaining housing by creating common sense regulations that account for public safety but allow for flexibility. Regulations should be designed to be inclusive and encourage expansion of access to housing.**
- 5) Invest in and create data systems that can timely match appropriate information across different systems to provide care coordination informed by both criminal justice and health care data.**
- 6) Support and expand existing programs and processes that coordinate releases from custody by providing a warm handoff of an individual leaving custody to appropriate services and resources in the community.**

- 7) **Increase capacity for Behavioral Health Court and consider a specialized track for those with co-occurring mental health and substance use disorders. Screen and assess certain classes of non-violent crimes for potential alternatives to custody early in the criminal justice process.**
- 8) **Create guidelines and structure for mental health diversion which ensures public safety, as well as equal access and equitable treatment for all participants.**
- 9) **Increase access to walk-in urgent mental health services by expanding hours of availability.**
- 10) **Work collaboratively with community partners to expand outreach and prevention programs and encourage the utilization of peer support. Stand up against mental health discrimination, stigma and unequal treatment.**

Supporting individuals with mental illness in our communities is a shared responsibility. As such, it will require a comprehensive and coordinated response between justice and behavioral health partners. We have a crisis here in our community that cannot be solved by public safety agencies alone. Nor can it be solved by public health agencies alone. San Diego County has increased funding of Behavioral Health Services by over 50 percent in the last four years. In fiscal year 2018-2019, the County budgeted \$658 million for Behavioral Health Services. According to data provided by Health and Human Services, thirty-three percent of Behavioral Health Services are provided to people referred from the justice system.

“A ‘sea change’ is defined as a profound or notable transformation. That is what is needed here.”

As we approach reforming our response to individuals living with mental illness, we should not just correct past practices, but rather we should look to future possibilities. A “sea change” is defined as a profound or notable transformation. That is what is needed here. Not just reform, but rather a significant transformation of an outdated approach into a system that values and strives for public safety, fairness, dignity and humanity.

Background and Statistics: The Road to the Symposiums

Our collective experiences at the District Attorney's Office tells us there is a strong intersection between mental health and criminal justice. At the same time, it is clear that mental health has become a public safety issue in our County. The percentage of incarcerated individuals with psychological or psychiatric disorders has been steadily increasing since the 1960s, mostly from the deinstitutionalization of state mental health systems. Individuals living with mental illness were often released from state mental health systems to the community without adequate supportive services, which led to many entering the criminal justice system and further recidivating at alarming rates as their underlying mental health needs remained unmet. Prisons and jails became the *de facto* state hospitals responsible for confining and caring for the mentally ill, yet they were never intended, nor designed, to cope with individuals with significant and varying degrees of mental illness.

While most individuals with a major mental illness do not commit violent acts, research shows a small but significant correlation between serious mental illness and risk of violence, particularly when the illness is a psychotic disorder. Substance use can increase this risk.² Those who commit violent acts should continue to be incarcerated or safely contained for their criminal behavior, while continuing to provide treatment in settings that protect them as well as our community. However, individuals with mental illness who commit low level offenses and who do not pose a safety risk to the public should be considered for programs that divert them away from jail and into community-based facilities to receive treatment where appropriate infrastructure exists and when safe to do so.

Safety of our communities is paramount. Because of the potential risk to the public, it is critical for law enforcement to play a principal role in shaping criminal justice and mental health reform. The District Attorney is uniquely situated to lead and coordinate this effort. The District Attorney's jurisdiction extends throughout the entire county, tying all the individual law enforcement agencies together. Additionally, prosecutors have simultaneous legal and ethical obligations to the victim, the community and the offender.

² FBI's Behavioral Analysis Unit (2017) *Making Prevention a Reality: Identifying, Assessing, and Managing the Threat of Targeted Attacks*, P. 9.

Mental illness itself must not be criminalized. However, approaches to reform mental health treatment within the criminal justice system must be balanced with a public safety approach that considers and addresses the impact criminal behavior has on victims. The District Attorney and her executive team have identified mental health as a top priority and are committed to proactive and progressive solutions that keep the public safe, protect victims' rights and treat individuals with mental illness fairly and compassionately when their conduct intersects with the criminal justice system.



To respond to this issue, we, the District Attorney Team, first had to study and understand the problem. To do this, we prioritized collecting data, researched national best practices and visited regions already implementing successful practices. It quickly became evident that we needed all our stakeholder partners to help us find meaningful solutions. San Diego has a rich history of stakeholders collaborating to solve problems, and this was no different. Stakeholders came together at two symposiums to look, for the first time in the County's history, at all three areas, mental health, homelessness and criminal justice, in one space.

Statistics demonstrate San Diego County, like the rest of our nation, is facing significant challenges in serving individuals with mental illness who intersect with our criminal justice system. Mental Illness affects one in five adults, however, at least one in three adults in the criminal justice system are affected by mental illness. Our San Diego Sheriff's Department reports approximately 30 percent of inmates receive medication for a mental health disorder. This number does not include those who refuse medication or whose symptoms are not severe enough to need medication. This number is consistent with that which is reported by the California Department of Corrections and Rehabilitation (CDCR). Approximately 30 percent of California's prison population has a major mental health designation.³ Most of these inmates will be coming back to our community when released from prison. Re-entry will be more safely

³ California Department of Corrections and Rehabilitation (2018) Offender Data Points: Offender demographics for the 24-month period, ending December 2017. Prepared by the Office of Research, Division of Internal Oversight and Research.

accomplished if we have strong, evidence-based programs in place to support their return.

Within our homeless population, the 2018 Point in Time Homeless Count identified 43 percent of those surveyed reporting a mental health disorder. Of patients being admitted for emergency psychiatric treatment, 25 percent return within 30 days.⁴ For sheriff's jurisdictions within the county, over the last five years, there has been a 23 percent increase in specific PERT (Psychiatric Emergency Response Team) related calls for service as tracked by Computer Assisted Dispatch (CAD) entries. Countywide, between 2009 and 2018, these calls for service more than doubled from 17,564 to 35,714.⁵ Our suicide rate has increased 45 percent between 2004, where 314 lives were lost, and 2017, where 458 lives were lost.⁶ Many in this vulnerable population struggle not only with a mental health disorder, but also with a substance use disorder. Nearly 70 percent of psychiatric hospitalizations involve patients with a co-occurring substance use disorder.

Substance use remains prevalent at dramatically high levels. In 2017, 79 percent of male arrestees and 73 percent of female arrestees tested positive for an illicit drug. Methamphetamine use is at an 18-year high, with 55 percent of arrested males and 58 percent of arrested females testing positive for the drug at arrest in 2017.⁷ Alarming, studies demonstrate that methamphetamine use is a risk factor for violence.⁸ Compounding the problem, substance use and mental health often co-exist. In our Drug Courts, approximately 42 percent of our participants present with a co-occurring disorder.

On the positive side, our intensive Collaborative Courts are working. In a recidivism study done with data from the District Attorney's Case Management System during the time-period of 2013-2017, participants who completed their specialized court diversion programs recidivated at significantly lower levels than those who did not complete their program.⁹ This is evidence that despite working with a population with

⁴ McDonald, J., Meant to help with mental illness, money from tax on millionaires piles up. (2018, October 14), *The San Diego Union Tribune*.

⁵ This 2018 PERT related CAD entry data does not include San Diego Police Department.

⁶ McDonald, 2018.

⁷ https://www.sandag.org/uploads/publicationid/publicationid_4526_24407.pdf

⁸ Baskins-Sommers, A. & Sommers, I, Methamphetamine use and violence among young adults, *Journal of Criminal Justice* 34 (2006) 661-674.

⁹ Note: recidivism rates for the current collaborative courts were determined using data from the District Attorney Case Management System and have not been validated. For purposes of this report, recidivism is defined as having a new case filed after program completion or termination.

challenging issues, the combination of treatment and compassionate accountability works.

Methodology for the April and October Symposiums

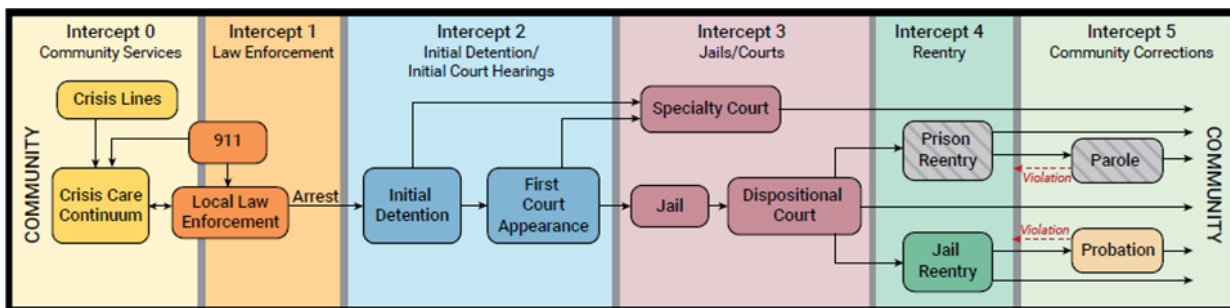
April 30, 2018: The First Symposium- Understanding the Issues

On April 30, 2018, District Attorney Summer Stephan hosted a symposium entitled, *Mapping the Intersection of Mental Health, Homelessness and Criminal Justice*. Approximately 200 subject matter experts and community stakeholders from across disciplines met for an informative morning of presentations and hands-on afternoon sessions of identifying gaps and needs in how the criminal justice system currently responds to people with mental illness. Los Angeles District Attorney Jackie Lacey was a keynote speaker at the event where she discussed her Blueprint for Change, a report and set of recommendations to address mental health and justice issues in Los Angeles.

WATCH a video from the Symposium [here](#).

Hallie Fader-Towe, from the Council on State Governments, spoke in detail about the “Stepping Up Initiative,” a nationwide call to action to reduce the number of individuals with mental illness who are in jail. Here in San Diego, in an action led by Supervisor Greg Cox and Sheriff Bill Gore, the Board of Supervisors adopted a resolution to support the Stepping Up Initiative on November 15, 2016. Finally, the morning session concluded with local subject matter experts from across each intercept speaking about what, from their perspective, has been working and what they believe are the biggest challenges.

The afternoon was spent in breakout groups where the experts and community stakeholders rolled up their sleeves and mapped the gaps and needs across the criminal justice system, and then prioritized them in order of urgency. To do this, we utilized the Sequential Intercept Model (SIM). For the Sequential Intercept Map created by stakeholders at the Symposiums, please see Appendix B.



Attendees were sent a survey prior to the Symposium to help start the mapping process. They were asked four questions. First, what is their primary area of mental health experience? Second, what resources are currently in place and working well for justice involved people with mental and substance use disorders? Third, what resources are currently in place for this population, but can be improved? And fourth, what are the major gaps in services or needs for this population? Responses were compiled and provided to the attendees at the Symposium. (See, Appendix C)

The Sequential Intercept Model (SIM)

The Sequential Intercept Model (SIM) was developed as a strategic planning tool to assist community responses to people with mental health and substance use disorders within the criminal justice system. Initially, Sequential Intercept Mapping consisted of five intercepts. Ultimately, it was expanded to look at ways to intervene prior to an individual intersecting with the criminal justice system. There are six intercepts: 0) Community Services; 1) Law Enforcement; 2) Initial Detention/Initial Court Hearings; 3) Jails/Courts; 4) Reentry; and 5) Community Corrections. During the Sequential Intercept Process, stakeholders and subject matter experts examine how individuals with mental illness and co-occurring disorders travel through and interact with the community and the criminal justice system. It provides a framework to identify resources, gaps and opportunities, as well as to prioritize needs. (See also, 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.)

October 22, 2018: The Second Symposium- Working Towards Solutions

On October 22, 2018, District Attorney Summer Stephan hosted a follow up to the April Symposium. This workshop was a smaller gathering of approximately 100 subject matter experts.

The workshop began by reviewing the findings from the first symposium, but most of the attendees' time was spent in work groups further developing the priorities established at the first symposium. A combined attendee list from both events is attached to this



DA Summer Stephan leading a symposium on mental health that brought 200 subject matter experts and community stakeholders from across the County.

report. (See Appendix D) The agendas, handouts and materials can be found [here](#).

The gaps identified through the Sequential Intercept Mapping exercise in San Diego fell into four main categories:

- 1) Mental Health Prevention and Intervention;
- 2) Acute Crisis Response and Stabilization Management;
- 3) Mental Health Diversion; and,
- 4) Data, Outcomes and Information Sharing.

Many of the resources and gaps crossed over multiple intercepts, and even fell into multiple categories. For example, gaps in prevention and intervention can occur at the community level, the law enforcement level, in-custody and during re-entry. Additionally, a recommendation for crisis stabilization and follow-up care can also be an avenue for prevention and intervention. With this understanding, the remainder of the report will be organized around these four categories. The following recommendations for improving the response of the criminal justice system to individuals with mental illness emerged from dedicated stakeholder engagement and are in line with the County's Live Well San Diego vision to build a region that is fostering better health, living safely and thriving.



Post- District Attorney Symposiums Developments

Board Conference: On October 30, 2018, the Board of Supervisors held a Board Conference, entitled, *Caring for People in Psychiatric Crisis in San Diego*. The Conference, prompted by the closure of the Tri-City Healthcare District's inpatient psychiatric facilities a few months prior, was requested under the leadership of then Chairperson, Supervisor Kristin Gaspar. The Board heard from subject matter experts and stakeholders on many of the system wide issues facing the county. A comprehensive assessment of the entire behavioral health system was presented and included an opportunity for justice partners to share their perspectives and challenges. District Attorney Summer Stephan presented many of the findings and recommendations from the two earlier DA symposiums and that are contained in this report. At a subsequent Board of Supervisors Meeting, Supervisor Gaspar directed the procurement of a consultant to facilitate follow up to the Board Conference.



Dianne Jacob, San Diego County Board of Supervisors Chair, delivers the State of the County Address.

State of the County Address: On February 6, 2019, Board of Supervisors Chairperson Dianne Jacob delivered the State of the County Address. Showing great leadership and announcing several ground-breaking immediate action steps, Supervisor Jacob propelled the momentum for mental health reform by highlighting the need to focus on effective response to individuals with mental health needs, ensuring they are provided a coordinated system of care, and identifying several specific priorities to be pursued. There were three specific priorities Supervisor Jacob identified that aligned with the recommendations from the DA Symposiums: 1) Establish a system of follow-up care to connect a person to appropriate services after a mental health crisis. 2) Establish Mental Health Crisis Stabilization Centers. And, 3) Deploy behavioral health responses (PERT School Model) for mental health related issues in our schools.

I. Mental Health Prevention and Intervention

Access to Urgent Walk-in Services

San Diego has many walk-in clinics available for urgent mental health services throughout the county. However, very few of them are available outside of regular business hours or on weekends. (See Appendix E) Further, several only have walk in services available on certain days during limited hours. This is insufficient to adequately serve a person in crisis or their loved ones. Walk in hours should be expanded, and there should be 24-hour options that do not involve an Emergency Department or the County Psychiatric Hospital.



Recommendation One:

- ✓ **Increase access to urgent mental health walk in services by expanding hours of availability.**

There is often tremendous stigma surrounding individuals living with a mental health disorder. Historically, seeing a psychologist or psychiatrist has been associated with shame and weakness, or as a family secret. When someone says they have an appointment with a therapist or psychiatrist, it is often accompanied by judgment and shame. This is not the case if someone says they have an appointment with a primary care doctor. Individuals with mental illness have been discriminated against, and yet mental illness likely touches all of us, our families or our friends in some way. We must stand up against the stigma as a community.

The National Alliance on Mental Illness (NAMI), is the nation's largest organization dedicated to improving the lives of those living with mental illness. On their website, they provide nine ways to fight the stigma that so often accompanies mental disorders.¹⁰ They are:

- 1) Talk openly about mental health.
- 2) Educate yourself and others.
- 3) Be conscious of language. Don't use a mental health condition as an adjective.
- 4) Encourage equality between physical and mental illness.
- 5) Show compassion for those with mental illness.
- 6) Choose empowerment over shame.
- 7) Be honest about treatment.
- 8) Let the media know when they're being stigmatizing.
- 9) Don't harbor self-stigma.

Campaigns to end the stigma of mental illness need to be supported and promoted countywide. These efforts, along with education and prevention, should be provided within our early education systems. The earlier mental health issues can be identified, the quicker and more comprehensive the response can be, which will lead to better outcomes.

Peer support

Peer support is where individuals with lived experience provide support and guidance for others struggling with mental health disorders. The use of Peer Support Specialists has been implemented in some jurisdictions with promising results and is strongly encouraged by the Substance Abuse and Mental Health Services Administration (SAMHSA) and NAMI. However, there is some conflicting research on whether evidence shows paid peer support improves meaningful outcomes.¹¹

In San Diego, NAMI's Next Steps program utilizes peer support and reports improved outcomes. Next Steps uses a team consisting of trained Peer Specialists,

¹⁰ For more detailed information, see their website at:

<https://www.nami.org/blogs/nami-blog/october-2017/9-ways-to-fight-mental-health-stigma>

¹¹ See, <http://www.psychiatrictimes.com/blogs/jury-out-paid-peer-support-people-mental-illness>.

Family Support Specialists, Recovery Services (AOD) Counselors, Nurses, Behavioral Health Consultants, and Health Navigators. Most team members have lived experience with serious mental illness, substance use or a co-occurring disorder or have a family member with lived experience. The program staff can relate well to program participants due to a sense of shared experiences and staff strive to empower participants to achieve their self-identified goals by collaborating and linking participants with providers at various health and social service agencies.

Intuitively, the use of peer support makes sense. The shared experience can help build a trusting and supportive relationship to assist engagement. Additionally, the success of utilizing Peer Support Specialists seems logically to be dependent on the quality of the support and the connection between the participants. Based on the highly individualized circumstances of every situation, the reports of success are encouraging and support further development here in San Diego. Programs utilizing peer support should be implemented and studied further to determine their effectiveness locally.

NAMI San Diego's oscER Smartphone App

Navigating the County's mental health system can be complex and difficult for families and patients. This is exacerbated during a time of crisis. To assist, NAMI San Diego created an app for smartphones called oscER (Organized Support Companion in an Emergency Situation).

There is also a version available for youth mental health services. The app is free and can be installed on an Android or iOS mobile device. It includes maps, phone numbers and hours for walk-in centers, emergency rooms and psychiatric hospitals, food, shelter and legal aid resources,



education, crisis line information, and even includes relaxing soundscapes. This

information was shared at our symposiums, and as a result, the San Diego Sheriff's Department provided their patrol deputies with information regarding how to download the app. Knowledge of this app should be more widespread and NAMI San Diego should be supported in efforts to keep the app available and up to date.

Recommendation Two:

- ✓ **Work collaboratively with community partners to expand and support outreach and prevention programs.**
- ✓ **Stand up against mental health discrimination, stigma and unequal treatment.**
- ✓ **Utilize Peer Support Specialists and study to determine if their use improves outcomes locally in San Diego. If outcomes are improved locally, use of peer support should be expanded.**
- ✓ **Increase awareness of the NAMI San Diego oscER app and support efforts to keep it available and up to date.**

II. Acute Crisis Response and Stabilization Management

Acute Crisis Response

PERT

We currently have a well-regarded Psychiatric Emergency Response Team (PERT) system in San Diego. In fact, the County just increased the number of PERT teams deployed countywide to 70 teams, which are embedded in 11 law enforcement agencies. PERT received high praise at both Symposiums. However, PERT currently only operates from 6:00 am to midnight. It was strongly suggested that PERT be made available 24 hours a day.



Law Enforcement Critical Incidents Involving Individuals with Mental Illness

Individuals in the midst of a mental health crisis frequently come into contact with law enforcement. In a 2015 national review of officer involved shootings done by

the Washington Post, 25 percent of those killed were actively in a mental or emotional crisis. Most of those killed were men, more than half of them white, 90 percent were armed with some type of weapon and most died close to home. During the first six months of 2015, on average, a person in mental crisis was killed in an officer-involved shooting every 36 hours.¹² The San Diego DA's [20-year study](#) of officer-involved shootings revealed that in 19 percent of the incidents, the subject made statements or behaved in a way that was considered "suicide-by-cop" (meaning it appeared clear the subject wanted police to shoot him or her). This could suggest a mental health component to the incident. A 25-year study of officer-involved shootings in San Diego County showed 79 percent of the incidents included subjects with drug and/or mental health issues.

After an incident where law enforcement uses force against a person with a mental health condition, there is often a public outcry that PERT should have been called to intervene. Many times, PERT is already on scene standing by to assist; however, it must be clearly understood that PERT cannot intervene until it is safe to do so. It is necessary and proper for law enforcement to make sure the situation is stable and safe enough for the PERT clinician to make contact.

Crisis/De-escalation Training

Many jurisdictions across the country have made efforts to improve the initial law enforcement response to an individual in a mental health crisis by providing comprehensive crisis intervention training to their officers. Models vary by jurisdiction, but the results have been promising. Evidence suggests that officers who go through crisis intervention training come away with more sympathetic attitudes toward people with mental illness. A 2014 study from Emory and George Washington Universities analyzed the use of force at six policing agencies in Georgia. Officers trained in crisis intervention techniques were more likely to verbally engage mentally ill people during interactions. They were also more likely to call for mental health transport rather than take the individuals to jail.¹³

San Francisco Police Department Assistant Chief Toney Chaplin studied five years of police shootings in that city. He found that when police shoot, they typically made the decision quickly. "In under a minute, 45 percent of the shootings occurred," he said. He explained further that at one minute, the number of shootings dropped to 10 percent and at two minutes, the number of shootings dropped to 5 percent. At three minutes,

¹² Lowery, W., Kindy, K., Alexander, K.L. & Rich, S., Distraught people, deadly results. (2015, June 30). *The Washington Post*.

¹³ Compton, et. al., The Police-Based Crisis Intervention Team (CIT) Model: II. Effects on Level of Force and Resolution, Referral, and Arrest. *Psychiatric Services*, April 2014, Vol. 65, No.4, 523.

Chaplin said, "The graph falls off a cliff with each minute that you stall these things out. If we create this time and distance, as you can see from this graph, we save lives."¹⁴

In 1993, the Los Angeles Police Department (LAPD) created a specialized Mental Evaluation Unit to respond to and assist with mental health crisis calls. They have also dedicated resources to train more officers on Crisis Intervention. In 2017, the Department responded to more than 22,000 mental health crisis calls, of which less than 3 percent resulted in the use of force.

The Dallas Police Department saw an 18 percent drop in use of force the year after they instituted de-escalation training. In addition, since 2010, excessive force complaints there have dropped by 83 percent. In 2012, the Dallas Police Department had 23 officer-involved shootings. This number has declined every year since. In 2017, there were seven. Las Vegas also reported a reduction in use of force and officer-involved shootings, which fell by more than half between 2012 and 2016, to just 10.¹⁵

The District Attorney is committed to engaging in the creation of effective and evidence based mental health crisis and de-escalation law enforcement training or augmenting existing training for law enforcement to provide additional skills for them to safely, effectively and compassionately respond to individuals in a mental health crisis.

"Stigma reduction and role-playing scenarios are critical components of improving law enforcement responses to mental health crises."

Sheriff Gore and his team along with many of our local police departments have worked on improving training in this important area. From our symposiums and research of national best

practices, we learned that stigma reduction and role-playing scenarios are critical components of improving law enforcement responses to mental health crises. Simulated exercises where officers role-play interacting with a person in a mental health crisis will allow officers to put into practice the skills learned during trainings. Additionally, certain trainings allow the officer to experience some of the symptoms a person in a mental health crisis might be battling. This provides the officer with the perspective of the person in crisis, helping the officer to understand why the person might not be responding to their commands. The District Attorney is prepared to lead and work with the Police Chiefs and Sheriff to find ways to reduce the time away from service while making sure every officer in San Diego is provided with this valuable

¹⁴ Gilbert, C., Not Trained to Not Kill, *APMreports*, (2017, May 5)

¹⁵ Gilbert, *APMreports*

training. These trainings can be done in conjunction with the eight-hour PERT training that is already available in San Diego County.

911 Dispatch

An important part of the law enforcement response to individuals in crisis relies on skilled 911 dispatchers. Emergency call takers are responsible for gathering critical information to assist law enforcement's response to a person in crisis. It is essential that they too are trained in screening mental health related calls, collecting essential information and perhaps in some cases beginning the de-escalation process.

LAPD's Mental Evaluation Unit created a 911 checklist to provide to family members that outlines the information they should provide to the dispatcher in a time of crisis. It also outlines what they should expect when the police respond, including preparing them for the arrival of uniformed officers who will likely detain and place in handcuffs. Educating family prior to a crisis occurring creates a safer situation for officers, family members and the person in crisis. The San Diego DA's Office has created a print version of a 911 checklist for family members and a strategy should be developed to work with various stakeholders to distribute thousands of these cards.

District Attorney Investigators and Process Servers

Investigators and Process Servers with the District Attorney's Office contact several thousand residents throughout San Diego County on a yearly basis. These contacts primarily occur while conducting follow up interviews and serving subpoenas. Through these contacts, investigators and process servers are positioned to identify potential mental health issues and provide families and individuals with relevant information of resources to assist them. Therefore, District Attorney Investigators and process servers should also receive mental health training. Victims, family members and witnesses who consent could be referred to victim advocates or to service providers to be connected to treatment and related services.

First Responder Mental Health & Wellbeing

Police officers and other first responders act with heroism daily. They respond to critical incidents, often placing themselves in harm's way. They must always remain vigilant, and are often exposed to stressful, dangerous and traumatic situations. There are studies that suggest 19 percent of sworn officers may have Post-Traumatic Stress Disorder, and approximately 34 percent suffer from symptoms associated with PTSD but do not meet the requirements for a full diagnosis. Officers face direct and secondary trauma, experiences which naturally can affect how they respond to a crisis.

Law enforcement officers can sometimes be reluctant to ask for help for fear of the stigma associated with mental health treatment. More officers die every year from suicide than an on-duty injury. In 2017, 46 police officers were fatally shot but more than triple that number committed suicide.¹⁶ Law Enforcement must work to foster a culture where seeking help is not seen as weakness. There should be avenues for law enforcement to seek treatment in a way that protects their privacy. Some agencies, such as LAPD, are providing their officers with training on career survival, including self-care, stress management, health, nutrition and physical fitness. Practices like this should be encouraged. As a community we must foster a culture where it is ok to ask for help, and a system that provides a safe space to get help. Common sense dictates first responder wellbeing will translate to them better able to respond to crisis situations.

Recommendation Three:

- ✓ **Support the creation and expansion of crisis/de-escalation training for law enforcement countywide.**
- ✓ **Evaluate and enhance current regional training for 911 call takers in identifying and properly screening mental health related calls.**
- ✓ **Print and widely distribute 911 checklist cards to those who have a family member with mental health issues.**
- ✓ **Provide mental health training to District Attorney Investigators and Process Servers.**
- ✓ **Build opportunities to enhance self-care and wellness for law enforcement officers and other first responders.**

Follow-up care after mental health crisis or law enforcement contact

All too often, after a critical incident involving use of force by police, it is learned that there were prior contacts where behavioral health issues were identified and the situation was only triaged and temporarily stabilized. However, there is no systematic protocol for follow up in the days after the immediate crisis is resolved. We should have a system through Behavioral Health Services where a mental health care provider is alerted immediately following a first responder, whether police, fire or EMS, contact with someone displaying symptoms of a mental health crisis. The provider would follow

¹⁶ Hayes, C., Silence can be deadly. (2018, April 11). *USA Today*.

up with the individual within a set time, for example 24 hours, to assess the situation and connect the individual to treatment, services and peer support programs if appropriate. The level of response would be individualized by a mental health navigator. This follow up care step must be included when persons are released from a mental health hold, commonly referred to as “5150,” regardless of if they were dropped off there by law enforcement or another method. There are many examples of homicides that occur following release by an individual from a 5150 hold without an appropriate hand off to case management and mental health care.

Mobile Mental Health Response Teams

Many communities have created mobile mental health response teams that respond directly to individuals to provide engagement, intervention, transport and follow-up support to overcome resistance to treatment. Some of these models utilize law enforcement, while some are a non-law enforcement response. Clearly, a non-law enforcement response could only be utilized in circumstances where the individual has been stabilized.

Colorado Springs created a mobile mental health crisis response unit that is empowered to perform psychiatric evaluations in the field and determine the appropriate immediate level of care needed. This team combines law enforcement, fire/paramedic and a behavioral health clinician. This frees patrol and fire units from being tied up on long psychiatric calls and avoids lengthy emergency department waits and evaluations. This model has since been deployed in other cities in Colorado, as well as Tulsa, Oklahoma.¹⁷

When PERT teams are deployed to a crisis, generally, this is accompanied by elements associated with a law enforcement response. With PERT comes marked police cars, emergency lights, uniformed officers and handcuffs. Understandably, family members might be hesitant to engage this level of response to their loved one’s mental health crisis. To avoid this, several California counties have implemented Mobile Crises Response Teams that do not include a law enforcement response. Contra Costa has the Mobile Crisis Response Team, which provides same day intervention for adults experiencing a mental health crisis. Licensed mental health clinicians, a family nurse practitioner and community and family support workers visit clients and their families in the field to prevent acute psychiatric crises from becoming emergencies that require a law enforcement response. The City of Berkley and Ventura County also have Adult Mobile Crisis Response Teams.

¹⁷ See, <https://www.emsworld.com/article/219668/close-colorado-springs-community-response-team>

San Diego currently utilizes a form of mobile response. In Home Treatment Teams (IHOT) are typically used to respond to individuals who have a serious mental illness and are resistant to treatment and is often used to lay the foundation for Assisted Outpatient Treatment (AOT). AOT is involuntary out-patient treatment that is court ordered and monitored. Extension of the use of mobile response models should be examined as a way of responding to mental health crises that do not yet meet the criteria for AOT and do not involve violence or threats of violence. These models could also be used to respond to referrals from police to follow up on calls involving potentially escalating behavioral health crises that have not yet risen to the level of an involuntary commitment.

Schools

Unfortunately, we are faced with the very stark reality that across our nation acts of targeted violence against and upon our school campuses has increased. In response, District Attorney Summer Stephan spearheaded a collaboration of stakeholders and experts that created a School Threats Protocol and enacted a School Threat Assessment Team.¹⁸



PERT clinicians educated in threat assessment, can be a critical part of responding to a threat of targeted violence to our schools. However, despite being deployed throughout the county in eleven law enforcement agencies, PERT clinicians are not linked with our school or

university police departments. For PERT to respond to a student mental health crisis, one of the eleven law enforcement agencies must be involved. This can create an unnecessary barrier or delay, or even worse, a gap in services, in what could be a critical situation. PERT should be expanded to provide clinicians to our school and university police departments. These clinicians should be trained in threat assessment and be used

¹⁸ On April 27, 2018, the District Attorney hosted a School Safety Summit to address threats of targeted violence to our schools. The Summit launched the School Safety Protocol and introduced a prevention, education and threat assessment school safety program to be used throughout the County of San Diego.

when there is an imminent threat, risk of harm or emergency. Balancing the addition of PERT clinicians to school law enforcement, a continuum of mobile crisis response for children and youth should be developed to address concerning behaviors that do not yet rise to the level of an imminent threat or emergency. The goal would be to foster a culture of support and connection to services for the youth and the youth's family without immediately invoking a law enforcement presence and response.

Recommendation Four:

- ✓ **Expand PERT to operate 24 hours and include paramedic response.**
- ✓ **Create protocol for follow-up care after the immediate crisis is resolved.**
- ✓ **Evaluate the use of Mobile Mental Health Response Teams and non-law enforcement response for crises that do not involve violence or threats of violence.**
- ✓ **Add PERT Clinicians to school law enforcement agencies as appropriate for imminent threats or emergencies and create a continuum of behavioral health crisis responses for youth in non-emergency situations.**

Mental Health Crisis Stabilization Centers

When a person is taken into custody in San Diego by law enforcement for erratic behavior, the officer has a few choices. The officer can take the person to jail, the emergency department of a hospital, or the County Psychiatric Hospital. Each of these options take the officer off his or her beat which leaves calls for service stacking up and areas not being patrolled. The quickest and easiest option is usually to take the person to jail. However, if the person needs to be seen immediately by a psychiatrist, that person must be transported to the County Psychiatric Hospital to get cleared before the person can get booked into jail.

There is a perception among law enforcement that sometimes the medical staff at psychiatric hospitals improperly reject people brought to them for psychiatric holds for being a danger to themselves or others. Contrast this with a perception among the medical staff that too frequently law enforcement defaults to psychiatric hospitals for a disposition of their arrestee out of a lack of other options. Often, after the psychiatric

evaluation, including a review of the person's criminal and mental health history, the doctors determine the person's erratic behavior is due to being under the influence of a controlled substance and not due to a mental disorder. Therefore, the person does not meet the criteria for a hold under Welfare and Institutions Code section 5150 (WI 51510) and instead needs detox. This leads to a great deal of frustration among law enforcement because of the time they have now spent away from their beat. It is unfair to expect our law enforcement officers to diagnose whether erratic behavior is being caused by a mental health issue or intoxication, or a combination of the two. This problem could be solved by having a sobering center at or near the County Psychiatric Hospital, or even better, creating a campus that addresses all these needs and more in one location. By addressing all of these needs at one location, the County could adopt a "no wrong doors" approach that would help simplify an already complex situation.

According to data from the San Diego Sheriff's Department, in 2018, there were 6,194 B (2) bookings. These are individuals who are booked into jail solely for being too intoxicated to care for themselves. They are taken into custody and are released when sober. In most, if not all, of these cases, criminal charges are never filed. This places a burden on the jail's resources and medical staff. San Diego has a limited number of sobering or detox centers. A sobering and detox center that is easily accessible to law enforcement would address this problem.

Currently, law enforcement officers who are not near the County Psychiatric Hospital can take potential WI 5150 arrestees to the Emergency Department of a hospital. The officer must walk the arrestee through the emergency department and wait for a doctor to perform an evaluation. If the doctor determines the criteria for WI 5150 are met, then the arrestee is discharged to crisis stabilization. However, the officer must remain with the arrestee the entire time. This can be up to six or eight hours, depending on how busy the emergency department is at that time.

Other counties in California, and across the country, have responded to these problems by establishing Crisis Stabilization Centers, or in some places, referred to as Mental Health Urgent Care Centers. These Crisis Stabilization Centers, some open 24 hours a day, offer walk in mental health services as well as provide a locked facility for involuntary holds pursuant to WI 5150. These centers allow an officer to drop off a person in a mental health crisis and get back to patrolling his or her beat within minutes.

Staffed with a psychiatrist, nurse practitioner, LCSW, peer support and housing navigators, the center can provide acute crisis stabilization, medication, as well as direct connection to appropriate levels of care. The environment is more conducive to stabilization than an emergency department or jail. Because they are staffed with nurses

equipped to handle non-emergency medical issues, a person does not need to be medically cleared prior to arrival.

Providing an efficient location for law enforcement to connect individuals with mental illness to immediate psychiatric care will relieve the burden on police resources, jails and emergency departments, which can be directly correlated to financial savings. Under our current operations, emergency departments and jails are put in the position of triaging and putting a band aid on a wound that requires so much more. Let us take this opportunity to create a system where our emergency departments can focus on treating traumatic injuries and our jails can focus on housing dangerous criminals.

Recommendation Five:

- ✓ **Build regional Mental Health Crisis Stabilization Centers that can provide walk in mental health and substance use disorder services, efficient law enforcement drop-offs and step-down care coordination/case management services.**
- ✓ **Adopt a “no wrong doors” approach where detox, mental health and substance use disorder services can be provided at one location.**

Booking

When a person is arrested and taken to jail, the jail medical staff screens the person before accepting him/her for booking. Currently, every inmate is screened for risk of suicide. If the person is determined by jail staff as needing to immediately see a psychiatrist, that person is transported to the County Psychiatric Hospital for evaluation. In the very near future, mental health screening will be done with every booking when the Sheriff’s new electronic health record system is implemented. This will expedite connecting the inmate to care and can also aid in early identification of appropriate cases for diversion or alternatives to custody.

Jail Based Competency Treatment Program

In January 2017, the Department of State Hospitals contracted with the San Diego Sheriff's Department to operate a 30-bed jail-based restoration of competency treatment program for male defendants at its San Diego Central Jail. The Jail Based Competency Treatment (JBCT) program in San Diego delivers comparable treatment and restoration of competency services to defendants as would be received if they were at the state hospital. Liberty Healthcare is the provider chosen by the San Diego Sheriff's Department to run this treatment program. Their team of forensic psychiatrists, psychologists and clinicians provide treatment services for mental illness, as well as physical, mental and social stimulation and psychotropic medications. Having the program in the jail allows certain defendants who are found incompetent to stand trial (IST) under Penal Code Section 1370 to begin treatment in jail which often decreases the total time the individual remains incarcerated.

Recognition of the Risk to Mental Health Care Professionals

Unfortunately, treating this population in psychiatric hospitals and emergency departments sometimes results in injuries to the staff and doctors. There is a feeling among some mental health care workers that their victimization is discounted because of their occupation. The District Attorney's Office considers crimes against mental health care professionals in the performance of their duties to be extremely serious. We should all do our part to make sure these dedicated professionals have the environment, support and resources to treat this vulnerable, yet sometimes dangerous, population. Therefore, the District Attorney's Office is designating a Deputy District Attorney to specialize in the monitoring of these cases to ensure that the office responds effectively and consistently to violence committed against all mental health care professionals in the performance of their duties.

Stabilization Management

Coordinated Release Planning

San Diego County Sheriff Bill Gore is to be commended for his tremendous efforts to improve reentry as well as in-custody treatment and programming for inmates. Sheriff Gore and his team have engaged in a dedicated and innovative effort to reduce recidivism of inmates released from county jail, including those with mental health challenges, by assessing and beginning treatment in jail and then connecting them with treatment upon release. Several programs were created to provide discharge planning for the Severely Mentally Ill individuals in custody.

Sheriff's - Supporting Individual Transitions (S-SIT)

S-SIT focuses on the top one hundred individuals that have averaged ten or more bookings per year over the last three years. On average, these individuals are in custody fourteen days per booking and remain in the community approximately 21 days before they return to custody. Approximately 80 percent of this population has had at least one previous contact with Behavioral Health Services. Because of their rapid cycling through the system, they are rarely connected to a provider in or out of custody. Taking a long-term look at the needs of these individuals is the focus of the S-SIT team. Counselors meet with S-SIT clients regularly to build rapport, assess the individual's interest in services, and provide support towards appropriate community referrals. Counselors are notified each time the person returns to custody so they can continue to build rapport and attempt to link him or her to community resources.

Project-in-Reach, SMI (Neighborhood House Association)

Project-in-Reach, administered by the Neighborhood House Association, is a long-term provider of discharge planning for the Sheriff's Department. This non-profit organization evaluates individuals, works with any family connections in the area and creates a discharge plan. While in custody, they see participants at least twice a month, establishing a relationship and attempting to strengthen the person's commitment to the release plan. Transportation from jail to treatment facilities or recovery residences is available. They will continue to work with the individual for three months after release from custody.

Coordinated Program Releases

The Sheriff's Department works with community partners to create coordinated release plans to take individuals directly from custody to treatment programs, probation officer check-ins or medical appointments. Providing continuity in treatment and medication is essential to successful re-entry. To support continued medication stability, arrangements are made with a conveniently located CVS to provide appropriate prescriptions. During 2018, 1439 Coordinated Program Releases were made.



It was noted several times during our Symposiums that releases from custody often occur after hours, sometimes in the middle of the night, which makes connecting

to services or programs extremely difficult. As a result of this, the Sheriff analyzed data and determined the primary reason for this was an information work flow issue between the Sheriff, the District Attorney's Office, the City Attorney's Office and the Courts. The Sheriff, the District Attorney and the City Attorney are already working together to improve the workflow to accelerate the release process.

San Diego Primary Public Defender Substance Abuse Assessment Unit

The Substance Abuse Assessment Unit (SAAU) of the County of San Diego Primary Public Defender's office is a vital resource to the community of San Diego. The SAAU is a full-service placement agency that assesses, transports and connects in-custody clients directly to residential treatment programs (RTP). For individuals with co-occurring disorders, the unit works closely with the Sheriff's Department to provide a supply of psychiatric medication directly to the treatment facility, within the same day of the client's arrival. The ultimate goal of the SAAU is to address substance abuse issues within the justice population with the hopes of reducing criminal recidivism.

The SAAU works closely with attorneys and the justice partners to identify those clients with both the need for treatment and amenability. An in-depth assessment designed around the American Society of Addiction Medicine (ASAM) criteria is conducted with every individual to establish the person's amenability and reception towards change. If the unit makes the recommendation for treatment, the assessors work directly with residential treatment providers to ensure a continuum of care from incarceration to admission into the program.

Not all who are assessed by the unit are recommended to be placed in treatment. In fiscal year 2017-2018, the unit assessed 1318 clients and placed 711 clients into RTP. In fiscal year 2018-19 to date, the unit has assessed approximately 900 clients and has placed 564 into RTP.

Recommendation Six:

- ✓ **Support and expand existing coordinated release from custody programs.**
- ✓ **Work collaboratively to minimize releasing individuals in the middle of the night.**

Housing

One needs only to drive or walk the streets of any of our cities and neighborhoods within the county of San Diego to see we are in the midst of a major housing crisis. Available affordable rental housing is scarce, and real estate costs are near all-time highs. Our vulnerable populations are in desperate need of safe and stable housing. In the 2018 Point in Time count of our homeless population, 43 percent reported mental health issues. Of those who receive inpatient psychiatric care, 24 percent are homeless. It is difficult to imagine trying to stabilize and manage a mental health disorder living on the streets. Safe, supportive and appropriate housing is a critical component to stabilizing individuals with mental and substance use disorders.

Some barriers to housing include federal, state and local regulations, as well as the concept of “not in my backyard.” Programs and projects have been designed and funded, only to die on the planning table because communities oppose their development. A community’s concerns about public safety risks are understandable. However, our local government and community leaders need to work collaboratively with stakeholders to create systems that support public safety within these specialized housing units.

There are many collateral consequences to a criminal conviction that last long after a person has completed a sentence and paid his or her debt to society. Collateral consequences come in the form of legal and regulatory sanctions and restrictions that affect a person’s ability to obtain employment, licensing, housing, education or even to vote. As of January 2019, the National Inventory of Collateral Consequences of Conviction recorded over 1600 potential collateral consequences in California, and over 44,000 nationally.¹⁹ Some of these collateral consequences reasonably serve to protect the public. However, some consequences can provide years or even a lifetime of insurmountable barriers to successfully reintegrating into society. As a system, we need to be cognizant of these consequences and ensure that they are commensurate to the criminal conduct.

In Los Angeles County, the Department of Health Services Housing for Health division provides housing and supportive services to homeless clients with physical and/or behavioral health conditions, high utilizers of county services and other vulnerable populations. Since Housing for Health began in 2012, 2,737 clients have obtained permanent housing. They have 850 interim housing beds and a 96 percent 12-

¹⁹ See, https://niccc.csgjusticecenter.org/database/results/?jurisdiction=&consequence_category=&na_row_category=&triggering_offense_category=&consequence_type=&duration_category=&page_number=1

month housing retention rate. In 2017, a study was done on 787 Housing for Health clients and they found that the supportive housing resulted in a 76 percent reduction in inpatient days and a 67 percent reduction in emergency room visits. Additionally, Los Angeles was able to navigate some of the federally imposed barriers to public housing by securing private and non-federal funds to build and support housing projects.²⁰

In San Diego, HHS recently released a notice of a public review period for four supportive housing development proposals to be funded through the State-administered Mental Health Services Act (MHSA) Local Government Special Needs Housing Program (SNHP). Two of the developments are for seniors (125 units), one for veterans (41 units) and one for adults over the age of 18 (82 units).

The application states that all four developments will use the San Diego Housing Commission's (SDHC) tenant selection criteria which has a local preference for applicants who live or work in the City of San Diego. A criminal background check will be completed on each applicant. Federal regulations exclude applicants subject to a lifetime sex offender registration requirement, or applicants who have manufactured or produced methamphetamine on federal property or on a federally assisted housing facility (lifetime). These two exclusions are finite and may not be waived.

However, SDHC utilizes these additional requirements: applicants may be denied tenancy for the following reasons:

- 1) Applicant may be denied if he/she has been arrested, convicted or otherwise have determined to have engaged in illegal drug-related or violent criminal activity within the prior five (5) years.
- 2) Applicant must be denied if using medical marijuana at the time of consideration for admission, even if the State of California medical marijuana card is issued to that person.
- 3) SDHC must permanently deny assistance to applicants convicted of manufacturing or producing methamphetamine in violation of any federal or state law.
- 4) Applicant has had a certificate or voucher assistance terminated from any participating public housing authority.
- 5) Applicant has been evicted from federally assisted housing within the last 10 years.

²⁰ Housing for Health, Health Services of Los Angeles County, Bringing Housing to Scale: Housing for Health Progress Report, (May 2017), pp. 9, 41.

Many of the bases for exclusion create insurmountable and unforgiving barriers for people who have made some mistakes in their past but have moved past them. Housing commissions should be encouraged to create common sense policies that provide some flexibility while keeping an eye toward public safety. Admission policies should be designed to be more inclusive and encourage expansion of opportunities.

Recommendation Seven:

- ✓ **Address barriers to obtaining housing by creating common sense regulations that account for public safety but allow for flexibility. Regulations should be designed to be inclusive and encourage expansion of access to housing.**
- ✓ **Work collaboratively with government and community leaders to create systems that support public safety within these specialized housing units.**

III. Mental Health Diversion

In the criminal justice system, diversion can have different meanings. In the Penal Code, diversion typically refers to postponing prosecution either temporarily or permanently, at any point from charging until adjudication.²¹ However, for purposes of this report, diversion is construed more broadly to include any effort to divert an individual from entry into the criminal justice system, any program designed to divert an individual once they have entered the criminal justice system, any program designed to divert an individual from incarceration or any program designed to prevent an individual from returning to the criminal justice system.

Penal Code section 1001.36

In June 2018, California Governor Jerry Brown signed a budget trailer bill that contained a broad mental health diversion provision. California Penal Code section 1001.36 provided pre-trial diversion for up to two years for individuals with a DSM-V diagnosis (Diagnostical and Statistical Manual of Mental Disorders, 5th Edition) where their mental health condition was a significant factor in the commission of their crime. A few months later, SB215 amended the section to preclude some violent offenses and allow for victim restitution during the two-year period of diversion. Once granted diversion, there are only a limited number of circumstances where diversion can be

²¹ See, California Penal Code section 1001, et. seq

revoked, and criminal proceedings reinstated. This diversion provision also applies to individuals found incompetent to stand trial.

One of the District Attorney's primary concerns with this new law is that despite displaying symptoms of mental illness, diversion participants are not statutorily prohibited from obtaining or possessing a firearm. In 2019, our office will support a proposed legislative "fix" that will prohibit those defendants in Mental Health Pre-Trial Diversion from possessing or purchasing a firearm.

The pool of cases this law will affect is potentially vast. There can be no one size fits all mental health diversion program. Each case will need to be handled individually and will depend on the unique characteristics of the participant and the infrastructure available to provide treatment. Unfortunately, the law was written in a way that could provide greater access to diversion for people who can afford to pay for doctors and individualized treatment plans. We need to be cognizant of this unacceptable and unintended consequence and guard against this as we create a program here locally.

A psychiatric bed registry, or similar database, would assist justice stakeholders in making well-reasoned diversion decisions and placements. Currently, there is no resource or database available that contains size, facility, service and population descriptions and qualifications for all the county contracted mental health service providers. (For a further discussion of Psychiatric Bed Registries, see Data Assisted Care Coordination, *infra*.) It is impossible, and irresponsible, for the criminal justice partners to build a program that diverts individuals from the criminal justice system before having a clear assessment of the infrastructure to which individuals are being diverted.

The District Attorney's Office is committed to working with stakeholders to create responsible mental health diversion programs that protect our victims and communities, while providing equal and fair access to diversion for those charged with crimes. To accomplish this, the District Attorney proposes to establish a multi-disciplinary team made up of law enforcement, prosecutors, health care professionals and case managers to work in unison with crisis stabilization centers. An individual who has committed a *non-violent* crime but is brought to the crisis stabilization center in lieu of jail could be screened and diverted from the criminal justice system if suitable. The case would be assessed, managed and tracked to ensure accountability and public safety. Compliance with treatment plans for an established time period would result in no charges being filed. Non-compliance or public safety risks that require a higher level of accountability would result in criminal charges being filed.

Recommendation Eight:

- ✓ **Create a working group of stakeholders to collaboratively create guidelines and structure for mental health diversion which ensures public safety, as well as equal access and equitable treatment for participants.**

Current San Diego Programs



Here in San Diego, we have some promising programs working to divert participants with mental and substance use disorders away from further involvement in the criminal justice system, as well as alternatives to incarceration.

The District Attorney Community Justice Initiative

The San Diego County District Attorney Community Justice Initiative (DA CJI) provides those facing low level criminal charges the opportunity to have their case dismissed before sentencing. Participants have four months to complete a 12-hour Cognitive Behavioral Therapy (CBT) class and four hours of volunteer work. The DA CJI uses evidence-based practices and restorative justice principles to hold individuals accountable, while giving them the opportunity to address their decision making and move forward without a criminal conviction. CBT is a problem-focused, therapeutic approach that attempts to help individuals identify and change beliefs, thoughts and patterns that contribute to problematic behaviors. CBT programs emphasize individual accountability and attempt to help individuals understand their thinking processes and the impacts of the choices they make. Participants in this program can also be connected with needed services, such as education, substance use disorder treatment, mental health treatment, housing assistance, transportation assistance, food and life skills training.

The pilot DA CJI program was launched April 2018, in the South Bay. As of January 2019, over 100 participants have successfully completed the program and had their cases dismissed. The program expanded to the East County in January 2019 and will expand to the North County in April 2019.

PROGRESS

PROGRESS (Programming for Reentry Support and Stability) is part of the Stepping Up Initiative and is a joint effort among the San Diego Sheriff's Department, the District Attorney's Office, the Public Defender's Office, Health and Human Services Agency and the Probation Department. The program aims to immediately reduce the number of people with mental illness in jail by offering an alternative custody setting focused entirely on community reentry. Participants are housed and receive services in a specialized residential setting where they begin seeing their psychiatrist at neighborhood clinics and participate in other supportive community programs. The program is designed for non-violent, non-sex offenders with low to moderate mental health issues who have been sentenced to a term in county jail. To ensure public safety and accountability, participants are supervised by the Sheriff's Department using GPS monitoring. In 2018, PROGRESS served 59 individuals. Recidivism, as measured here by return to custody, was 17 percent.

Collaborative Courts:

Collaborative Courts are also referred to as "problem solving" courts. While models differ slightly, they generally combine rehabilitative services with intensive judicial supervision. San Diego has a robust collaborative court system that is fully supported by the Superior Court, the District Attorney, the Public Defender and the Probation Department. Both the District Attorney and Public Defender have dedicated, specially trained attorneys staffing the collaborative courts. The Court has a judge designated as Assistant Criminal Supervising Judge who is assigned to supervise the collaborative courts. The judges assigned to the various collaborative courts also serve on the Court's Collaborative Courts Committee. Probation has specialized officers dedicated to the collaborative courts. The success of these participants and programs depends heavily on probation's supervision and reporting to the other stakeholders. Probation's ability to adequately staff these courts plays an important role in protecting the public.

Drug Court

Drug Court is San Diego County's longest existing collaborative court. Started locally by former District Attorney, then Judge Bonnie Dumanis, Drug Court hears selected cases involving non-violent offenders who are charged with certain non-violent offenses and whose crime is related to a substance use disorder. It saves taxpayer dollars, reduces recidivism, and it helps get people's lives back on track. Drug Court utilizes frequent random drug testing, judicial supervision, drug treatment counseling, educational and vocational training opportunities. Participation in the program has

declined as a result of Proposition 47, which made certain felonies – such as drug possession – a misdemeanor. However, despite that challenge, the program continues to be an important option for holding defendants accountable and getting them the help they need to address substance abuse problems. Upon successfully graduating from the program, most participants get their charges dismissed.

Capacity in each adult drug court is 86 participants. Currently, all four drug courts are operating at or above capacity. A total of 124 defendants graduated from Drug Court across the county in 2018. Between 2013 and 2017, of participants who graduated successfully from the program, 37 percent recidivated after program completion. Of participants who failed to complete the program, 70 percent recidivated.

Reentry Court Program

Reentry court is based upon the drug court model but provides an even higher level of supervision and support and is intended for higher risk, higher needs individuals. Participants in this program typically have been in and out of prison multiple times and have a long history of substance use disorders. Reentry Court has the capacity for 60 participants. As with Drug Court, the program lost participants due to Proposition 47. To accommodate, the program began to accept defendants with more serious criminal records and co-occurring disorders. There has also been an expansion to accept defendants on mandatory supervision and parole revocations. To graduate, participants must complete a rigorous treatment program, advance their education, participate in job training, and maintain their sobriety. Participants in Reentry Court do not get their charges dismissed. Between 2013 and 2017, of participants who graduated successfully from the program, only 32 percent recidivated after their completion. Of participants who did not successfully complete the program, 57 percent recidivated. Considering the extensive criminal and substance use disorder histories, the recidivism rate of those successfully completing the program should be seen as a great success. By diverting these individuals away from prison, we save a tremendous amount of tax payer dollars.

Veterans Treatment Court

A pilot of Veterans Treatment Court (VTC) was started in the North County Branch in 2011 at the recommendation of Deputy District Attorney George Loyd, a Marine Veteran. Since then, VTC was regionalized and formalized through collaboration between stakeholders. This cutting-edge, collaborative justice project is designed to assist veterans who commit crime because of mental illness or substance abuse related to their military service. Treatment providers from the military community join with the Superior Court, Probation Department, defense attorneys, and District Attorney's Office to create customized rehabilitative plans for each veteran. The program strives to

reintegrate veterans into law-abiding society. Each year, participation in the program increases.

To graduate from the program, participants must successfully complete an intensive program of therapy, give back to the community through service projects, and demonstrate they are no longer a threat to public safety. The program typically lasts from 18 to 36 months. Upon completion of the program, these deserving veterans have their cases expunged and rights restored as a result of their participation and rehabilitation. Between 2013 and 2017, of participants who graduated successfully from



Participants in Veterans Treatment Court during a graduation on the U.S.S. Midway.

the program, only 8 percent recidivated after their completion. Of participants who did not successfully complete the program, 30 percent recidivated. Sadly, we lost DDA George Loyd when he passed away on September 1, 2013, but the San Diego Veterans Treatment Court continues to thrive in legacy to his heroism.

Homeless Court/Stand Down

Homeless Court operates monthly at St. Vincent DePaul Village or Veterans Village of San Diego. In 2018, Homeless Court handled approximately 200 cases for 60 participants each month. While not operating as a true collaborative court, we should look at opportunities to work with the court and other stakeholders to regionalize and structure Homeless Court to be more consistent with traditional Collaborative Court models.

Additionally, in coordination with Homeless Court, Stand Down operates as an annual summer event that connects services with veterans at a central location in the city of San Diego. Stand Down is an innovative program that helps local homeless veterans get off the streets and connected to services. The District Attorney's Office, the City Attorney's Office, the Public Defender's Office and the Court work together to bring court to the participants to clear warrants, outstanding fines and some criminal convictions, allowing these deserving veterans get back on their feet.

Behavioral Health Court

Behavioral Health Court (BHC) aims to provide services to defendants who are suffering from serious mental illness. In 2016, capacity for this program was expanded from 30 to 60 spots for participants. Currently, Behavioral Health Court is operating close to capacity and will be looking to expand again. Participants are supervised intensively to ensure a safe transition into the community where they are provided stable housing, counseling/psychiatric care, and medication when warranted. To graduate, participants must successfully complete four performance-based phases over a minimum period of 18 months. The participants have intensive case management and regular meetings with a multi-disciplinary team and are monitored by a designated BHC Probation Officer to ensure compliance. Additionally, the participants are required to participate in monthly court appearances before the BHC Judge. Upon successful completion, some participants receive a dismissal of charges, and some receive early termination of probation. Between 2013 and 2017, of participants who graduated successfully from the program, only 27 percent recidivated after their completion. Of participants who did not successfully complete the program, 59 percent recidivated.

Behavioral Health Court has demonstrated exceptional results working with a population that has many challenges. It provides long term recovery and stabilization, as well as a second chance for many of the participants. It has proven as an effective way to provide individuals with mental illness who find themselves in the criminal justice system with the support to safely steer them back onto the right path. Because of the formalized structure and intense supervision, elements not present in the new Mental

Health Diversion law pursuant to Penal Code section 1001.36, Behavioral Health Court offers a fair opportunity to provide a second chance while still accounting for public safety. Behavioral Health Court should be expanded both in capacity and in admission criteria so we can maximize this great program.

Mandatory Supervision Court

In 2011, the California legislature enacted several changes to the law which are collectively referred to as Realignment. Distilled to its simplest terms, Realignment shifted responsibility for housing and supervision of many state prisoners from state to local jurisdictions. To accommodate the increase in capacity, the legislature created mandatory supervision pursuant to California Penal Code section 1170(h)(5)(B). Mandatory Supervision is a period of time, determined by the court, where a local prison inmate shall be released from custody and supervised in the community. Responsibility to supervise this population lies with the Probation Department.

On any given day, there are, on average, about 650 participants in the program. Participants are brought to court approximately four weeks before their release from custody to review the terms of supervision. These terms are guided by their risk and needs assessment and case plan (i.e., residential/outpatient treatment, cognitive behavioral therapy, job training, mental and physical health, etc.). Upon release, participants reside in a home that has been pre-approved by probation or live in a residence provided by a treatment program or sober living facility. Participants must submit to random drug testing, meet with mental and physical health professionals and take prescribed medication if necessary. They meet regularly with probation officers, must successfully complete appropriate treatment programs, and attend regular court review hearings. For the fiscal year 2017-2018, the Probation Department reports the recidivism rate for those on mandatory supervision to be 15 percent. For purposes of this statistic, recidivism is defined as a conviction for a felony or misdemeanor offense during the period of supervision.

Gap in Current San Diego Programs: Co-occurring disorders

At our symposium, it was recognized that often individuals suffering from a co-occurring mental health and substance use disorder are not found suitable for either Drug Court or Behavioral Health Court. This is an understandable problem when both courts operate with limited resources. Drug Court is not designed to treat moderate to significant mental health issues, and Behavioral Health Court is not designed to treat substance use disorders. The result is the case gets passed back and forth, and sometimes neither court accepts the participant. Drug Court tries to accept as many as they can, however, the mental disorders consume more time and resources than the

substance use disorders. In fact, approximately 42 percent of our Drug Court participants have been diagnosed as co-occurring.

“Certain classes of non-violent crimes should be screened and assessed for potential alternatives to custody early in the criminal process.”

It is unclear exactly how many of the justice involved population has a co-occurring disorder, however, 70 percent of psychiatric hospitalizations involve patients with a co-occurring disorder. So, the

number is likely to be very high. Many other jurisdictions have established a specialized collaborative court just for co-occurring participants. This allows Drug Court to more effectively treat participants with substance use disorders. San Diego should establish a new collaborative court or add a specialized track to either Drug Court or Behavioral Health Court, that focuses on those individuals struggling with both a mental health and substance use disorder. This would prevent these individuals from falling in the gap and would provide them with much needed services, support and supervision.

Early Screening for Specialty Court/Program Participation

The earlier appropriate cases are identified, the earlier connection to a collaborative court can be made, which means earlier diversion away from custody and into treatment. Certain classes of non-violent crimes should be screened and assessed for potential alternatives to custody early in the criminal process. Disposition policies should encourage use of collaborative courts, alternatives to custody and diversion programs where appropriate. Before making any agreements or decisions resulting in any alternative programs, the safety of the victim and community must be a primary consideration.

Recommendation Nine:

- ✓ **Increase capacity for Behavioral Health Court.**
- ✓ **Add a specialized court for participants with co-occurring mental health and substance use disorders.**
- ✓ **Screen potential participants for alternatives to custody early in the criminal justice process.**

IV. Data, Outcomes and Information Sharing

At our Symposiums, stakeholders consistently cited the need for better sharing of information. Greater information sharing will lead to more efficient and appropriately matched services that in the end will help save lives. There are many misconceptions about the legal framework of sharing criminal justice and health information which stand in the way of collaboration. This is such a large and complex area, and there are legal and technological hurdles that need to be surpassed. However, this is a critical piece of the puzzle and one perhaps an expert consultant in this field can assist with.

Data Driven Justice

While we want to be as forward thinking and ambitious as possible, we also recognize that we must operate within the confines of budgets and be financially responsible. Therefore, we need a strong focus on collecting, sharing and analyzing data to ensure our programs are effective and financially efficient. We should prioritize the individuals who are uninsured or underinsured, and who repeatedly cycle through our jails, emergency departments and County Psychiatric Hospital. Programs that identify the correct target populations, supported by data, and that demonstrate cost savings as a result, should be created and supported.

One such program, Project 25: Housing the Most Frequent Users of Public Services Among the Homeless, was discussed at the Symposium. Project 25 worked intensively with the most frequent utilizers of public service, including emergency departments, hospitals, jails and ambulances, and provided participants with housing and a full array of health and other services. The three-year pilot program demonstrated a reduction in total costs and utilization of ambulance transports, emergency department visits, hospitalizations, arrests and days in jail. The pre-program cost per person living in the streets in 2010 was \$111,000, compared with less than \$12,000 median per person expense after being placed in permanent supportive housing in 2013. Despite the demonstrated success of this program, it was not continued.²²

Another such program noted at our Symposium was the Resource Access Program (RAP), which was a community paramedic and case management system that focused on a small number of high utilizers of fire and EMS services who call 911 with non-emergency situations. The RAP program resulted in identified savings of over \$500,000 per year based on a decrease in emergency room transports. This program existed in the City of San Diego from 2010 to 2016, and despite the financial savings, the program was ultimately defunded. The 2017/2018 San Diego Grand Jury recommended the San Diego Mayor and City Council consider exploring ways to replicate this

²² See, https://uwsd.org/files/galleries/Project_25_Report.pdf

program.²³ Our own programs here in San Diego have demonstrated that if we wisely invest on the front end, we can save long term by reducing over utilization of emergency services, law enforcement response and jail space.

Outcomes

Currently, mental health and substance use disorder contracts to provide services to justice involved clients do not put enough emphasis on fidelity in quality of outcomes. Is the treatment working? Is the treatment reducing relapses? Are the services lengthening time between relapses or returns to custody? Contract compliance is monitored, but not the participants' future performance and outcomes over time. Understandably, the service providers do not readily have access to this information. Much of this information is held by the criminal justice stakeholders, so we must develop a method to gather and report these outcomes. Awarding of future contracts should look at longer term performance measures and outcomes to effectively allocate resources. We should not continue to put money towards programs that data shows are not working.

On a related note, insufficient data is currently available for how many individuals seeking mental health services through the county are justice involved or are co-occurring. Gathering this information is critical to effectively and adequately dedicating resources.

In San Diego, justice and behavioral health stakeholders have begun to work on measuring and improving the quality of services to the justice involved population. Both the Correctional Program Checklist and the Justice Involved Services Training Academy seek to measure and improve the quality of these services.

Correctional Program Checklist: Advancing best practices in recidivism reduction for those with mental illness

While treatment of mental illness has traditionally fallen under the purview of public health, out of necessity, law enforcement in San Diego is taking a lead role in addressing the complicated needs of this sizeable and unique population. As prosecutors, our mission is to do more than just prosecute cases. Further, law enforcement officers are being asked to do more than just solve crime and catch criminals. Criminal justice stakeholders are being asked to find ways to allow for second chances and assist in transitioning individuals safely from custody back into the community, all while still protecting the public from harm. This paradigm shift requires

²³ See, <https://www.sandiegocounty.gov/content/dam/sdc/grandjury/reports/2017-2018/TheResourceAccessProgramReport.pdf>

us to take a more active role in matters that were before seen as the purview of Health and Human Services by leveraging multi-disciplinary solutions.

Research shows that recidivism can be significantly reduced by targeting the drivers of criminal behavior.²⁴ However, robust effects are only achieved when treatment is of high quality and closely follows principles of effective interventions.²⁵ Treatment providers who serve the justice involved population, both with and without mental illness, are often unfamiliar with evidence-based practices for reducing criminal behavior. Because of this, beginning in 2015, the San Diego County Public Safety Group initiated a process for both filling this knowledge gap and increasing the quality of services for the justice involved. This effort was led and coordinated in great part by the San Diego Probation Department.

The Correctional Program Checklist (CPC) is a 78-item validated instrument that assesses how well a treatment program follows evidence-based practices known to reduce criminal behavior and decrease recidivism.²⁶ An eight-hour on-site evaluation is conducted by a team of trained and credentialed CPC evaluators. The District Attorney's Office, Office of the Public Defender, Probation Department, Sheriff's Department, Superior Court and Behavioral Health Services all contributed staff to be trained and certified to perform these evaluations. The evaluations include direct observation of treatment groups, interviews with individual staff, program managers, and clients, as well as client file and curriculum review. Results are provided in a detailed 20-25-page report that gives an objective measure of program performance, along with specific recommendations.

Since inception in San Diego, 19 treatment programs have been evaluated, and 28 CPC assessments have been conducted. In aggregate, CPC scores at first evaluation (mean = 42 percent) fell in the Low Adherence to evidence-based practice category, indicating that most programs serving the justice involved are unaware of the most effective treatments. Many programs' adherence improves from first CPC to second CPC a year later. On average, these programs scored 71 percent, with the majority improving from Low Adherence to High or Very High Adherence. This significant gain supports this

²⁴ Andrews, D. A., & Bonta, J. (2010). Rehabilitating Criminal Justice Policy and Practice. *Psychology, Public Policy, and Law*, 16(1), 39-55. doi:10.1037/a0018362

²⁵ Lowenkamp, C. T., Latessa, E. J., & Smith, P. (2006). Does Correctional Program Quality Really Matter? The Impact of Adhering to the Principles of Effective Intervention. *Criminology & Public Policy*, 5(3), 575-594. doi:10.1111/j.1745-9133.2006.00388.x

²⁶ CPC; Matthews, B., Jones Hubbard, D., & Latessa, E. J. (2001). Making the next step: Using Evaluability Assessment to Improve Correctional Programming. *The Prison Journal*, 81 (4), 454-472.

quality assurance process as a successful educational intervention and meaningful program improvement catalyst. More importantly, this law enforcement effort to provide the highest quality services will reduce the likelihood of returning to criminal behavior and benefit the large population of mentally ill that are encountering the criminal justice system.

Justice Involved Services Training Academy

In 2018, led by Behavioral Health Services in partnership with the Probation Department, Public Defender's Office, the Sheriff's Department and the District Attorney's Office, the County developed and implemented the Justice Involved Services Training Academy (JISTA) to support mental health and substance use disorder treatment providers with education and skill development in Evidence Based Practices for justice involved populations. The BHS/PSG JISTA provides focused and specialized training in effective models of recidivism reduction by addressing the unique needs and characteristics of this population. With mental illness increasingly over-represented in jail and prison settings, significant training is dedicated to best practices for addressing the complex needs of justice involved individuals with mental illness.

In April, University of Cincinnati Corrections Institute (UCCI) and Correctional Program Checklist (CPC) founder, Dr. Edward Latessa, served as the keynote speaker at the JISTA kickoff event attended by nearly 300 justice partners and community treatment providers. From August to November, JISTA trained its first cohort of 30 attendees from 14 justice partners and providers. This partnership between the County and its contractors/providers is designed to improve use of best practices, adoption of Evidence Based Practices, and ultimately, reduce recidivism and increase pro-social community functioning among this population. In February 2019, JISTA will begin to train its second cohort.

Data Assisted Care Coordination

In San Diego, for the most part, behavioral health services are not provided directly by the Health and Human Services Agency. Rather, they are outsourced to individual providers through a contracting process. Clients often migrate between providers and between different levels of care. Currently, there is no way to have an expansive view across systems, or to timely match data between our jails and our Health Information Exchange (HIE). As a result, we have no case management or care coordination to facilitate access to care and supportive services. Data collection and Information sharing were identified as gaps here in San Diego across many of the intercepts, and creating a universal database is the first step to creating an organized system of care. We should strive to build criminal justice programs that look at and treat

the person as a whole, not just as the current case that is in the system. Until we build a system of case management, care coordination and warm-hand-offs, we will not build a community of healthy productive individuals.

Some states have deployed real-time psychiatric bed registries. For a person in crisis, time is of the essence. A real-time psychiatric bed registry would allow clinicians to quickly locate placements for individuals which would match their need with the appropriate type of placement. This would result in more efficient use of the capacity we have, and more timely transfer of patients from emergency departments or crisis stabilization units, which in turn should support better outcomes for the individual.

Barriers for smaller community treatment providers

Contracting and procurement with governmental agencies can be a complicated, lengthy and overwhelming process. Some of the requirements are unobtainable for small community providers. These smaller providers do outstanding work in their communities and should be given the opportunity to engage with our criminal justice populations. We must avoid allowing the delivery of behavioral health and substance use disorder services to turn into big business. More importantly, smaller community-based providers may be able to provide culturally specific services which may produce more effective outcomes. We should find ways to reduce some of the barriers for smaller providers to deliver these services, such as offering smaller grant awards, or requiring larger organizations to contract delivery of some services to smaller community providers.

Legislation

We must work together as a county when appropriate to support federal and state legislation aimed at filling gaps identified by stakeholders at the Symposium and Follow-Up Workshop. On the federal level, District Attorney Summer Stephan has met with Congressman Brian Babin and supports his Threat Assessment, Prevention and Safety Act (H.R. 838), which is an effort to develop a national strategy to prevent targeted violence through threat assessment and management.

On the state level, the District Attorney is working towards a Mental Health Pre-Trial Diversion data-sharing bill to help law enforcement and first responders receive vital information about a defendant, who is already in treatment, but who has decompensated and is in a mental health crisis. This bill supports the “continuum of care” model by creating options other than incarceration for law enforcement and other first responders who are called to the scene. Our office will also support a proposed legislative “fix” that will prohibit those defendants in Mental Health Pre-Trial Diversion from possessing or purchasing a firearm.



There are many additional opportunities for us and other stakeholders to have our voices heard by supporting innovative and long overdue legislative proposals to address important issues, such as the shortage of psychiatrists and mental health clinicians in the state, and another bill that will authorize the state to apply for federal funding to create a statewide psychiatric bed registry.

Recommendation Ten:

- ✓ **Invest in and create a data system that can timely match data across different systems to provide care coordination informed by both criminal justice and health care data.**
- ✓ **Create clear information sharing policies and MOUs.**
- ✓ **Create a Countywide psychiatric bed registry.**
- ✓ **Reduce the barriers for smaller providers to engage in working with government agencies to provide treatment and services.**
- ✓ **Support legislation that aims to fill the gaps identified by stakeholders at the Symposium and Follow Up Workshop.**

Conclusion

Addressing the myriad of issues surrounding mental health and the criminal justice system is a complex and monumental task involving many disciplines. The recommendations contained in this report are not intended to cast blame on any one party or agency for the crisis we are now facing. Rather, the recommendations acknowledge the shared responsibility we all have in creating a better, more humane way to serve individuals with mental illness when they find themselves entangled in the criminal justice system. The issues cannot be solved or fixed by one agency alone. Rather, it will take a coordinated response to create a shared strategic plan for the entire county that leverages our resources in a way that is best for the people in our communities. The recommendations in this report can serve as the basis of this strategic plan from the criminal justice perspective. An advisory council made up of all stakeholders should be created to continue to develop and expand these recommendations, and to create an action plan to be implemented by working groups. No longer can we operate in silos- it is ineffective and financially irresponsible. We must come together and develop one masterplan with priorities for funding based on need, as well as a plan to put words into action- and then we must stay the course.

Acknowledgments

Recognizing the complexity and urgency of this issue, District Attorney Summer Stephan appointed Deputy District Attorney Rachel Solov to a new position dedicated to this critical public safety issue. Rachel Solov, as Chief of Criminal Justice and Mental Health Reform Strategies, has devoted her decades of prosecution and threat assessment experience to this innovative and prioritized initiative. Chief Solov's collaborative leadership was the critical ingredient that made the Symposiums and resulting *Blueprint for Mental Health Reform* possible.

Additional thanks to DA Administrative Chief Michelle Bush for her dedicated work on every detail of this project. Thanks to DA Legislative Director Gail Stewart-Brockman and Deputy District Attorney Laura Tanney for helping lead the planning for this priority project.



(Left to right) San Diego County Probation Chief Adolfo Gonzalez, San Diego County Sheriff William Gore, Los Angeles County District Attorney Jackie Lacy, San Diego County District Attorney Summer Stephan, and Deputy District Attorney Rachel Solov, Chief of the DA's Criminal Justice and Mental Health Reform Strategies.

Special thank you to Los Angeles County District Attorney Jackie Lacey for her generosity and leadership in sharing steps taken in the Los Angeles County region on this issue and serving as the keynote for our San Diego Symposium held in April of 2018; which later paved the way for the follow-up Workshop held in October of 2018. DA Lacey and her staff spent hours and days with the District Attorney and her team in Los Angeles, generously sharing the details of their experiences, which enabled us to expedite our progress.

This work, as well as both the Symposium and Workshop programs, would not have been possible without the tremendous support and assistance of so many people. The length of these acknowledgments demonstrates the depth of the participation in this effort. The District Attorney would like to thank all the stakeholders who took the time to share their passion and expertise in discussing these critical issues. This includes, but is not limited to Sheriff Bill Gore, San Diego County CAO Helen Robbins Meyer, San Diego County Public Safety Group Deputy CAO Ronald Lane, San Diego City Attorney Mara Elliott, Public Defender Randy Mize, Probation Chief Adolfo Gonzales, San Diego County Supervisor Kristin Gaspar, the Health and Human Services Agency, San Diego Police Department Chief David Nisleit and Assistant Chief Paul Connelly, National Alliance on Mental Illness San Diego CEO Cathryn Nacario, numerous community based organizations and faith based leadership, Fire and Emergency Medical Services, and local, state and federal law enforcement agencies. (A complete list of participants is in Appendix D.)

The District Attorney expresses gratitude to Board of Supervisors Chairperson Dianne Jacob for supporting and advancing the collaboration and initiatives produced by the Symposiums and resulting *Blueprint for Mental Health Reform*.

The District Attorney would also like to thank Health and Human Services Director Nick Macchione, outgoing Behavioral Health Services Director Alfredo Aguirre and incoming Behavioral Health Services Director Dr. Luke Bergmann for their support and partnership as we move forward together in pursuit of our common goal, to best serve the people of San Diego.

Thank you to Superior Court Presiding Judge Peter Deddeh and Assistant Criminal Supervising Judge Desiree Bruce-Lyle for their insight and support.

Special thanks and deep appreciation to the subject matter experts who spoke and shared their wisdom and experience, which includes Hallie Fader-Towe, Hon. Judge David Danielsen (Retired), Hon. Judge Desiree Bruce-Lyle, Supervisor Kristin Gaspar, SDSO Lieutenant Chris May, PERT Director Dr. Mark Marvin, NAMI San Diego Next Steps Director Dr. Linda Richardson, NAMI San Diego Hospital Transitions Director Luz Pinto, SDSO Chief Medical Officer Dr. Alfred Joshua, Deputy Public Defender Neil Besse, Deputy City Attorney Lara Easton, Deputy District Attorney Harrison Kennedy, SDSO Reentry Services Manager Christine Brown-Taylor, BHS Medical Director Dr. Michael Krelstein, SDSO Commander Hank Turner, Supervising Probation Officer Christiene Andrews, and Deputy District Attorney Jessica Lees. Additional special thanks go to all of the breakout session and work group facilitators, including Scott Brown from the Superior Court, Christine Brown-Taylor from the Sheriff's Department, Michelle Bush

from the District Attorney's Office, Julie Gibson from the Public Defender's Office, Dr. Geoff Twitchell from the Probation Department, DDA Ana De Santiago, DDA Melissa Diaz, DDA Matthew Dix, DDA Brian Erickson, DDA David Grapilon, DDA Jennifer Kaplan, and DDA Harrison Kennedy.

Thank you to Policy Research Associates for their permission to use materials associated with the Sequential Intercept Model.

These programs would not have been possible without the assistance of our hard working and professional staff at the District Attorney's Office. Special thanks and recognition to Jim Kelly for putting the program and materials together to ensure everything ran smoothly; to Elaine Bissett, Patty Ramirez and Mariana Zavala for their work in managing the massive invite and RSVP lists; and, to those who helped on-site, including Elaine Bissett, Claudia Delgadillo, Julia Diaz, Edith Flores, Florinda Johnson, Marisela Martinez, Omar Pena, AJ Pierite, and Briana Zavala. Thank you to Communications Director Steve Walker for his assistance with this project. Finally, we would like to extend deep appreciation to the Jacobs Center for Neighborhood Innovation and Kitchens for Good for their exceptional service and hospitality.



Appendix A



Blueprint for Mental Health Reform

*A Strategic New Approach
Addressing the Intersection of
Mental Health, Homelessness
and Criminal Justice in San
Diego County*

TEN RECOMMENDATIONS

Recommendation One:

- ✓ Increase access to urgent mental health walk in services by expanding hours of availability.

Recommendation Two:

- ✓ Work collaboratively with community partners to expand and support outreach and prevention programs.
- ✓ Stand up against mental health discrimination, stigma and unequal treatment.
- ✓ Utilize Peer Support Specialists and study to determine if their use improves outcomes locally in San Diego. If outcomes are improved locally, use of peer support should be expanded.
- ✓ Increase awareness of the NAMI San Diego oscER app and support efforts to keep it available and up to date.

Recommendation Three:

- ✓ Support the creation and expansion of crisis/de-escalation training for law enforcement countywide.
- ✓ Evaluate and enhance current regional training for 911 call takers in identifying and properly screening mental health related calls.
- ✓ Print and widely distribute 911 checklist cards to those who have a family member with mental health issues.
- ✓ Provide mental health training to District Attorney Investigators and Process Servers.
- ✓ Build opportunities to enhance self-care and wellness for law enforcement officers and other first responders.

Recommendation Four:

- ✓ Expand PERT to operate 24 hours and include paramedic response.
- ✓ Create protocol for follow-up care after the immediate crisis is resolved.
- ✓ Evaluate the use of Mobile Mental Health Response Teams and non-law enforcement response for crises that do not involve violence or threats of violence.
- ✓ Add PERT Clinicians to school law enforcement agencies as appropriate for imminent threats or emergencies and create a continuum of behavioral health crisis responses for youth in non-emergency situations.

Recommendation Five:

- ✓ **Build regional Mental Health Crisis Stabilization Centers that can provide walk in mental health and substance use disorder services, efficient law enforcement drop-offs and step-down care coordination/case management services.**
- ✓ **Adopt a “no wrong doors” approach where detox, mental health and substance use disorder services can be provided at one location.**

Recommendation Six:

- ✓ **Support and expand existing coordinated release from custody programs.**
- ✓ **Work collaboratively to minimize releasing individuals in the middle of the night.**

Recommendation Seven:

- ✓ **Address barriers to obtaining housing by creating common sense regulations that account for public safety but allow for flexibility. Regulations should be designed to be inclusive and encourage expansion of access to housing.**
- ✓ **Work collaboratively with government and community leaders to create systems that support public safety within these specialized housing units.**

Recommendation Eight:

- ✓ **Create a working group of stakeholders to collaboratively create guidelines and structure for mental health diversion which ensures public safety, as well as equal access and equitable treatment for participants.**

Recommendation Nine:

- ✓ **Increase capacity for Behavioral Health Court.**
- ✓ **Add a specialized court program for participants with co-occurring mental health and substance use disorders.**
- ✓ **Screen potential participants for alternatives to custody early in the criminal justice process.**

Recommendation Ten:

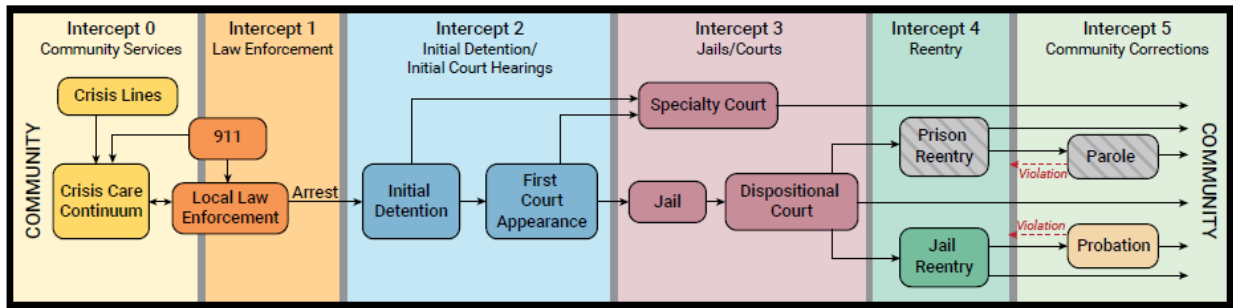
- ✓ **Invest in and create a data system that can timely match data across different systems to provide care coordination informed by both criminal justice and health care data.**
- ✓ **Create clear information sharing policies and MOUs.**
- ✓ **Create a Countywide psychiatric bed registry.**
- ✓ **Reduce the barriers for smaller providers to engage in working with government agencies to provide treatment and services.**
- ✓ **Support legislation that aims to fill the gaps identified by stakeholders at the Symposium and Follow-Up Workshop.**





Appendix B

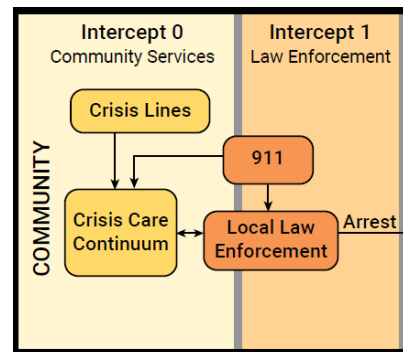
Mapping the Intersection of Mental Health, Homelessness and Criminal Justice in San Diego County



Intercepts 0/1

Current Resources/Strengths:

- Exodus, Telecare, Tri-City, Jane Weston Center
- PERT Teams, HOT Teams
- PERT Training
- 211
- SIP program
- Veteran’s Crisis Line
- School reporting apps
- PR campaigns (it’s up to us)
- Regional Center
- Information Sharing re: Juveniles
- SDSO App for patrol
- NAMI app “OSCAR”
- NAMI Peer Support
- Project One for All
- ACT Programs
- Medical Uber
- 24/7 crisis lines
- Rady’s Urgent Care for juveniles



Gaps/Needs (Priorities as identified by stakeholders are in BOLD):

***Data/Information Sharing (Universal release of info, central hub where info is available across disciplines (first responders, ER, Criminal Justice, treatment) (HIPPA-under what circumstances can it be waived)**

***24-hour PERT Teams**

***More training to dispatch and officers re: responding to crisis (Crisis Intervention Training) (Crisis response vs. LE response)**

***Mental Health Urgent Care Centers- one stop facility**

***Follow up with individual and family after law enforcement contact involving mental health issues**

***Lack of access for co-occurring disorders**

***Warm handoff at early stage to a behavioral health specialist**

***Housing**

Threat Assessment Teams

Mobile Crisis Response teams that don't rely on uniformed officers

Expand peer-based programs (link to peers earlier in process/ background checks for peers take too long)

Enhanced training on what resources are available

Increased funding for EMS/Fire

Expand Detox services

Legislative change to allow EMS to transport someone other than to jail or ER

Training to Family & public re: what to do, what info to have available

Access to treatment without barriers, and access to treatment w/o police response

Community Paramedic Model

Disparity in the way assessments take place (central coordination site for law enforcement)

Lack of focus on prevention, early intervention programs, Mental Health "First Aid."

More case management services

Need more hospital beds instead of jail beds

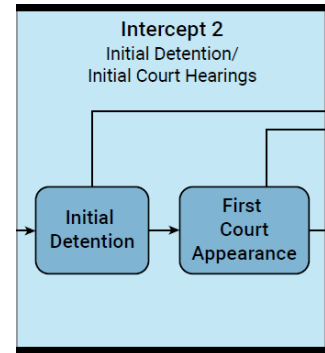
Use of a universal mental health screening/assessment tool

Expanded options once PERT responds (not just jail)

Intercept 2

Current Resources/Strengths:

SMART
Sobering Center
SIP
Inmate Screening
Pretrial Services
CERNER



Gaps/Needs (Priorities as identified by stakeholders are in BOLD):

***Lack of data/information re: the individual. Need improved info sharing and IT solutions for privileged/private info**

***Standardized Mental Health Screening upon admission**

***Pre-charging diversion options for adults**

Lack of 24-hour psych coverage at jail- staffing resources

Capacity of PSU

Pre-trial/bail alternatives

Service referrals for cases not filed

Info needs to be available and shared at 1st court appearance

Communication & connection/reconnection to existing programs

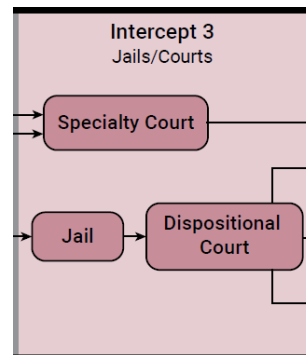
Housing- reduce barriers/policies

Develop system to utilize existing beds better

Intercept 3

Current Resources/Strengths:

Defense Transition Unit- should be expanded
Collaborative Courts (strength of justice partners)
Inmate Safety Program
Mental Health Clinician Program
PSU
East Mesa Re-entry Facility



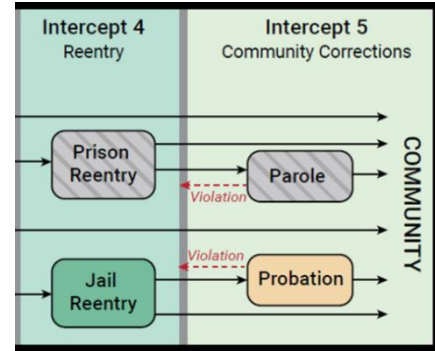
Gaps/Needs (Priorities as identified by stakeholders are in BOLD):

- ***Restoration of Competency in the community (long waits for Patton bed)**
- ***Co-occurring/ Dual Diagnosis Court**
- ***Increase engagement/enrollment in collaborative court programs**
 - increase incentives for participation
 - more attorney/judge training
- ***Universal screening process for collaborative court referrals**
- ***More funding and increase capacity for collaborative courts (some courts need to be less “picky” about admitting defendants)**
- ***Housing- need safe sober living space while defendants are in programs**
 - Increase transitional services for misdemeanor and low-level felony population
 - Decreased length of sentences leads to limited options to get into programs
 - Get info to defense attorney at earliest possible point
 - Standardized consent/release of info
 - Dedicated case management
 - Set release times because inconsistent or middle of the night releases make smooth transition into community difficult
 - Medications (getting correct meds into jail, expanding medicated assisted treatment)
 - Expand DTU

Intercepts 4/5

Current Resources/Strengths:

Sheriff's East Mesa Re-entry Facility
Sheriff's extensive re-entry services
Collaborative Courts
DTU (Defense Transition Unit)
Project In-Reach
Training Center
Community Transition Center
Probation's MIO Unit
Telecare
ACT Programs (Assertive Community Treatment)
Parole Outpatient Clinic
Family Resource Centers



Gaps/Needs (Priorities as identified by stakeholders are in BOLD):

- *Housing- dual diagnosis, high risk, including sex offenders. Need more housing navigators. Address barriers/regulations e.g., housing for felons**
- *Sober living/recovery residences**
- *Warm handoff** upon release: Support systems at time of release- peers, case managers, family, etc. to provide warm hand-off
- *Inmate release time not in the middle of the night**
- *Information sharing- link computer software so providers don't have to start at square 1 with re-entry.**
- *Track progress/outcomes upon release** Partner with faith based/community groups
- Oversight of shelters and recovery residences
- Exit interviews with successful clients to see what worked, what didn't
- Family support/educational services so they can assist
- Forced medication to make sure medication compliance is maintained



Appendix C

Survey Results

Results taken directly from Survey Responses:

1) What is your primary area of mental health experience?

ANSWER CHOICES	RESPONSES
▼ Community Service Provider	34.38%
▼ Law Enforcement/First Responder	37.50%
▼ Medical	9.38%
▼ Detentions/Jail	15.63%
▼ Courts/Legal	15.63%
▼ Re-entry	15.63%
▼ Other (please specify)	Responses 18.75%

2) In your experience, what resources are currently in place and working well for justice involved people with mental and substance use disorders?

- Alpha Project Home Finder links homeless SMI with outpatient treatment programs. Additional funding for this program is needed.
- PERT: helps ensure people routed to the correct facility (i.e., CMH, another LPS facility, or jail). Could be expanded.
- The Serial Inebriate Program (SIP) is a national model to address chronic public intoxication, but only operates in the City of SD.
- Jail mental health services is available to individuals who are in custody and this includes risk assessment, evaluation, medication management, inpatient and outpatient services.
- IHOT PERT Project In-Reach Resource Access Program (SD City)
- The “BHOT” (Behavioral Health Oversight and Treatment) calendar in South Bay seems like a good model for identifying and tracking probationers in need of extra supervision and assistance.
- Standard settlement courts generally are amenable to treatment via “NOLT 365 releasable” format, which seems to work well.
- Drug Courts, Re-entry Courts
- Discharge planning
- Public Defender’s Defense Transition Unit

- Probation's Community Transition Center for the PRCS and Mandatory Supervision Populations.
- PROGRESS, which is an alternative custody setting for sentenced inmates with low to moderate mental illness where they receive programming and treatment. Participants begin to receive treatment in the community while living in the facility which is secured but not locked.
- Project In-Reach
- Collaboration between Probation, Sheriff, Courts, Law Enforcement, and Behavioral Health improves with each passing year.
- Work-related programs like the Center for Employment Opportunities

3) In your experience, what resources are currently in place for this population, but that can be improved?

- ACT Programs are a good resource, but availability can be limited.
- Expansion of PERT team
- Transportation to assist with connecting people to services
- Access: Capacity at existing programs needs to be expanded
- The San Diego Resource Access Program (RAP) partnership with PERT and SDPD was an effective example of effective program until it was largely defunded. The collaboration reduced police response time for non-violent mentally ill clients. RAP also supported the City S.M.A.R.T. program by identifying repeat low-level offenders for intervention (ex., suboxone) and was a key ally to SDPD's SIP and Homeless Outreach Team (HOT).
- Project 25 demonstrated the remarkable success of collaboration in addressing the City's most impactful individuals by improving healthcare and lowering cost but has not been taken to scale. Other communities (ex., Denver) have employed "Social Impact Bond" funding mechanisms to attract funding to house and support such super-users who (while relatively small in #) dramatically and disproportionately affect the welfare of communities.
- Out-patient services, mental and behavioral illness care, and a need for a psychiatric hospital. The jail nor the juvenile detention facilities should not be the primary mental health providers in the county.
- Co-occurring diagnoses remain a difficult area. It appears courts equipped for SUD cannot accept SMI clients and vice versa.
- SMART, SDPD HOT, SMART, SIP long term inpatient treatment beds need expanding

- Resources for parents like Friends in the Lobby during visitation hours for parents. This is a resource NAMI San Diego provides for families in ED's, Behavioral Health Units, and Rady's Children's Unit. Very successful and would benefit JJS parents!
- Additional staffing to provide individuals more access to frequent contacts with mental health staff and treatment; expanded jail housing for those with mental health issues; discharge activities that provides wrap-around services so that the individual when released from custody has shelter, food, job opportunities, and access to continuity of care for treatment and medications.
- Mandatory court ordered rehabilitation and transitional housing
- We may want to consider more probation modification motions to return to court and reassess needs when probationers are struggling and need a higher level of care. Should not just be waiting for violation and placing into custody.
- Dual diagnosed programs which understands the issues of the justice populations
- Community behavioral health programs specifically for persons released from jails and prisons
- Expand resources for discharge planning and connecting to services upon release from jail. Expansion of intensive reentry support programs (e.g., Project In-Reach)
- Mailing address/ID Cards
- Co-Occurring Treatment options and access to Psychiatric care for medication management
- Identifying inmates early in the booking process would help provide situational awareness to inmate processing staff and / or detentions deputies and potentially receive extra attention from the outset.
- There needs to be more service providers other than CMH that offer bed space for those in crisis.
- More accessibility to mental health court, and judges that understand mental health and co-occurring disorder issues.
- Veterans, have been upgraded as it relates to treatment.
- Outreach to decrease stigma associated with mental illness and increase awareness to identifying symptoms to enhance early diagnosis of the ages 12-25 in the inner cities.

4) In your experience, what are the major gaps in services or needs for this population?

- Housing, Housing, Housing
- Non-law enforcement mobile outreach, both pre-crisis and during crisis.

- Crisis stabilization/mental health urgent care centers.
- Post-crisis step-down resources, including intensive case management.
- Pretrial services: Options for community-based treatment pre-trial
- We should explore the idea of better clinical input at the point of arrest v. LPS hold. This decision has long lasting, expensive, often inefficient effects and perhaps should be better informed.
- More residential programs that accept all types of mental health diagnoses and don't cater to certain mental health diagnoses; for example, shelters that accept people with mental health (no matter their diagnoses).
- Remove the stigma of mental health issues by having discussions about mental health and bringing awareness to the communities and to the clients. Outreach to bring awareness to the importance of medication(s) compliance, as well as continuing to take the medication, even when the client feels "better".
- There are too many barriers (cost , access and transportation)
- There is a lack of follow-up after crisis
- San Diego lacks "Intercept Zero" programs: 1 - There is no warm handoff (from Emergency Departments to treatment providers) for individuals with substance abuse or mental illness. This is true for narcotic ODs awakened by naloxone as well as patients with alcohol poisoning who are brought to an ED. There is currently no effective way to consistently provide medical support (i.e., suboxone) to an active heroin addict who wants to stop using. They return to the street and frequently re-overdose. 2 - Lack of effective jail diversion. Ex., there is no "medical clearance" facility to which law enforcement can transport individuals for expeditious medical clearance. San Antonio and Tucson accomplish such turnover in < 10 min (90%-ile) while providing medical screening whether the individual is destined for jail, detox or a psychiatric facility. The current Sobering Center on India St. is a social model, i.e., no medical staff so they cannot accept the spectrum of patients that others can (San Fran is another example). Currently SD emergency departments become a default destination, which is costly and often ineffective. 3 - the Jail is challenged to connect substance abuse/mentally ill individuals to community resources upon discharge. Better health information exchange with community-based providers through the CIE would create an opportunity for warm hand-offs, similar to when SIP clients are released from custody to a SIP officer for re-introduction to their new medical home, housing and treatment. 4 - lack of in-patient psych beds causes backlog of 5150 patients in Emergency Departments. This compromises care and leads to burnout among law enforcement, fire, EMS and hospital personnel who perceive the system as indifferent to their true roles.

- Capacity for medical/psychiatric management and treatment, especially for pediatric and geriatric patients. Patients frequently "board" for long periods of time in emergency departments due to lack of placement options. This also contributes to ED crowding.
- A question to be addressed is how much mental health and connection to services should impact the bail / OR decision. Perhaps better use of SOR to keep mentally ill clients out of custody as appropriate.
- More treatment - immediate access to treatment - sharing information across systems - quality treatment
- Social Security/ Disability enrollment can be very difficult
- Alternative options than traditional treatment and therapy. Examples: Community engagement, Employment opportunities, and adjunctive therapies like Equine Therapy, Recreational Therapy
- Lack of available transitional housing and related services for individuals with mental illness who are released from custody. Lack of available beds at the County Mental Hospital for emergent services.
- Lack of care coordination between criminal justice behavioral health providers and community behavioral health providers
- Housing is a big issue for this population. Many programs require the client to have their ID or SS card prior to applying. Many of these clients don't. Additionally, many of their charges mean they aren't eligible for the housing vouchers. Additionally, one of the BIGGEST gaps is trying to get co-occurring treatment for individuals with a SMI and a substance abuse issue. Residential drug treatment programs aren't taking our clients from custody if they have a mental health need.
- The lack of a "stick" in the carrot and stick scenario for many drug-related offenses. Residential facilities for SMI. Housing for homeless with these disorders.
- Housing. Justice involved individuals may not be eligible for shelters, residential treatment programs, etc. Lack of information. As providers, we may not realize an individual is justice involved. We have to rely on our clients to inform us because we don't have a way to find this information, and some clients do not feel comfortable sharing this information initially.
- We need a mental health urgent care with a referral system to community services for addiction and even abuse.
- There is a gap for people who are not SMI but experience mild to moderate MH issues. Often, we work with the individual and do not include the family in the treatment/intervention process.
- Coordinated care between psychiatric, medical and Co-Occurring treatment

- Screening to identify inmates who have previously attempted suicide in custody, had certain charges which could be attributed to one's mental health or emotional wellbeing inmates can get identified and assisted earlier in the booking process.
- 1. Longer rehab programs. 2. More time in wrap services before community re-entry. 3. Specific peer-led jobs open to recent graduates at re-entry to society. 4. Options for population to remain in wellness peer-led community programs for extended time with the option to stay indefinitely if they are successful. 5. MAT programs offering housing and job placement assistance. 6. Continued efforts to educate the public about addiction, and increased de-stigmatization efforts against mental health, addiction and people who commit crimes. 7. Early childhood intervention, including educating parents, teachers, and school administration about mental illness in children and youth beginning in elementary school. 8. Parents associated with a school district must take parenting classes in order to be better equipped to address behavioral problems in their school aged children.
- The Gaps are experienced care givers who can identify with the root of the core symptoms. Then case by case basic develop treatment plans relative to each family. Because if it's one there are multiples in a family unit. Because some of it is learned behavior.
- More treatment - immediate access to treatment - sharing information across systems - quality treatment
- System navigation and community support. The people we serve spend unnecessary time repeating their trauma and establishing relationships with multiple agencies to receive critical services.
- Long term inpatient treatment beds need expanding



Appendix D

NAME, L	NAME, F	TITLE	ORGANIZATION
Alatorre	Jonathan	Homeless Outreach Worker	Vista Hill
Anderson	Jeffery	Crime Analysis Administrator	San Diego County District Attorney
Andrews	Christiene	Supervisor Probation Officer	San Diego County Probation Department
Anglea	Greg	CEO	Interfaith Community Services
Apodaca	Phil	Lieutenant	California Highway Patrol - El Cajon
Banuelos	Victor	Harbor Police Sergeant	San Diego Harbor Police
Bartosik	Angela	Chief, Deputy Primary Public Defender	San Diego County Public Defender
Bautista	Dave	Lieutenant	San Diego Police Department
Beach	Craig	Forensic Specialist	HHSA - Behavioral Health Services
Beck	Dijana	Chief of Agency Operations, Central and South Regions	HHSA - Regional Self Sufficiency
Becker	Gregory	District Attorney Investigator	San Diego County District Attorney
Benson	William		Pastors on Point SD
Benton	Randy	Harbor Police Officer	San Diego Harbor Police
Besse	Neil	Deputy Public Defender	San Diego County Public Defender
Bissett	Elaine	Legislative Coordinator	San Diego County District Attorney
Botsford	Stacee	Sergeant	San Diego Police Department
Brechtel	Jay	Clinical Supervisor	Alpha Project
Brown	Gerald	Executive Director	United African American Ministerial Action Council (UAAMAC)
Brown	Scott	Special Projects Manager	Superior Court of San Diego
Brown-Taylor	Christine	Reentry Services Manager	San Diego County Sheriff's Office
Bruce-Lyle	Desiree	Judge	San Diego Superior Court
Bruland	Ruth	Chief Programs Officer	Father Joe's Village
Burke	Cindy	Director, Applied Research Division	San Diego Association of Governments (SANDAG)
Bush	Michelle	Chief, Administrative Services	San Diego County District Attorney
Carlos	Rick	Unit Supervisor	California Department of Corrections and Rehabilitation (CDCR)
Carr	Lynn	Justice Program Coordinator	HHSA - Integrative Services
Ceballos	Patricia	Reentry Program Coordinator	San Diego County Sheriff's Office
Cipriani	Cindy	Senior Management Counsel	US Attorney's Office
Coneley	Deadrian	Doctor / Pastor	
Connelly	Paul	Assistant Chief	San Diego Police Department
Cookson	Renee	Director of Community Development	NAMI San Diego
Cramer	David	Lieutenant	Escondido Police Department
Danielsen	David	Judge, Retired	Superior Court of San Diego
Davies	Christine	Assistant Director	PERT
De Santiago	Ana	Deputy District Attorney	San Diego County District Attorney
Dean	Robert	CEO	Vista Hill

Delgadillo	Claudia	Staff Development Specialist	San Diego County District Attorney
Zavala	Briana	Legislative Assistant	San Diego County District Attorney
Diaz	Melissa	Deputy District Attorney	San Diego County District Attorney
Dix	Matthew	Deputy District Attorney	San Diego County District Attorney
Donofrio	Jolle	Associate Medical Director	City of SD, Fire Rescue
Dugo	Dominic	Chief Deputy District Attorney	San Diego County District Attorney
Dunford	James	Emeritus Professor of Emergency Medicine	University of California, San Diego (UCSD)
Easton	Lara	Chief, Deputy City Attorney	Office of the City Attorney
Elliott	Mara	Deputy City Attorney	Office of the City Attorney
Erickson	Brian	Deputy District Attorney	San Diego County District Attorney
Espiritu	David	Police Captain	National City Police Department
Esposito	Nicole	M.D.; Medical Director	HHSA - Behavioral Health Services
Fader-Towe	Hallie	Senior Policy Advisor	Council of State Governments (CSG) Justice Center
Fischetti	Peter	Chief Licensed Mental Health Clinician	San Diego County Sheriff's Office
Flowers	Karen	Special Agent in Charge	Drug Enforcement Administration (DEA)
Forrester	Kim	Chief of Agency Operations, East & North Regions	HHSA - Regional Self Sufficiency
Frank	Caylin	Senior Policy Advisor	Board Of Supervisor - Sup Horn Office
Fritz	Kimberly	Associate Vice President	Care 1st Health Plan Greater San Diego
Gaines	LaShaunda	Program Manager	HHSA - Aging and Independent Services
Garcia	Piedad	Deputy Director	HHSA - Behavioral Health Services Adult/Older Adult System
Gaspar	Kristin	Supervisor	Board Of Supervisor - Sup Gaspar Office
Gesternzana	Jennifer		
Giaime	Frank	Sergeant	Chula Vista Police Department
Gibson	Julie	Deputy Public Defender	San Diego County Public Defender
Gilbert	Dori	Deputy Director Regional Operations, East & North Central Regions	HHSA - Regional Self Sufficiency
Gonzales	Adolfo	Chief	San Diego County Probation Department
Gordon	Sarah	Program Coordinator	Public Safety Group (PSG)
Gore	Bill	Sheriff	San Diego County Sheriff's Office
Grapilon	David	Deputy District Attorney	San Diego County District Attorney
Hassane	Taha	Director	Islamic Center of San Diego
Hawker	Megan	Clinical Director	Interfaith Community Services
Hawkes	Tina	Psychologist	Naval Criminal Investigative Services
Hebert	Valerie	CYFL Family Specialist Trainer	NAMI San Diego

Heiser	Chris	Deputy Fire Chief	City of SD, Fire Rescue, EMS Division
Hernandez	Mike	Commander	San Diego County Sheriff's Office
Hodgkins	Christopher	Senior IT Engineer	San Diego County Sheriff's Office
Hoerman	Frank	District Attorney Investigator	San Diego County District Attorney
Humphrey	Bahija	Assistant Chief of Initiatives	Office of the City Mayor
Jensen	Anne	Resource Access Program Manager	City of San Diego, Fire Rescue, EMS Division
Johnson	Belinda	Lady	Greater Harvest Church
Johnson	Florinda	Confidential Legal Secretary	San Diego County District Attorney
Johnson	Gerald	Chaplain	Greater Harvest Church
Jones	Sheri	Licensed Clinical Social Worker (CSW)	California Department of Corrections and Rehabilitation (CDCR)
Joshua	Alfred	Chief Medical Officer	San Diego County Sheriff's Office
Kahn	Christopher	EMS Medical Director	Fire Department
Kaplan	Jennifer	Deputy District Attorney	San Diego County District Attorney
Karmach	Izzy	Administrator	San Diego County Psychiatric Hospital
Kaye	Charles	Commander	San Diego State University Police Department
Kelly	Jim	Asst. Director of Training	San Diego County District Attorney
Kennedy	Harrison	Deputy District Attorney	San Diego County District Attorney
Kight	Jeff	Lieutenant	California Highway Patrol - Oceanside
Koenig	Kristi	Medical Director	HHS - Emergency Medical Services
Koh	Steve	Associate Professor	University of California, San Diego (UCSD)
Kolbe	Beth	Community Engagement Manager	Alpha Project
Korte	Kameron	Special Agent	Drug Enforcement Administration (DEA)
Krelstein	Michael	Medical Director	HHS - Behavioral Health Services
Lacey	Jackie	District Attorney	Los Angeles County District Attorney
LaCroix	Christina	Licensed Mental Health Clinician	San Diego County Public Defender
Lane	Ronald	Deputy Chief Administrative Officer	Public Safety Group (PSG)
Lara	Charles	Lieutenant	San Diego Police Department
Larios	Araceli	Homeless Outreach Worker	Vista Hill
Law	Angela	Supervising Deputy City Attorney	Office of the City Attorney
Lebensohn-Chialvo	Florencia	Assistant Professor	University of San Diego (USD)
Lee	Barbara	Medical Administrator	San Diego County Sheriff's Office
Lees	Jessica	Deputy District Attorney	San Diego County District Attorney
Lipson	Dr. Glenn	Clinical/Forensic Psychologist	

Littlejohn	Reuben	Asst. Chief	Probation
Lucky	Michael	Program Director	Alpha Project
Lynch	Katy	Assistant Lieutenant	La Mesa Police Department
Martin	Henry	Lieutenant	Chula Vista Police Department
Marvin	Mark	Psychologist	PERT
May	Chris	Lieutenant	San Diego County Sheriff's Office
Mays	Josh	Chief	San Diego State University Police Department
McAlister	Jeanne	Founder and CEO	McAlister Institute
McCulloh	Kaitlynn		
McNamara	James	Lieutenant	California Highway Patrol - San Diego
Mercado	Marco	District Attorney Investigator	San Diego County District Attorney
Mitchell	Kimberly	CEO	Veterans Village of San Diego (VVSD)
Mize	Randy	Public Defender	San Diego County Public Defender
Moxham	Ellen	Doctor	
Mullen	David	Program Coordinator	HHSA - Behavioral Health Services
Murphy	Justin	Captain	Escondido Police Department
Myers	Kathy	Program Coordinator	San Diego County Sheriff's Office
Nacario	Cathryn	CEO	NAMI San Diego
Naimark	David	Psychiatrist	HHSA - Behavioral Health Services
Nicholas	Matt	Captain	La Mesa Police Department
Olin	Beth	Program Manager	Office of the Public Conservator
Opeka	Ryan	Sargeant	Carlsbad Police Department
Palkovic	Dan	Captain	San Diego Unified School District
Park	Marilyn	RN, BSN, Patient Care Navigator	Scripps Mercy Hospital
Penwell	Christine	District Attorney Investigator	San Diego County District Attorney
Pinto	Luz	Director, Hospital Transitions	NAMI San Diego
Renner	Tyler	Council Representative	San Diego City Council, District 3
Richardson	Linda	Program Director, Next Steps	NAMI San Diego
Rios	Filipa	Chief Programs Officer	Interfaith Community Services
Rowe	Angela	Program Director	Vista Hill
Russoniello	Kellen	Staff Attorney	American Civil Liberties Union (ACLU)
Salazar	Holly	Asst. Director of Department Operations	HHSA - Behavioral Health Services
Salazar	Lisa	Program Manager	Vista Hill
Sawin	Lisa	Deputy Chief Probation Officer	San Diego County Probation Department
Seabloom	Lynne	EMS Manager	SD County Fire Chiefs Association EMS Section
Sellers	Mark	Public Conservator	Office of the Public Conservator
Shadoan	David	Special Agent	Drug Enforcement Administration (DEA)
Shea	Dan	TBD	Paradigm Investment Group

Sieber	William	Clinical Professor	University of California, San Diego (UCSD)
Snyder	Deborah	Recovery and Wellness Director	Interfaith Community Services
Solov	Rachel	Chief, Collaborative Courts & Reentry	San Diego County District Attorney
Stainbrook	Mark	Acting Chief	San Diego Harbor Police
Steele	Ken	Pastor	San Diego Mission Team
Stephan	Summer	District Attorney	San Diego County District Attorney
Stewart-Brockman	Gail	Special Assistant To DA	San Diego County District Attorney
Sweeney	Ray	Captain	La Mesa Police Department
Taney	Laura	Deputy District Attorney	San Diego County District Attorney
Tellez	Jose	Asst. Chief	National City Police Department
Terry	Michael	Clinical	University of San Diego (USD)
Thrush	Dorothy	Chief Operations Officer	Public Safety Group (PSG)
Thunberg	Eric	Captain	Chula Vista Police Department
Turner	Hank	Commander	San Diego County Sheriff's Office
Turner	Suzanne	ASAC	Federal Bureau of Investigations
Tuteur	Jennifer	Deputy Chief Medical Officer	HHSA - Medical Care Services
Twitchell	Dr. Geoff	Director of Treatment & Clinical Services	San Diego County Probation Department
Vargas	Deacon Jim	President & CEO , Deacon	Father Joe's Village
Waczek	Laszlo	Captain	Coronado Police Department
Wahl	Scott	Captain	San Diego Police Department
Warren	John	Chief Editor	San Diego Voice and Viewpoint
Weinreb	Lisa	Chief, Deputy District Attorney	San Diego County District Attorney
Whitney	Tracey	Mental Health Liaison	Los Angeles County District Attorney
Willenborg	Danielle	Licensed Mental Health Clinician	San Diego County Public Defender
Williams	Mickey	Captain	Carlsbad Police Department
Woods	Margie	Judge	Superior Court of San Diego
Yu	Fanny	Deputy District Attorney	San Diego County District Attorney
Zizzo	Lou	Lieutenant	San Diego Community College
Zotalis-Ferreira	Deanna	Deputy Director North Region	HHSA - Regional Self Sufficiency



Appendix E

Adult/Older Adult Mental Health Outpatient Clinics

Urgent Walk-in Services Schedule and Contact Information

The hours posted below are for urgent walk-in services only at regional clinics which provide psychiatric outpatient services, including medication.

The programs serve Medi-Cal beneficiaries and uninsured adults, age 18 and over. Insured persons are referred to their own providers.
This schedule, arranged by Region, provides the Clinic's addresses, contact phone numbers, and urgent walk-in days/hours.
Whenever possible, please call in advance to arrange an appointment.

REGION	CLINIC	DAY(S) AVAILABLE FOR WALK-IN	TIME(S) AVAILABLE FOR WALK-IN	ADDRESS	PHONE / FAX NUMBER	PROGRAM MANAGER	COUNTY BHS PROGRAM COORDINATOR
Central	CRF/Jane Westin Walk-In Center *one visit only	Mon - Fri	10:00 AM - 4:00 PM	1045 9th Avenue San Diego, CA 92101	(619) 235-2600 FAX: (619) 696-9573	Kenna Mauhili	Cecily Thornton-Stearns, MFT 619-563-2754 Cecily.Thornton-Stearns@sdcounty.ca.gov
	Neighborhood House Assn, Inc. / Project Enable	Mon - Fri	10:00 AM - 2:00 PM	286 Euclid Avenue Suite 102 San Diego, CA 92114	(619) 266-2111 FAX: (619) 266-0496	Bernard Carrasco, MFT	David Mullen, MFT (619) 584-3023 David.Mullen@sdcounty.ca.gov
	UPAC Community Wellness Clinic	Mon - Fri	8:30 AM - 5:00 PM Urgent Walk-In Services Hours: M-F 8:30 AM - 12:30 PM	5348 University Ave., Suite 108 San Diego, CA 92105	(619) 255-7550 FAX: (619) 795-6909	Joshua Zang, MFT	Maria Morgan, MFT (619) 584-5028 Maria.Morgan@sdcounty.ca.gov
North Central	CRF/Douglas Young BPSR Center	Mon - Wed, & Fri	9:00 AM - 11:00 AM	10717 Camino Ruiz Suite 207 San Diego, CA 92126	(858) 695-2211 FAX: (858) 695-3521	Laura Talbott	Betsy Knight, MFT 619-584-5029 Elizabeth.Knight@sdcounty.ca.gov
		Thurs	12:00 PM - 2:00 PM				Phuong Quach, Psy.D, LMFT 619-584-3028 Phuong.Quach@sdcounty.ca.gov
North Central	North Central Mental Health Center	Mon - Fri	8:30 AM - 3:30 PM	1250 Morena Blvd. 1st Floor San Diego, CA 92110	(619) 692-8750 FAX: (619) 692-8779	Lisa Thiel	Phuong Quach, Psy.D, LMFT 619-584-3028 Phuong.Quach@sdcounty.ca.gov

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REGION	CLINIC	DAY(S) AVAILABLE FOR WALK-IN	TIME(S) AVAILABLE FOR WALK-IN	ADDRESS	PHONE / FAX NUMBER	PROGRAM MANAGER	COUNTY BHS PROGRAM COORDINATOR
East	CRF/Heartland BPSR Wellness Recovery Center *Walk-in hours 40 hrs per wk Mon-Fri until 12/15/18	Mon	9:00 AM - 11:00 AM	460 N. Magnolia Ave. Suite 110 El Cajon, CA 92020	(619) 440-5133 FAX: (619) 440-8522	James McMahill	Charity White Voth, LCSW 619-563-2770 Charity.White-Voth@sdcounty.ca.gov
		Wed & Fri	9:00 AM - Noon				
		Tues & Thurs	9:00 AM - 4:00 PM				
	East County Mental Health Center *No walk-ins until 12/15/18	Mon & Fri	9:00 AM - Noon	1000 Broadway Suite 210 El Cajon, CA 92021	(619) 401-5500 FAX: (619) 401-5454	Michelle Raby	Phuong Quach, Psy.D, LMFT 619-584-3028 Phuong.Quach@sdcounty.ca.gov
		Tues-Thurs	1:00 PM - 4:00 PM				
		Mon-Thurs	9:00 AM - Noon 1:00 PM - 3:30 PM				
		Fri	9:00 AM - Noon 1:00 PM - 2:30 PM				
South	CRF/Maria Sardiñas BPSR Center	Tues & Thurs	9:00 AM - 3:00 PM	1465 30th Street Suite K San Diego, CA 92154	(619) 428-1000 FAX: (619) 428-1091	Paul Van Portfliet	Cara Evans Murray, MFT 619-563-2796 Cara.EvansMurray@sdcounty.ca.gov
	CRF/South Bay Guidance BPSR Center	Mon, Wed, & Fri	9:00 AM - 1:00 PM	1196 3rd Avenue Chula Vista, CA 91911	(619) 427-4661 FAX: (619) 426-7849	Mary Wheeler	

Adult/Older Adult Mental Health Outpatient Clinics

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The programs serve Medi-Cal beneficiaries and uninsured adults, age 18 and over. Insured persons are referred to their own providers.

**This schedule, arranged by Region, provides the Clinic's addresses, contact phone numbers, and urgent walk-in days/hours.
Whenever possible, please call in advance to arrange an appointment.**

REGION	CLINIC	DAY(S) AVAILABLE FOR WALK-IN	TIME(S) AVAILABLE FOR WALK-IN	ADDRESS	PHONE / FAX NUMBER	PROGRAM MANAGER	COUNTY BHS PROGRAM COORDINATOR
North Coastal	MHS, Inc. BPSR – Vista	Mon - Fri	8:30 AM - 4:00 PM	550 W. Vista Way Suite 407 Vista, CA 92083	(760) 758-1092 FAX: (760) 758-8481	Kathy Robbins	Liane Sullivan 619-584-5021 Liane.Sullivan@sdcounty.ca.gov
	MHS, Inc. North Coastal Mental Health Clinic	Mon-Fri	9:00 AM - 4:00 PM	1701 Mission Ave. Suite 210 Oceanside, CA 92058	(760) 712-3535 FAX: (760) 439-6901	Myesha Barton	
	Exodus Recovery, Inc. North County Walk-In Assessment Center	Mon - Fri	9:00 AM - 4:30 PM	524 W. Vista Way Vista, CA 92083	(760) 758-1150 FAX: (760) 758-1808	Angela Romero	
North Inland	MHS, Inc. Kinesis North WRC	Mon - Fri	8:30 AM - 4:00 PM	474 W. Vermont Avenue Suite 101 Escondido, CA 92025	(760) 480-2255 ext. 105 FAX: (760) 741-6645	Edward Quintana	Maria Morgan, MFT (619) 584-5028 Maria.Morgan@sdcounty.ca.gov
	MHS, Inc. North Inland Mental Health Clinic	Mon - Fri	8:30 AM - 4:00 PM	125 W. Mission Avenue Suite 103 Escondido, CA 92025	(760) 747-3424 FAX: (760) 747-3435	Sarah Breeding / Christina Glassco	
	Exodus Recovery, Inc. North County Walk-In Assess. Center	Mon - Fri	8:00 AM - 4:00 PM	1520 S. Escondido Blvd. Escondido, CA 92025	(760) 871-2020	Autumn Johnson	Liane Sullivan 619-584-5021 Liane.Sullivan@sdcounty.ca.gov