# A DISJOINTED SYSTEM:
# County of Santa Clara Mental Health Supports for Justice-Involved Clients

2023-24 Santa Clara County
Civil Grand Jury

*June 12, 2024*

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## CONFLICTS

Members of the Civil Grand Jury are conflicted from a Civil Grand Jury investigation if, as a result of prior or current employment or associations, investment in public or private enterprise, financial interest, bias, or personal relationship, they are subject to recusal from participating in a matter before the Civil Grand Jury. One juror recused themself from this matter.

# GLOSSARY AND ABBREVIATIONS

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| **5150 Hold** | Section 5150 of the California Welfare and Institutions Code, or the Lanterman–Petris–Short (LPS) Act, allows an adult to be involuntarily detained for a 72-hour psychiatric hospitalization if, as a result of a mental health disorder, they are evaluated to be a danger to others or to themself, or to be gravely disabled (defined by statute as being unable to provide for their personal needs for food, clothing, or shelter). |
| **Aftercare** | Services aimed at reintegrating clients into the community and reducing recidivism, which include mental health treatment, case management services, medication support services, and crisis intervention. |
| **Arraignment** | The first criminal court appearance before a judicial officer where individuals are informed of their rights. |
| **Behavioral Health** | The prevention, diagnosis, and treatment of mental health and substance use disorders, life stressors and crises, and stress-related physical symptoms. |
| **Behavioral Health Services Department (BHSD)** | A County of Santa Clara department that offers a wide range of mental health and substance use treatment services. |
| **California Advancing and Innovating Medi-Cal (CalAIM)** | A five-year initiative implemented in January 2022 by the California Department of Health Care Services to improve the quality of life and health outcomes for Medi-Cal beneficiaries. |
| **Client Status Report (CSR)** | A document provided by the client's treatment facility that reports on compliance with the care plan. |
| **Collaborative Court** | Programs within the California state court system that combine judicial supervision with rehabilitation services that are rigorously monitored and focused on recovery to reduce recidivism and improve offender outcomes. |

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| **Community-Based Organization (CBO)** | A nonprofit, local organization that provides services in the community. Public entities frequently contract with CBOs to fill in gaps of care or provide for unique needs. |
| **Consent Decree** | A legally binding agreement among parties to a dispute that a court supervises and enforces—for example, to compel a jail system to reform. |
| **Continuum of Care** | A concept involving an integrated system of care that guides and tracks patients over time through a comprehensive array of health services including community services, custody, or hospitals, and spanning all levels of intensity of care. |
| **Crisis Intervention** | A response to a mental health crisis by phone or in the community meant to enhance interaction between individuals experiencing mental illness, law enforcement and mental health agencies. |
| **Custody Health Services** | A County of Santa Clara department that provides health services, including behavioral health supports, in County-maintained detention facilities. |
| **Decompensate** | To lose the ability to maintain normal or appropriate psychological defenses, sometimes resulting in depression, anxiety, or delusions. |
| **Diversion Programs** | Programs that allow defendants with behavioral health disorders to reduce or avoid custody time by receiving mental health treatment. |
| **Emergency Psychiatric Services (EPS)** | A 24-hour psychiatric emergency room operated by the County of Santa Clara. |
| **Forensic, Diversion, and Reintegration (FDR)** | A division of BHSD designed to address the behavioral health needs of individuals with mental health, substance use disorders, or both who are involved in the criminal justice system. |

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| **Jail Assessment Coordination (JAC) List** | Identifies individuals assigned by Behavioral Health Treatment Court for mental health and substance use treatment services. |
| **The Lanterman-Petris-Short (LPS) Act** | The Lanterman-Petris-Short Act (California Welfare and Institutions Code section 5000, et seq.) was enacted in 1967 to end the indefinite and involuntary commitment of people with mental health disorders. |
| **Lived Experience** | Knowledge, insight, and expertise due to a first-hand understanding of the challenges people face while navigating behavioral health disorders or the justice system. |
| **Medicaid** | Federal insurance program that provides free or low-cost health coverage to some low-income people. |
| **Medi-Cal** | The Federal Medicaid program in California. |
| **Mobile Crisis Response Team (MCRT)** | A team that provides 24/7 crisis intervention services for people in the County of Santa Clara who are experiencing a behavioral health crisis. |
| **Pre-Arraignment Representation and Review (PARR)** | A program operated by the County of Santa Clara Public Defender's Office where the public defender meets with clients before court arraignment. |
| **Psychotropic Drugs** | Medication used to treat mental health disorders. |
| **Recidivism** | A person's relapse into criminal behavior, often after the person receives sanctions or undergoes intervention for a previous crime. |

## SUMMARY

County of Santa Clara (County) leaders have expressed a commitment to the goal of keeping people with serious behavioral health disorders out of County jails. The 2023-24 Santa Clara County Civil Grand Jury (Civil Grand Jury) investigated County systems and programs designed to accomplish this goal and found some areas that merit commendation and others that need improvement. The County has many innovative programs in the areas of crisis intervention and diversion, as well as a variety of supports for those who have recently been incarcerated and are returning to the community. There are many highly dedicated, qualified, and knowledgeable County employees who are committed to doing their part to support this population through County programs.

However, the County could improve in several areas. First and foremost, many of the departments and programs are siloed and could be more effective if there were more systematic coordination among them. The lack of coordination leads to many low-level offenders with behavioral health disorders serving longer time in the Main Jail or Elmwood (County Jails) where their illnesses often worsen. Another consequence is that too many people from this population fall between the cracks in their transition between custody and the community. Too often, there is not a consistent connection between an individual at risk and the supports they receive throughout the process. Too much of the responsibility for initiating and keeping up with care is left to the client. The unfortunate result is that many people become stuck in a revolving door of arrest for a low-level offense, time in County detention facilities, and release into the community, followed by re-offending and repeating the cycle. These issues are exacerbated by the lack of availability of County-operated treatment beds, staffing shortages, and the housing crisis.

# BACKGROUND

## A Historical Shift in the Treatment of Individuals with Behavioral Health Disorders in California

During the 1960s, the United States began moving towards a policy of ending the indefinite involuntary institutionalization of people with mental illness and promoting a shift towards community-based healthcare and individual rights. However, much of the funding for community-based programs did not materialize (Yohanna, 2013). The State of California was no exception to this trend.

California's goals to care for those with behavioral health disorders, while simultaneously protecting the rights of those individuals, can be summarized with some of the major legislation that has been passed, including:

- Lanterman-Petris-Short (LPS) Act (1967): The act fundamentally changed the mental health care system in California by emphasizing community-based care and sought to "end the inappropriate, indefinite, and involuntary commitment of persons with mental health disorders…" (Welf. & Inst. Code § 5001(a).) It also established a right to prompt psychiatric care and treatment.
- Lanterman Developmental Disabilities Services Act (1977): This legislation expanded services for individuals with developmental disabilities, focusing on community-based care and support services.
- Proposition 63: Mental Health Services Act (MHSA) (2004 and amended in 2020): MHSA imposed a 1% tax on personal incomes over $1 million to fund mental health services in California. It prioritized prevention, early intervention, and innovative treatments, empowering local communities to develop programs tailored to their needs. In the March 2024 primary election, California voters approved Proposition 1, a two-part initiative that amended the MHSA to rename it the Behavioral Health Services Act (BHSA), expand it to encompass treatment for substance use disorders, and modify allocation of treatment resources (with the bulk of the funding still going to counties). Proposition 1 also authorized a general obligation bond of more than $6 billion to fund behavioral health treatment and residential facilities in California.
- AB 1421: Assisted Outpatient Treatment Demonstration Project Act, known as Laura's Law (2002): Named after Laura Wilcox, who was tragically killed by an individual with untreated mental illness who had refused psychiatric care, the law allows for court-ordered, involuntary outpatient treatment for individuals with severe mental illness who meet specific criteria. It aims to provide intensive community-based treatment to prevent crises and promote stability. The law allowed counties to establish "Assisted Outpatient

Treatment" (AOT) programs to create an additional way to engage people who are resisting mental health treatment.

- SB 855: Mental Health Parity (2020): The law strengthened mental health parity laws in California, requiring health insurance plans to cover mental health and substance use disorder services on par with medical and surgical services.
- SB 43: Expanding Conservatorship Law (2023): The law expanded the state's conservatorship laws. The law updates the definition for conservatorship eligibility to include those who are unable to provide for their personal safety or necessary medical care due to severe substance use disorder or mental illness.
- SB 1338: Community Assistance, Recovery and Empowerment Act (CARE) (2022): The law provides for behavioral health services to individuals with severe schizophrenic and psychotic disorders in California with the goal of preventing more restrictive conservatorships or incarceration.

Legislation has evolved to reflect changing understandings of mental health and the needs of diverse communities, with a growing emphasis on community-based care, early intervention, and holistic approaches to treatment (County of Santa Clara, Behavioral Health Services, n.d.).

## Increase of People with Behavioral Health Disorders in Jails

According to the Prison Policy Initiative, 43% of people in state prisons throughout the country have been diagnosed with a mental disorder, a rate that is far higher than the estimated 22.8% of U.S. adults who experienced mental illness in the general population in 2021 (National Alliance on Mental Illness, 2023). Further, it is estimated that 15-25% of people who are incarcerated in California correctional facilities have a serious mental illness causing correctional facilities to become our nation's de facto locked mental health treatment facilities (Franco, 2020).

Jails, which were originally intended as facilities used for temporary and short-term confinement, were designed to serve essential functions within the criminal justice system. These include detention, punishment, public safety, correction, and rehabilitation. They were never envisioned to treat mental illness or substance use disorders. Furthermore, studies show that simply being in custody exacerbates the symptoms of mental illness (Quandt and Jones, 2021).

Additionally, people who are incarcerated and have a behavioral health disorder face a heightened risk of suicide and may also be more vulnerable to victimization within the jail and prison systems. They also receive sentences that are 12% longer than individuals without a mental health diagnosis who are convicted of the same crimes (Franco, 2020). Conclusive causes for this are unclear.

The average cost of incarcerating one person in California is currently $132,860 per year (Hwang and Duara, 2024). The cost is even higher for people with mental illness, including extra medical

and psychiatric care as well as psychiatric medications (Franco, 2020). Studies show that community treatment programs often cost significantly less than incarceration and have a much higher rate of success in reducing recidivism (Vanable, 2021).

## County Correctional Facilities

County jail facilities consist of the County Main Jail Complex (Main Jail) and Elmwood Correctional Complex (Elmwood) (together, the County Jails). The Main Jail is located at 150 West Hedding Street in downtown San José. Its annual budget is approximately $37 million. Each year it "receives and books about 65,000 persons" (County of Santa Clara, Office of the Sheriff: Main Jail Complex, n.d.). It is designed to house up to 919 males requiring a higher level of security. Any person incarcerated in the County jail system with an acute psychiatric illness is housed on the eighth floor of the Main Jail.

Elmwood Correctional Complex in Milpitas is designed to house 2,600 medium and minimum-security males, as well as 500 females of all security levels separately from the men's facility (County of Santa Clara, Office of the Sheriff: Custody, n.d.).

### Consent Decrees

In 2019, the County agreed to enter into two federal consent decrees that mandate the improvement of conditions in the County Jails in order to resolve class-action litigation (County of Santa Clara, Jail Reforms: Consent Decree Status, n.d.). The two lawsuits *Chavez v. County of Santa Clara, et. al* (U.S. District Court, Northern District of California, Case No. 15-CV-05277-NJV) and *Cole v. County of Santa Clara, et. al.* (U.S. District Court, Northern District of California, Case No. 16-CV-06594-LHK) were the basis for these 2019 consent decrees.

The consent decrees detailed the areas requiring improvements in the County jails (Figure 1). The federal courts approved remedial plans to address these problems, as well as a system to monitor and report on progress (County of Santa Clara, Jail Reforms: Consent Decree Status, n.d.). This monitoring will continue until a federal court declares compliance.

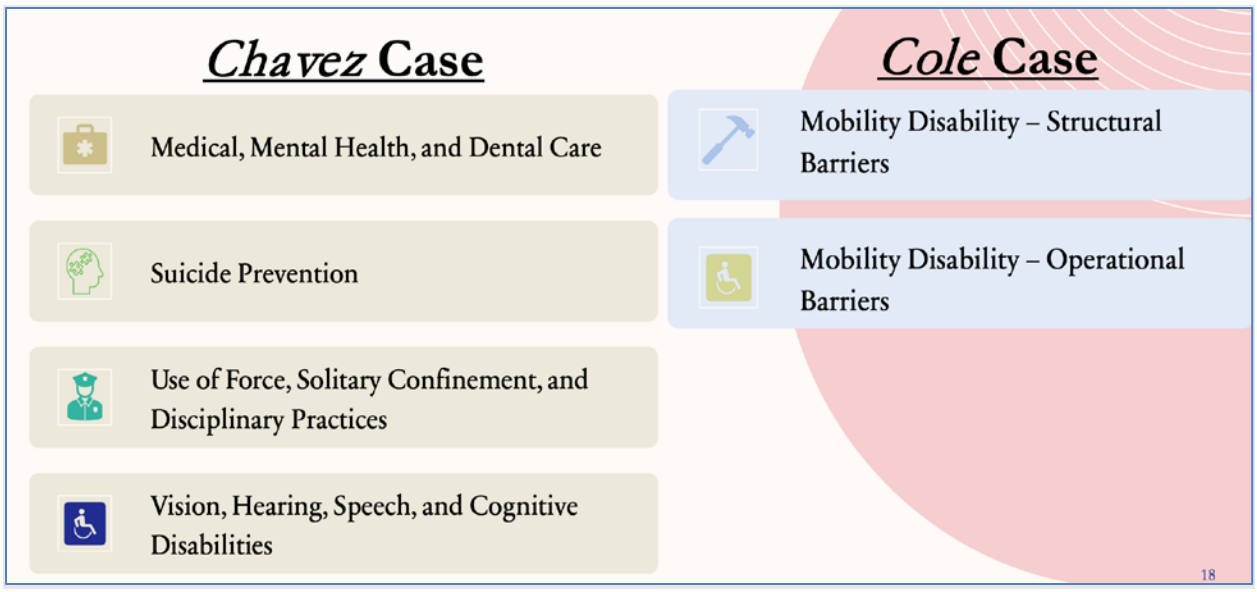



**Figure 1: Topics covered in the 2019 Consent Decrees (County of Santa Clara, 2022)**

## Funding of Behavioral Health Services

The County of Santa Clara, like other counties in California, funds behavioral health services through a combination of three main funding sources—federal, state, and local—with the federal and state sources making up the bulk of the funding. Due to MHSA, counties are the primary providers of local mental health and substance use disorder programs.

The primary federal funding source is Medicaid, which is implemented as the California Medical Assistance Program, or Medi-Cal. This provides reimbursement for eligible mental health and substance use treatment services for eligible residents. In January 2022, California launched California Advancing and Innovating Medi-Cal (CalAIM), a multiyear plan to transform California's Medi-Cal program, integrating more seamlessly with other social services. This coordinated care approach considers both mental and physical facets of a person's health providing a continuum of care.

The state funding source as authorized by MHSA provides significant funding for behavioral health programs to all counties in California. To access these state funds, the County's Behavioral Health and Services Division (BHSD) must prepare and submit a three-year program and expenditure plan followed by annual plan updates. The funding components of these plans fall into multiple areas which include Community Services and Supports (CSS), Prevention and Early Intervention (PEI), Innovations (INN), Workforce Education and Training (WET), and Capital Facilities and Technological Needs (CFTN). Each county will develop a plan based upon local needs with the allocated percentage of the overall funding for each component being uniquely

tailored to meet the needs of its residents (County of Santa Clara, Behavioral Health Services Department: MHSA Plans and Reports, n.d., 2024).

Local funding sources may include, but are not limited to, allocations from the County's general fund, local tax measures and propositions, private or public grants, and private/public donations from foundations supporting specific behavioral health programs or initiatives.

By using funding from multiple sources and engaging in partnerships with various stakeholders, the County strives to ensure robust high-quality behavioral health services for all its residents.

## Mental Health Treatment Infrastructure

Psychiatric treatment beds are essential infrastructure in the care of people with behavioral health disorders. These beds are found in various types of facilities ranging from locked acute inpatient units to community care unlocked beds (Figure 2). The most acute beds often include an LPS involuntary admission with 24/7 care of physicians, nursing staff, and other therapists monitoring patients closely for any behavior of self-harm or thoughts about harming others. Typically, patients only stay long enough for their condition to be stabilized (days to weeks) before being transferred to a less restrictive environment (McBain, Cantor, Eberhart, Huilgol, and Estrada-Darley, 2022).

Sub-acute beds are a step down from acute care. They are typically in an unlocked, voluntary setting where people are not monitored as intensively and can include more treatment modalities. A stay in these less acute beds can be longer (weeks to months).

The least restrictive beds are community beds, or residential placements, that provide voluntary care for lower acuity patients, and are often longer-term (months or years).

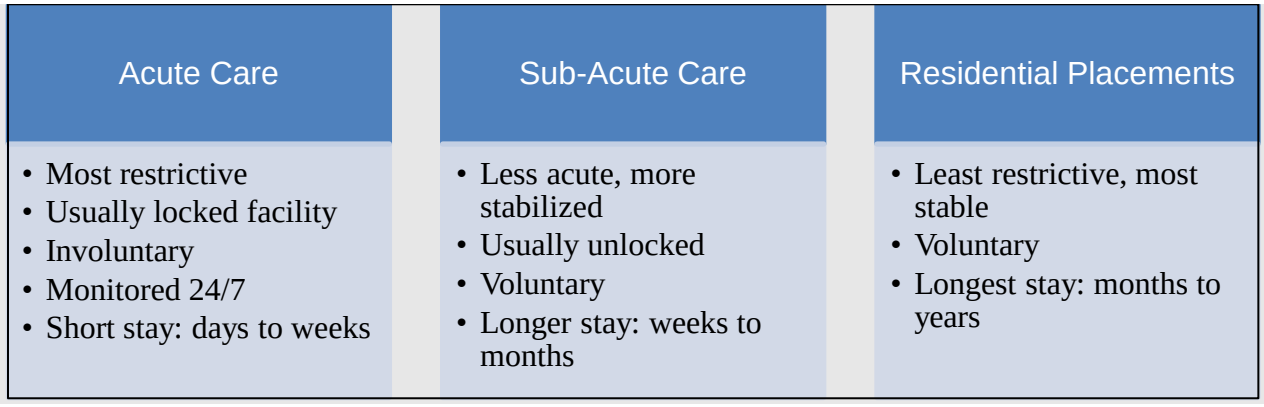



**Figure 2: Types of Mental Health Treatment Facilities**

## County Programs for People with Behavioral Health Disorders

The County has responded to the ongoing behavioral health crisis by creating several types of programs with the primary goals of either preventing incarceration or diverting people as quickly as possible out of County Jails and into the community when appropriate (Figure 3).

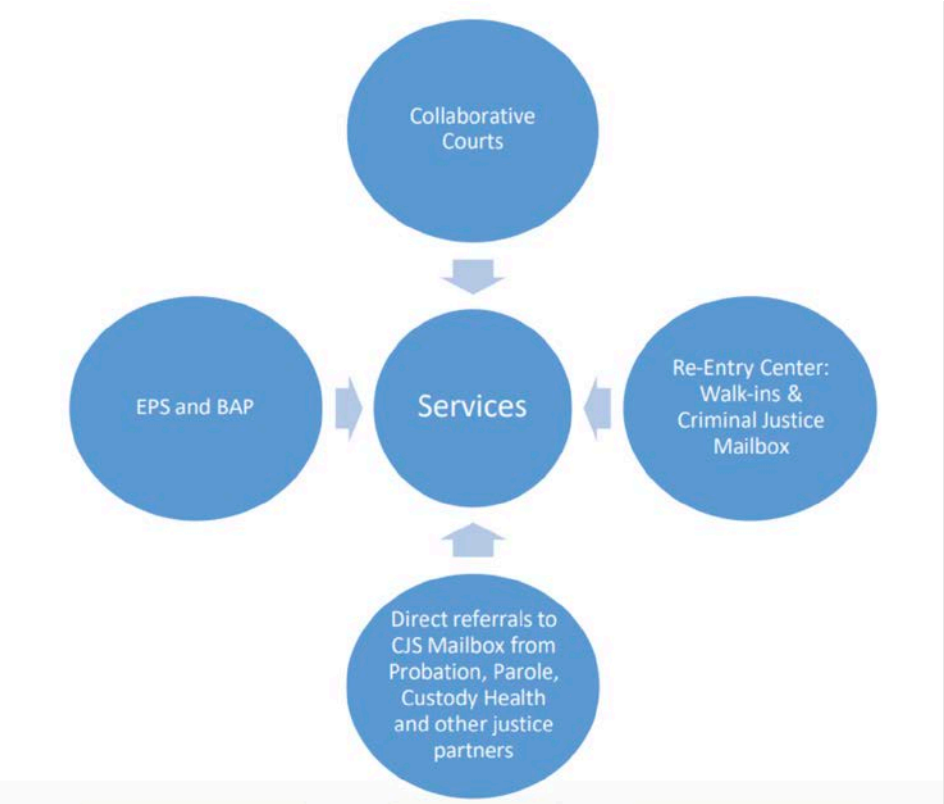



**Figure 3: How Justice-Involved Clients Access Services (see Appendix 1)**

### Crisis Intervention and Support

BHSD has initiated programs for crisis intervention and support for people in the community with behavioral health disorders. One of the primary goals of many of these programs is to reduce unnecessary incarcerations whenever possible. Examples of these programs are:

- County Mobile Response Teams: Community programs that provide effective and compassionate crisis intervention to those who exhibit mental health symptoms and may be at risk for self-harm or harm to others. Four teams serve adults, including In-Home Outreach Team (IHOT), Trusted Response Urgent Support Team (TRUST), Mobile Crisis Response Team (MCRT), and Psychiatric Emergency Response Team (PERT) (County of Santa Clara, Behavioral Health Services: Community Mobile Response Teams, n.d.).
- 988 phone number: A new lifeline, similar to 911, that is staffed 24/7, designed to deliver callers who are experiencing a crisis to the National Suicide Prevention & Mental Health

Crisis Lifeline and provide compassionate support to those having a mental health or substance use crisis.

- Mission Street Recovery Station (MSRS): A voluntary program that provides immediate alcohol sobering services to people referred by local agencies including law enforcement, emergency rooms, and Emergency Medical Services.
- Emergency Psychiatric Services (EPS): A 24-hour locked psychiatric emergency room that provides emergency psychiatric care to residents of the County.
- Behavioral Health Urgent Care (BHUC): A walk-in clinic for County residents experiencing a behavioral health crisis.

**Criminal Justice Jail Diversion Programs for Adults**

Criminal justice diversion programs redirect people who may have committed low-level offenses from County Jails into alternative settings or programs. Some of these programs specifically target people with behavioral health disorders. These programs can help people avoid incarceration and criminal records (County of Santa Clara, Criminal Justice Reforms: County Diversion Programs, n.d.). Some examples of these programs are:

- Custody Alternative and Mental Health Unit (CAMP): Created by the County Office of the District Attorney, the unit focuses on exploring alternatives to incarceration for many non-serious/non-violent offenses as well as criminal defendants with mental illness or substance use disorders. Alternatives include sentence recalls for people who are incarcerated and who demonstrate readiness for early release, post-sentencing supervision hearings, and diversion for lower-level crimes and drug possession. This program was recently created and was not included as part of the Civil Grand Jury investigation.
- Pre-Arraignment Representation and Review (PARR): Launched by the County Public Defender's Office in 2019, this program provides early engagement and legal representation to low-level offenders, who may or may not have a behavioral health issue, prior to their criminal arraignment, with the purpose (among others) of reducing the time spent in jail prior to trial.
- Collaborative Court: An alternative to the traditional criminal justice system that combines judicial supervision with rehabilitation services, these programs are collectively known as collaborative justice courts or problem-solving courts. They aim to address the underlying issues that cause people to become involved with the justice system, and provide access to services such as counseling, treatment, housing, vocational skills, education, assistance in accessing government benefits, and linkage to other support services. County Collaborative Courts that offer alternatives to incarceration for adults with serious behavioral health disorders including but not limited to: Drug Treatment Court (DTC), Mental Health Treatment Court (MHTC), Mental Health Diversion, and Incompetent to Stand Trial Court.
- Forensic, Diversion, and Reintegration Division (FDR): Diverts people with mental illness, substance use disorders, or co-occurring disorders from incarceration into treatment and

supports their reintegration into the community to allow them to live meaningful lives (see Appendix 1).

**Post-Justice Supports: Aftercare**

Aftercare programs provide behavioral health services to criminal justice-involved individuals with behavioral health disorders. Individuals served are nearing graduation from a diversion program or have recently left the criminal justice system. Services are aimed at reintegrating clients into the community and reducing recidivism. The vast majority of these programs are not run by the County itself, and instead are contracted out by the County to third parties known as Community-Based Organizations (CBOs) or are provided in partnership with other governmental agencies.

Many aftercare programs that support justice-involved people with behavioral health disorders are part of the FDR programs that serve clients seen in a Collaborative Court. Figure 4 details the continuum of care offered by FDR in the context of the entire BHSD, with those specialized services highlighted.

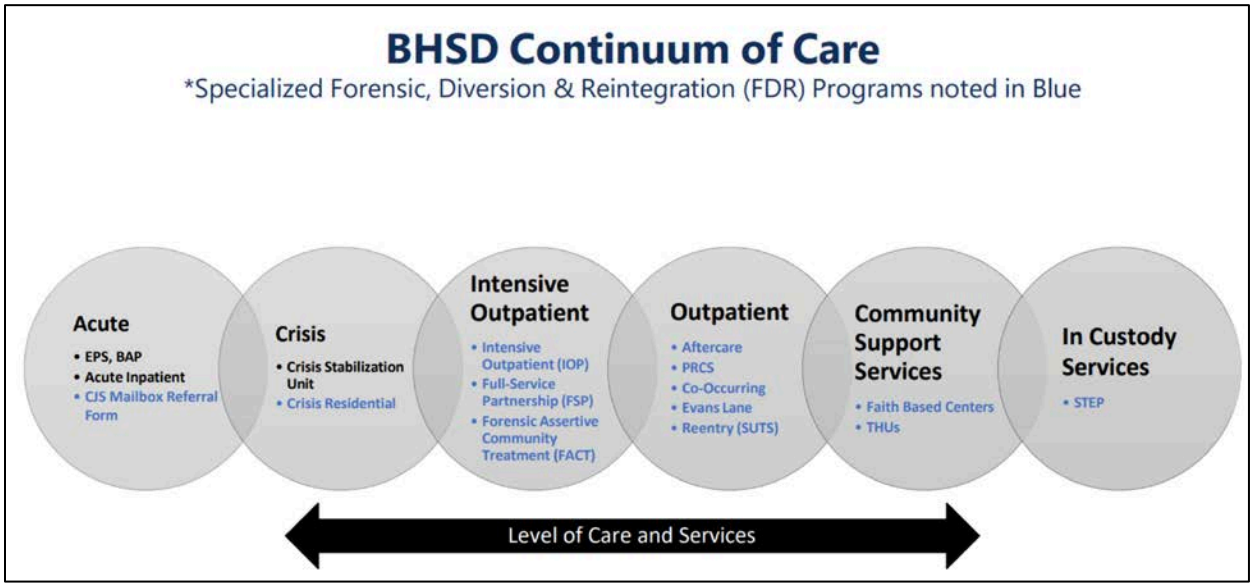



**Figure 4: BHSD Continuum of Care (see Appendix 1)**

**Office of Diversion and Reentry Services/Reentry Resource Center**

In response to the passage of AB 109 the "Public Safety Realignment Act", the County Board of Supervisors (BOS) directed a team to develop and implement a reentry plan for the County. The County's Reentry Resource Center, run by the Office of Diversion and Reentry Services, is the result of this initiative, providing many services to all people recently released from jail. It has two locations: one across the street from the Main Jail in San José, and one in Gilroy. A shuttle is

available to transport newly released people from the Elmwood Complex to the San José Reentry Resource Center during certain hours. Clients can be referred by many different groups including parole agents, probation officers, attorneys, and the Superior Court of California, County of Santa Clara (Court). During the first six months of 2023, the San José Reentry Resource Center had an average of 1,074 unique visitors per month, while the South County Reentry Resource Center had an average of 38 unique visitors per month (County of Santa Clara, Diversion and Reentry Services, 2023).

The Reentry Resource Center has a wide variety of resources available to clients who have been in and out of the justice system, including but not limited to:

- Healthcare services, including mental healthcare or substance use supports.
- Housing support from the Office of Supportive Housing.
- Public benefits, including social services, food stamps, employment services, etc.
- Education services for clients seeking a high school diploma or high school equivalency certificate.

## METHODOLOGY

The Civil Grand Jury interviewed more than 50 people who either work for the County or are justice partners in a position to support justice-involved people with behavioral health disorders in various capacities, including elected and unelected leaders; and criminal justice, healthcare, and support services leaders and staff.

Members of the Civil Grand Jury toured both County Jails, observed Collaborative Court calendars, and toured the Reentry Resource Center. In addition, the Civil Grand Jury reviewed thousands of pages of reports, documents, County BOS presentations, and presentations of other programs.

# INVESTIGATION

The County BOS has consistently expressed the goal to keep people with behavioral health disorders who commit low-level offenses due to their illness out of custody whenever possible. The BOS has publicly stated that "mentally ill people need to be connected with services as quickly as possible to prevent them from being incarcerated in the first place" (Wolfe, 2021). To that end, the BOS developed the ATI Workplan which established three workgroups to identify opportunities to "safely divert people from incarceration and/or reduce the need for incarceration in the first place" in the following areas: Intervention at the Start, Criminal-Legal Process, and Re-entry (County of Santa Clara, Criminal Justice Reforms: Alternatives to Incarceration (ATI) Workgroup, 2023). The ATI Workgroup Recommendations Implementation Plan was presented to the BOS on October 3, 2023.

The Civil Grand Jury investigated the services and supports within the County designed to further the BOS's goal. This included community services, behavioral health services in-custody, diversion, and aftercare.

## Behavioral Health Treatment in County Jails

As part of its investigation, the Civil Grand Jury worked to understand the process and complexity of treating incarcerated people with special needs due to behavioral health disorders.

County Jails house approximately 3,000 people at any given time, and "as of April 2022, 1,148 (44%)" of those individuals "had a serious mental illness" (see Appendix 1). When a person is booked into the Main Jail facility after arrest, they receive a mental health screening by a Custody Health nurse at booking, which includes questions about mental health, suicidality, and psychosis. The results determine whether the person is flagged for a further, more detailed behavioral health assessment by a Custody Health clinician, which should occur within four hours of booking, per the consent decrees. Alternatively, when the person is initially brought into jail, the arresting officer can flag a specific form to note that the person has exhibited symptoms of a behavioral health disorder before or during arrest and needs a behavioral health assessment at booking.

People who are booked into the Main Jail and assessed as having acute mental illness can either be sent to the EPS, which is located within the Santa Clara Valley Medical Center (VMC) campus, or housed in the acute psychiatric unit, which is on the eighth floor of the Main Jail. The acute psychiatric unit of the Main Jail is staffed by Custody Health, including psychiatrists, nurses, and others, as well as deputies from the Office of the Sheriff. It is monitored 24/7, similar to an acute psychiatric hospital ward. The goal of this acute unit is to stabilize the patients and then transfer them to less intensive care in a step-down unit on the same floor.

**Delays in Assessment and Treatment**

Incarcerated people who have previously been on psychotropic medications, as corroborated by their medical chart, a prescription, or a doctor, ideally receive their medications within 72 hours of being booked into the Main Jail. Two factors that can lead to delays in meeting this goal are the following: First, if Custody Health does not have a client's specific medication available, they must obtain it from an outside pharmacy. Second, if the medication is deemed to be at risk for abuse, an alternative must be determined and obtained.

Custody Health reported that this 72-hour timeframe is regularly adhered to, barring some of the circumstances mentioned above; however, the Civil Grand Jury learned that, in fact, many people wait much longer to obtain their medications. This is particularly a problem in cases where people are not exhibiting acute symptoms of their illness at the time of arrest or booking, do not self-report being on medication, or do not have records reflecting a prior or current prescription regimen.

People booked into the Main Jail for whom a screening does not show acute signs of mental illness, or where current prescriptions cannot be corroborated, sometimes wait weeks for a mental health assessment. Possible causes for this delay are a shortage of doctors and clinicians in Custody Health and constraints on jail facilities, where few private interview rooms are available. Another factor is the ongoing shortage of County staff in County Jails, resulting in fewer available deputies to escort people to appointments. Currently, each deputy is mandated to work two overtime shifts every pay period to help alleviate the shortage.

Another cause of delays in getting a behavioral health assessment for people incarcerated in County Jails is that appointments for a mental health assessment or a medication evaluation with a psychiatrist are sometimes canceled due to a conflicting date where the individual is required to appear in court, causing an additional two-to-three-week delay in receiving this critical medical care. It is not clear why conflicting appointments occur since Custody Health has access to the court calendar. However, this cancelation of appointments has led to seemingly preventable delays in care.

A final and all too common reason some people who are incarcerated with behavioral health disorders do not receive care is they refuse it. This occurs because, unless a person has been declared a danger to themselves or others, opting not to consent to treatment is their legal right.

The unfortunate result of delays in behavioral health assessment and care is people languishing in custody, while untreated, for an extended time. The stress of more time in custody can lead to decompensation, or the deterioration or worsening of a person's mental health condition.

**Increased Risk of More Jail Time**

Because eligibility for County programs—which offer the option of diversion to behavioral health services for low-level offenders in lieu of time in custody—relies on a behavioral health disorder diagnosis and a patient's illness to be stabilized, delays in behavioral health and medication assessments by Custody Health may lead to unnecessary time spent in jail. This is a significant barrier to progress on the BOS's expressed goal of keeping low-level offenders with behavioral health disorders out of County Jails.

**Outdated and Dilapidated County Jail Facilities**

Leaders in the County are well aware that County Jail facilities are inadequate for all incarcerated people, especially those with a behavioral health disorder. At the January 25, 2022, meeting of the Board of Supervisors, Supervisor Otto Lee stated that the County does "*not* have a humane carceral facility to house those in our county right now" (Bandlamudi, 2022). As part of this investigation, members of the Civil Grand Jury toured County Jail facilities and concurred with this assessment.

Furthermore, the jail consent decrees have detailed that County Jails have only been partially compliant in providing mental health treatment and programming space. A significant barrier to achieving compliance is the jail facilities themselves. County Jails are old buildings with few places to offer confidential care such as individual therapy, and few cells are equipped to handle incarcerated people who are suicidal. As of April 1, 2024, the County acknowledged 93 recommendations highlighted by the consent decrees for needed improvements in jail facilities, 55 of which related to suicide prevention (County of Santa Clara, Jail Reforms: Consent Decree Status, 2024).

The BOS has had a lengthy ongoing debate for nearly a decade about whether to build new jail facilities or put the money into building a mental health facility (Wolfe, 2021; Bandlamudi, 2022). In August 2022, the BOS voted to stop the plan to build a new facility because the 2016 design had become outdated. Currently, County Administration leadership is working on a jail facility needs assessment and community engagement efforts at the BOS's direction. Therefore, as of the writing of this report, a decision on whether the County will build a new jail, renovate the current facility, or build a mental health facility still has not been made, leaving the County without a clear direction on this critical issue going forward.

## County Diversion Programs

The County has a variety of programs for justice-involved clients who may have committed low-level offenses, which are meant to divert them from incarceration. For the purposes of this investigation, the Civil Grand Jury focused on some of the principal programs that are available to clients with behavioral health disorders.

**Pre-Arraignment Representation and Review**

The PARR program provides legal representation to clients accused of low-level offenses earlier in the process than what is typically provided, which can help reduce time spent in jail. Traditionally, most people booked into jails do not connect with their Public Defender until arraignment, which can occur several days after booking. The PARR program allows this connection to take place much sooner. An earlier connection means that the defense attorney can have more time to learn the unique circumstances of the client and be better prepared to present a compelling case to the court for why they should be released earlier or enter a diversion program. Evidence has shown that this program has had real success in reducing jail time for its clients (Fischer, Lacoe, and Raphael, 2023).

Currently there are seven attorneys who work in the PARR program. The Civil Grand Jury observed that they are overwhelmed with eligible clients, and are therefore not able to serve everyone due to insufficient resources. Furthermore, although the current PARR program ends up serving some clients with behavioral health disorders, that is not the program's focus. The Public Defender's Office is poised to begin a PARR pilot program specifically for clients with behavioral health needs. A PARR program with a behavioral health focus could be a tremendous asset in the bid to reduce jail time for people with behavioral health disorders.

**Forensic, Diversion, and Reintegration Division and Collaborative Court**

FDR "is designed to address the behavioral health needs of individuals with mental health, substance use disorders, or both who are involved in the criminal justice system" (County of Santa Clara, Behavioral Health Services: Forensic Diversion and Reintegration, 2024). In Fiscal Year 2022, the FDR Division served 2,088 unduplicated clients. The BHSD was unable to provide statistics on long-term success rates of preventing recidivism by individuals served by FDR.

Collaborative Court is one of the principal ways that justice-involved people accused of low-level offenses with serious behavioral health disorders can access the FDR programs discussed above as an alternative to incarceration in the County.

The Court was among the first courts in the nation in the early 1990s to establish specialized courts and calendars that use the principles of therapeutic and restorative justice to deal with the problems of certain target populations more effectively (Superior Court of California, County of Santa Clara, Collaborative Courts, n.d.). Today, the Court offers over a dozen collaborative court calendars. The Collaborative Courts that serve adults with serious behavioral health needs include Drug Treatment Court (DTC), Mental Health Treatment Court (MHTC), and Mental Health Diversion. Clients must also be residents of Santa Clara County and be either Medi-Cal beneficiaries or unsponsored.

People who are incarcerated can be referred to Collaborative Court at the first adjudication by a judicial officer, by Custody Health, or by a public defender. Although Collaborative Court programs allows people to get earlier treatment and earlier release from custody, it is a voluntary program that may involve a longer monitoring "sentence" than if the incarcerated person just serves out their time in custody. At any time, the individual may choose to return to custody to finish their sentence, or if the client does not meet the expectations given by the Court, the judge can choose to send them back to custody. If a client graduates from the program, they often can have their charges expunged or cleared from their record.

The program involves appearing in court before the judge with a court reporter and the public defender representing each client in their active legal case. Others involved in the care of the client sometimes join as well, including the district attorney representative, probation officer, a BHSD team member, or case manager. Clients and other members of this multi-disciplinary care team have the option to join remotely. This can be especially helpful for clients without means to conveniently travel to the courthouse.

Before clients appear in court, the care team, including the judge, meets to discuss the plan for each individual. During the court appearance, the judge either explains the prescribed plan to the individual (if it is their first visit) or reviews their progress in their treatment program. The judge does this using the following means:

- Reviewing the Client Status Report (CSR), a document provided by the client's treatment facility that reports on compliance with the care plan.
- Questioning the client, their attorney, or other members of the care team present, to determine if they are following the prescriptive plan or if they need more support to comply. Often the questions involve medication adherence, behavior in their treatment program, job status, or housing status. It can also include other avenues of need for clients, including bus tokens, taxi vouchers, or food cards.

The County's Collaborative Court system offers a variety of benefits to clients. Specifics include:

- Judges, public defenders, BHSD team members, and others who demonstrate a great deal of compassion combined with a firm expectation that clients are expected to meet their prescribed goals to stay out of custody.
- A committed willingness by the team supporting clients to creatively problem-solve with them by connecting them to resources both big (more appropriate housing) and small (socks or granola bars) to help them meet their goals.
- Clients who beam with pride at being recognized for meeting goals with courtroom applause.
- Utilization of a gentle "carrot and stick" approach that truly makes a difference in the lives of those who end up meeting their goals.

- A real opportunity for clients to receive treatment for their illnesses and return to the community as productive members often with their criminal record expunged or cleared, as opposed to languishing in jail or returning to the community without supports.

## Barriers to Improved Effectiveness of Forensic, Diversion, and Reintegration

FDR systems of care could be made more effective with improvements in the following areas:

- Availability of treatment beds.
- Client adherence to treatment.
- Judges receiving electronic CSRs before the court date.
- Multiple BHSD staff vacancies and low morale.

### Availability of Treatment Beds

One of the primary barriers to improved effectiveness in many locales throughout the nation, as well as the County, is that there are not enough treatment programs or available beds to meet demand (Levin, Gandhi, Hawkins, Matthews, Cantor, McBain, and Eberhart, 2023). This greatly impacts the ability of FDR to successfully do its job.

Generally, there are enough acute-care beds, but there are not nearly enough step-down beds for those who become less acute as treatment progresses. According to a 2023 RAND study covering the psychiatric and substance use disorder bed capacity and needs, the acute inpatient facilities in the County have a more than 90% occupancy rate, but if a lower level of care were available, they could transfer 40% of these patients to step-down beds (Levin et al., 2023). Subacute beds currently have a higher rate of occupancy and a longer waitlist; thus, patients are either kept in higher acuity beds or in County Jails serving out their sentences due to the shortage. This was corroborated by many sources as the primary bottleneck of treatment of individuals with behavioral health disorders (Levin et al., 2023).

The shortage is even more acute for treatment programs that specialize in the care of justice-involved clients. Recently, Momentum for Health, a CBO that provides a variety of such specialized care, was forced to close a number of its outpatient programs due to a budgetary shortfall exacerbated by CalAIM reforms (Hase, 2024). Some County leaders reported that they were working to make up the shortfall by having other CBOs take on more clients, but many of these programs lack the comprehensive treatment tailored to the specific needs of these clients. Such supports can include:

- Coordinating with Custody Health, which allows the treatment provider to be informed of the client's release time. This means the treatment provider can send a staff member to the County Jails to pick up the client and transport them to the treatment facility immediately upon release, increasing the likelihood that the client will engage in treatment.

- Engaging housing providers to ensure clients will have an appropriate supportive housing placement upon release.
- Accompanying the client to their court dates and completing CSRs to ensure the Collaborative Court judges have the data they need to hold clients accountable for progress during treatment.
- Increasing support in finding employment, accessing benefits, and helping clients with expenses while they are working towards financial independence.

Many CBO treatment programs that do not specialize in caring for justice-involved clients are eligible to accept them, but prefer not to, because of their often highly complex cases. Furthermore, the intensive services offered by the programs that specialize in their care are more likely to lead to better outcomes for clients.

Lastly, the County Jail and Collaborative Court have a Jail Assessment Coordination (JAC) list which contains the names of incarcerated people waiting for a treatment bed. The number of people on the list is constantly in flux but often adds up to more than 100 people. The JAC list is not automatically updated electronically and requires a member of the Collaborative Court's BHSD staff to update it. Because the staff has multiple duties, the list is sometimes updated only once or twice a week, so there is no daily accounting of available beds in each facility. Sometimes, if an individual's wait for a bed exceeds the length of their sentence, they may even get released from custody with no support in place, since it is illegal to hold a person in jail past the end of their sentence. This scenario creates a lost opportunity to connect a client to treatment because there is no longer an incentive to choose treatment as an alternative to incarceration.

**Client Adherence to Treatment**

A second barrier to the effectiveness of FDR is clients' refusal of treatment, which is their right unless they are legally deemed to be a danger to themselves or others. One example is medication adherence. Many CBOs require a client to be compliant with their medication recommendations to enter their program. People voluntarily refuse to take medications for a wide variety of reasons; however, in some instances, Custody Health does not ensure that people with behavioral health disorders in the jail are getting the medication needed for release into a program. For example, those who deliver medications in County Jail sometimes do not attempt to wake up a person who is sleeping to encourage them to take their medication. The reasons why this sometimes occurs are not completely clear, although the chronic understaffing at the County Jail facilities could be impacting Custody Health's ability to positively impact medication compliance.

A second example of lack of client adherence to treatment which occurs all too frequently is that, because treatment is entirely voluntary, many clients who are released to treatment simply leave their treatment facility, sometimes immediately after arrival. This often leads to the client re-offending and being re-arrested for another minor crime, followed by more time in custody where

they again wait to receive medication or treatment before release back into the community, and having the cycle repeat itself (Figure 5).

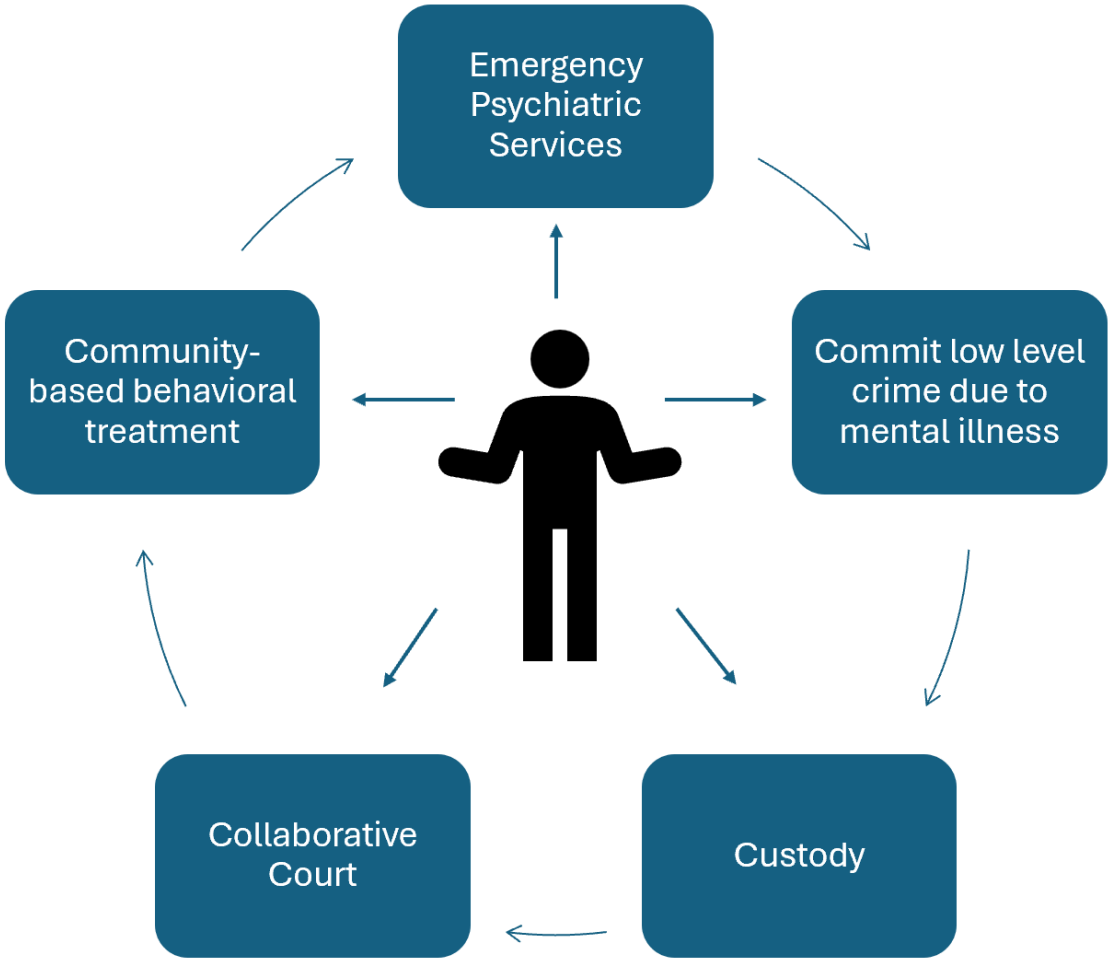



**Figure 5: The Revolving Door of Non-Compliant Clients**

**Judges Not Receiving CSRs Before Court Date**

A third barrier within the operation of the Collaborative Court is purely logistical. One of the most important components of the Collaborative Court process is a judge's ability to hold a client accountable for their adherence to the agreed-upon prescriptive plan. When a client enters an FDR plan and begins a treatment program, the judge must be able to ensure that they stick to it. One of the primary tools the judge uses to understand the details of a client's adherence is a CSR, which documents their progress or lack thereof. The CSR is completed by the CBO staff who treat the client and is ostensibly returned to the judge before the client's next appearance in court. It allows the judge to address the client in court fully informed about their treatment progress and the needs of this specific client and meaningfully engage with the client about its contents. If the CSR says the client is progressing, the judge rewards them with positive praise which in this population has

been shown to be a powerful incentive (All Rise, 2024). If it says they are not, the judge can impose consequences or question the client about reasons why.

The Civil Grand Jury learned that judges in Collaborative Court rarely receive the CSR electronically before the clients' court dates for two reasons. First, CBOs sometimes do not complete the CSR in time. The second reason is a complicated and convoluted communication system. The process by which a judge receives it is the following: The CBO must complete the form and then upload it to myAvatar, the electronic system used by BHSD. Next, a BHSD staff person at Collaborative Court must get it to the judge, which can happen by printing it out, emailing it, or putting it in an electronic mailbox that for many was not user-friendly. Judges are not able to access the myAvatar system directly. Although CBOs can upload CSRs to myAvatar, they cannot complete the forms directly in myAvatar because they all have their own independent electronic records system.

The disconnect in communications has been such a fundamental barrier that judges have begun asking clients to bring paper copies of their CSRs to court or self-report their progress if they did not obtain it, often a challenging task for people with serious behavioral health disorders. The Civil Grand Jury was stunned that in Silicon Valley in 2024, a system was relying so heavily on paper records to function.

**Staff Shortages and Low Morale**

BHSD staff members in Collaborative Court are passionate about their work and highly dedicated to their mission. However, during the last few months, there has been a high rate of staff turnover, and the County has yet to rehire for the many vacant positions. As of the writing of this report, the Collaborative Court team was short approximately six clinicians and six other staff people.

BHSD staff in the Collaborative Court have been leaving for a variety of reasons. First, the jobs are often very fast-paced and stressful. Staff are responsible for ever-increasing caseloads and long lists of clients coming through the Courts. Judges are understandably always wanting to serve more clients, and staff feel a great deal of pressure to do more. Further, Custody Health has been offering higher wages and other incentives, so some have left Collaborative Court and gone to work there.

Unfilled staff vacancies and insufficient resources in Collaborative Court and FDR, despite a growing list of clients, create the perception that BHSD leadership does not sufficiently prioritize services for justice-involved adults. This has led to low morale within the Collaborative Court team, which risks causing further staff departures.

Reduced staffing has also meant longer wait times for assessments since clients must receive an assessment from a BHSD clinician stationed at the Court before being put on the JAC list for

program placement. This means that more people who could be eligible for earlier release to a program must remain in custody for longer.

## Reentry Resource Center

Despite the robust services offered by the Reentry Resource Center, a very small percentage of people released from County Jails use their services. Those in charge have worked hard to fix this problem. Some of the strategies employed include providing a shuttle to transport newly released people from the Elmwood complex to the San José Reentry Resource Center across from the Main Jail and sending employees, including three case navigators, into the County Jails to distribute information on services and talk with incarcerated people about their resources. The Reentry Resource Center also hires a high number of staff with lived experience, including alumni from treatment court programs, which can help with making a stronger connection to clients.

### Barriers to Increased Client Use of Reentry Resource Center

There are multiple barriers to increased usage of the services that particularly affect those with behavioral health disorders.

One such barrier is the fact that clients are expected to both initiate their first visits to the Reentry Resource Center and initiate most of any follow-up visits or use of services to which they are connected. To understand why this barrier is so significant, one must consider the extraordinarily high level of need of this population. The majority are unhoused, experience the effects of trauma, have few sources of income, have substance use disorders, and have few people in their lives upon whom they can rely. Some may have no access to a car, or no ID or phone. When they walk out of County Jail, a visit to the Reentry Resource Center is often not their priority.

The Civil Grand Jury learned that perhaps if there were a person, such as a social worker or peer navigator, who had developed a rapport with the client and was available to physically escort them to the Reentry Resource Center, there might be a higher likelihood that a client would use their services. Although there are a few cases where clients are connected with a provider to support them post-release, most do not have this.

Additionally, if a client is referred to another service organization from the Reentry Resource Center, they are often expected to follow up on the contact by themselves. Nevertheless, these services are not universal, and navigating the web of services and referrals remains a high barrier for many clients. This follow-up might be more likely if it were a standard practice for a social worker or a peer navigator to escort the client to the facilities of the next provider. At a minimum, such a support person could follow up with a phone call to the client asking if they had reached out to the provider and, if they had not, offer encouragement and support to do so. This extra support happens on occasion, but it is not standard practice.

A second barrier to using services at the Reentry Resource Center is what some viewed to be cumbersome paperwork. A visit to the Reentry Resource Center frequently means filling out several forms to be eligible for certain services, often time asking very personal information; again, not an easy task for this population. Often, a client is unable to complete what is required in one visit and they are told to return the next day. When this occurs, the client frequently does not return.

A third barrier is that individuals in County Jails are sometimes released late at night, after the Reentry Resource Center is closed. All too often, they never return to access services.

## Systemwide Issues

There are a number of specific concerns that exist across the spectrum of countywide services for justice-involved people with behavioral health disorders. These are outlined below.

**Lack of Coordination Among County Service Providers**

Many County agencies and their partners servicing this population are siloed in their responsibilities, which leads to a lack of coordination among them. This impacts all areas, including community services, in-custody supports, diversion, and aftercare. There is no agency charged with the continuum of care for the client or that supports them in their journey among the different agencies or programs from the community, through custody, and back to the community. There is also no official system or procedure in place to attempt to overcome this barrier. Some collaboration on client care does occur due to the diligent work of individual employees or agencies, but it is ad-hoc and piecemeal. It occurs through email, word-of-mouth, and occasional meetings. This greatly impedes the County's ability to care for these individuals efficiently and effectively.

For example, if a client receives services from the MCRT and then follows up this crisis with a visit to EPS, clinicians at EPS may not ever know what transpired during the MCRT service call. If a client receives services from an outpatient mental healthcare CBO and then receives services from a BHSD agency, the BHSD agency may not ever know of their treatment by the CBO.

A significant consequence of the siloing of responsibilities countywide is that this vulnerable population has little opportunity to acquire a consistent personal connection throughout their contacts with services. Successful integration into the community is more likely if clients develop a rapport with a service provider that could bridge services and consistently assist them with navigating the system for the long term, such as a caseworker with lived experience, a peer navigator, or a trained social worker.

If the system were set up in a more coordinated way, it could foster more consistent relationships for this population across systems of care. This could increase the likelihood of individuals reaching out for help as needs arose, since they would know who to contact regardless of need and feel comfortable doing so. Such relationships could also decrease the likelihood of a client's refusal of care in custody, in treatment programs, and in the community.

**Inability to Share Electronic Data Across County Agencies**

One of the primary reasons for an absence of coordination among County agencies is an inability to share electronic data, similar to what was previously detailed as a barrier to serving clients in the Collaborative Court. In fact, all of the following departments use different data systems of records:

- BHSD uses myAvatar for patient records.
- Custody uses Criminal Justice Information Control (CJIC), an antiquated system that the County has been working on updating.
- Custody Health, EPS, and Valley Medical Center use HealthLink.
- The Court uses Odyssey.
- CBOs all have their own systems of electronic records.

All of these systems are separate and do not share data, although some members of some agencies do have view-only access to other agency records. The lack of communication impedes the County's ability to coordinate care among all of its agencies.

One of the primary reasons for this barrier is a legal one, and therefore very difficult for the County to surmount: patient privacy. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law created to "protect sensitive patient health information from being disclosed without the patient's consent of knowledge" (Centers for Disease Control and Prevention, 2024). Similarly, Title 42, Part 2 of the Code of Federal Regulations ("42 CFR Part 2") restricts the use and disclosure of patient records relating to substance use disorder education, prevention, and treatment in order to "help address concerns that discrimination and fear of prosecution deter people from entering treatment" for substance use disorders (U.S. Department of Health and Human Services, 2024).

However, a patient can sign a Release of Information (ROI) to give permission for the sharing of otherwise HIPAA-protected information, and for the sharing of certain 42 CFR Part 2-protected information for treatment purposes. Signing an ROI can surmount the legal barrier but does nothing to solve the electronic one. Further, there is a lack of coordination among agencies on the signing of the ROI, so if a client signs it for one agency, others may not know that the client has given permission for sharing records.

**Insufficient In-Reach Services**

One area of opportunity for more connection among services for this population is increased in-reach to County Jails by community service providers. If a client developed a relationship with a service provider during their incarceration that could be carried through to available services upon release, they might be more likely to continue with the services.

The implementation of CalAIM could help improve the current system. The County expects to begin a 90-day in-reach program funded by CalAIM grant money where BHSD or CBO staff will be able to begin supporting clients in County Jails to help with a more seamless transition to their release.

**A Divide Between Custody Health and BHSD Staff in FDR**

The focus of Custody and Custody Health is to maintain the health and welfare of incarcerated people while they are in the County Jail system. The goal of BHSD staff in FDR is to care for individuals as they integrate into the community. Neither agency is systematically charged with bridging the care of the client between being in custody and released into the community. Although Custody Health and BHSD staff in FDR are aware that they need to work together to coordinate care, there is no effective system in place for this coordination to occur. The result is either no coordination at all, or piecemeal and ad hoc collaboration by well-intentioned individuals.

The following are examples where lapses in communication and coordination occur:

- There is no consistent communication between Custody Health staff in booking and BHSD staff in FDR. Therefore, FDR rarely learns of clients at this early stage of the custodial process who could be candidates for Collaborative Court, or who have previously been in FDR programs, and could be quickly diverted from County Jail and into programs.
- Custody Health staff do not participate in Collaborative Court proceedings regarding client treatment plans or attend court when clients appear. This means that their input on how the client may be faring in custody or what programs may be appropriate for them outside of custody is not considered. It also means they are unaware of a client's treatment plan, so they cannot support the client's adherence to it in custody.
- BHSD staff in FDR and Custody Health staff do not attend the same trainings, even though there is overlap in some of the procedures and skills they use.

**Missed Opportunities for Earlier Discharge Planning**

Another consequence of the lack of collaboration between community service providers and Custody/Custody Health is missed opportunities for earlier discharge planning for eligible individuals. It is not always possible to predict when an incarcerated person will be released from custody, but for a person with a behavioral health disorder, earlier coordination of discharge planning would help ensure that whenever their release occurs, it does not undermine their continuity of care. For example, if it were clear from the moment an individual was booked into

the jail, or soon after, that they were a low-level repeat offender with an untreated behavioral health disorder who could benefit from treatment over incarceration, an appropriate discharge plan for this person should be immediately created. Currently, there is no coordinated effort to identify incarcerated individuals who would benefit from such a plan, or to systematically develop one in those instances. Instead, clients are simply booked into County Jails where their behavioral health disorders typically worsen, and they may not be connected to a community treatment program for days or weeks, or ever.

**Onus on Clients to Access Services**

As mentioned previously, clients are expected to initiate access to services at the Reentry Resource Center. In fact, the onus is on clients to initiate services throughout the County system. For example, if a MCRT responds to an emergency and provides a recommendation for certain care, it is completely up to the client to follow up on the recommendation independently. There is no systematic follow-up from mobile crisis units to encourage a client to access services. They may be homeless, without access to transportation, and clearly ill-equipped, and therefore unlikely to follow up, yet it is still their responsibility to do so.

If the County system provided an opportunity for more clients to have a personal connection with a service provider who could support them in navigating a more coordinated system, the responsibility would be shared. Presumably, additional help and coordination would make the system more hospitable, and therefore more successful.

**Homelessness Crisis and Lack of Appropriate Housing**

It cannot be overstated how much pervasive homelessness, lack of availability of affordable housing, and lack of permanent supportive housing are negatively impacting justice-involved people with behavioral health disorders in the County. Too many individuals who may have shown progress in their treatment at some point cannot get access to housing and are left with no other option than to remain unsheltered, which often makes it extraordinarily difficult to maintain stability, take medications, or stay clean and sober. Leaders throughout the County, state, and nation continue to work on easing this problem. Many complexities make it one that is neither quickly nor easily solved.

## CONCLUSION

The County is genuinely committed to working towards keeping low-level offenders with serious behavioral health disorders out of County Jails and in treatment. To this end, leaders have created some very innovative programs staffed and managed by many qualified and dedicated individuals. However, in order to be more effective, there needs to be better coordination among these stakeholders. The current system is set up as many separate puzzles, each with its own individual pieces, rather than one whole puzzle with its pieces all connected. It is incumbent upon County leadership to creatively further this goal of keeping eligible people with serious behavioral health disorders out of County Jails by devising the best ways for all of these programs to work in tandem, rather than separately.

# FINDINGS AND RECOMMENDATIONS

## Finding 1

The continuum of care for justice-involved people who have committed low-level crimes due to their behavioral health disorder is disjointed between BHSD, CBOs, community programs, the Court, and Custody Health. The County and its partners' programs and services are too siloed, resulting in a lack of coordinated care.

## Recommendation 1

No recommendation.

## Finding 2

BHSD staff in Collaborative Court and Custody Health do not systematically collaborate to support the clients they have in common, resulting in clients spending unnecessary time in custody.

## Recommendation 2

BHSD staff in Collaborative Court and Custody Health should establish more effective systems of collaboration. Some examples could include:

- Custody Health being present in Collaborative Court to ensure collaboration in client support.
- Have BHSD staff from FDR and Custody Health attend mutually relevant trainings together.

This recommendation should be implemented by December 31, 2024.

## Finding 3

The current system does not allow for discharge planning for people accused of low-level offenses with behavioral health disorders soon after arrest and booking.

## Recommendation 3

Appropriate County agencies should create a system that allows for the possibility of discharge planning for appropriate individuals to occur much earlier in the process. This recommendation should be implemented by December 31, 2024.

## Finding 4

The current countywide system is not conducive to justice-involved clients with behavioral health disorders establishing a personal connection with a service provider who can help them navigate all available services for the long-term. Such a personal connection could increase the likelihood of clients participating in treatment plans and transitioning more smoothly to the community.

## Recommendation 4

The County should coordinate systems of care more effectively to make it easier for clients to establish personal connections. Some examples could include:

- Increased in-reach services to County Jails (peer navigators, social workers, etc.) to work with clients to build trust and form a relationship to smoothly transition into community programs.
- A more coordinated system of communication among service providers countywide regarding clients' history and needs.

This recommendation should be implemented by March 31, 2025.

## Finding 5

County services do not have a central repository for client digital records. This impedes coordination of care.

## Recommendation 5a

To the maximum extent legally allowable, the County should develop an initial plan of how to improve coordination of client digital records across its currently disparate network of data systems in different service areas, beginning with the following agencies:

- Custody Heath
- BHSD and the CBOs
- EPS
- Collaborative Court
- And other related agencies

This recommendation should be implemented by December 31, 2024.

## Recommendation 5b

Once a coordination plan is established, the County should have regular meetings every 6 months to monitor progress and implementation of the plan. This recommendation should be implemented by March 31, 2025.

## Finding 6

Collaborative Court judges are often forced to rely on clients bringing paper copies of their CSRs to court to be able to assess their adherence to program requirements. This is a cumbersome barrier toward program graduation and reentry into the community.

## Recommendation 6

BHSD should devise a reliable and user-friendly system to provide electronic copies of CSRs to judges in advance of each client's court date. This recommendation should be implemented by December 31, 2024.

## Finding 7

Insufficient staffing and an increased workload of BHSD in FDR has negatively impacted staff morale and led to longer wait times for clients who are incarcerated to enter treatment programs.

## Recommendation 7

BHSD should prioritize staffing and resources in Collaborative Court and FDR. This recommendation should be implemented by December 31, 2024.

## Finding 8

Innovative programs such as PARR successfully reduce time incarcerated for their clients.

## Recommendation 8

The County should prioritize the current PARR program and the proposed expansion of this program for people with behavioral health disorders ensuring an earlier possible referral to Collaborative Court. This recommendation should be implemented by December 31, 2024.

## Finding 9

Custody Health's current procedure for mental health screening and assessment allows too many incarcerated people with non-acute behavioral health disorders to go undiagnosed and untreated.

## Recommendation 9a

Custody Health should review its procedures for behavioral health disorder screening of newly booked clients to determine why so many are passing through without getting flagged. This recommendation should be implemented by December 31, 2024.

## Recommendation 9b

Once the County determines the issues related to flagging clients the County should fix the screening process. This recommendation should be implemented by March 31, 2025.

## Finding 10

Custody Health does not consistently check clients' court schedules, leading to scheduling conflicts of court dates and medical appointments.

## Recommendation 10

Custody Heath should consult the Court calendar using a system such as the Inmate Finder website to view court dates to ensure they do not schedule a client's medical appointments at the same time as their court date. This recommendation should be implemented by September 30, 2024.

## REQUIRED RESPONSES

Pursuant to California Penal Code section 933(b) et seq. and California Penal Code section 933.05, the 2023-24 Santa Clara County Civil Grand Jury requests responses from the following governing body:

| Responding Agency | Findings | Recommendations |
|---|---|---|
| The County of Santa Clara | 1, 2, 3, 4, 5, 6, 7, 8, 9, 10 | 2, 3, 4, 5a, 5b, 6, 7, 8, 9a, 9b, 10 |

## APPENDIX 1: FDR Overview

Selected slides from a presentation on the Forensic, Diversion, and Reintegration Division by the County of Santa Clara Office of Behavioral Health Services.

## Behavioral Health Needs of the Justice-Involved Population

**People who presently are, or have spent time, in jails and prisons experience disproportionately higher rates of physical and behavioral health diagnoses and are at higher risk for injury and death resulting from trauma, violence, overdose, and suicide than people with no history of incarceration.**

***People with behavioral health disorders are overrepresented in the criminal justice system.***

- 51% of people in prison and 71% of people in U.S. jails have/previously had a mental health problem
- 58% of people in state prison and 63% of people in U.S. jails meet the criteria for drug dependence or abuse
- Overdose deaths are >100x more likely for justice-involved individuals two (2) weeks post release than the general population

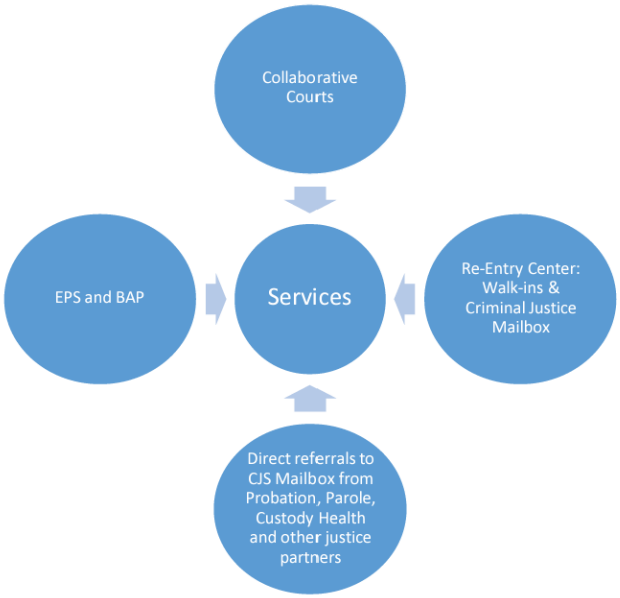
***Focus on California***

- Over the past decade, the proportion of incarcerated individuals in California jails with an active mental health case rose by **63%**
- California's correctional health care system experience drug overdose rate for incarcerated individuals that are **3x** the national prison rate
- Among justice-involved individuals, **2 of 3** individuals incarcerated in California have a high or moderate need for substance use disorder treatment

3

# How to Access Services

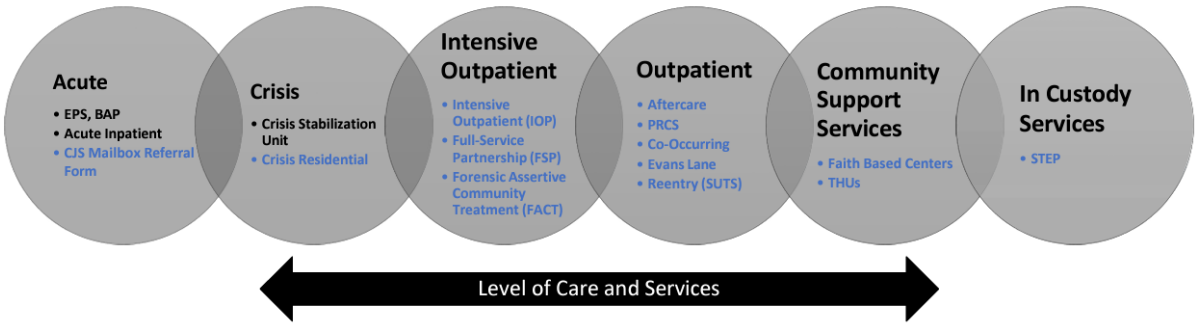
## How Justice Involved Client Access Services



# Program Overview

## BHSD Continuum of Care

*Specialized Forensic, Diversion & Reintegration (FDR) Programs noted in Blue



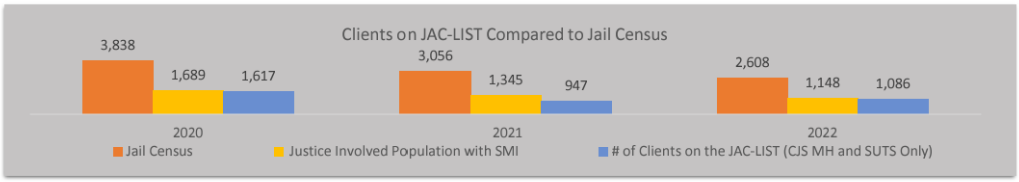
# Highlights & Successes

# Demographics

FY2020-2022*

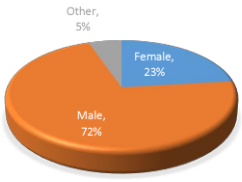
Percent of people in Santa Clara Jails with a Serious Mental Illness

44%

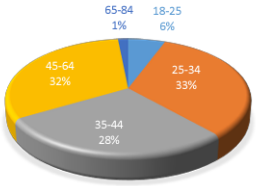



Jailreport.pdf (amazonaws.com)

GENDER




AGE RANGE

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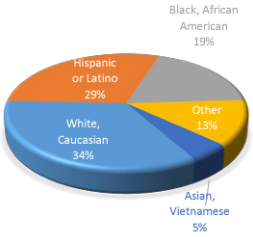


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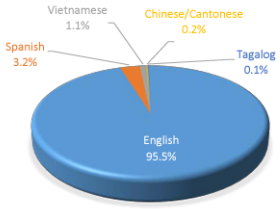


Excludes: SUTS RRC and SUTS Prop 47
Data as of 4/30/2022

13

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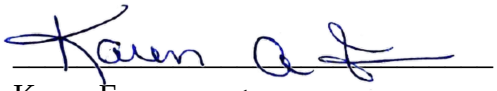
This report was **ADOPTED** by the 2023-24 Santa Clara County Civil Grand Jury on this 12th day of June, 2024.



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Foreperson