Data-Driven Approach to Protecting Public Safety, Improving and Expanding Rehabilitative Treatment and Services, and Advancing Equity Through Alternatives to Incarceration

Draft Comprehensive Report

December 16, 2022

SANDAG

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Executive Summary

Introduction

On October 19, 2021, the San Diego County Board of Supervisors directed County staff to issue a Request for Proposals (RFP) entitled "A Data-Driven Approach to Protecting Public Safety, Improving and Expanding Rehabilitative Treatment and Services, and Advancing Equity through Alternatives to Incarceration: Building on Lessons Learned during the COVID-19 Pandemic." As noted in this Board item, "mass incarceration disproportionately impacts the poor, homeless, mentally ill, and people of color and does not make us safer." Through a competitive process, the Criminal Justice Research Division (CJRD) of SANDAG was selected to serve as the independent consultant on this effort.

On March 15, 2022, SANDAG staff presented on the Preliminary Report for the project to the San Diego County Board of Supervisors, which included an overview of the goals, methodologies, and timeline. The Initial Interim Report was later presented to the Board of Supervisors on May 24, 2022. This Initial Interim Report provided an overview of community outreach efforts; described policy drivers of decreased incarceration rates and how the incarcerated population changed during the pandemic; and presented recent crime statistics for the region. A Second Interim Report, which focused on the results of the ATI Community Survey that was conducted in Spring 2022 and four Community Forums that were held in June and July, was completed on July 29, 2022 and a Third Interim Report was completed on October 14, 2022 that provided an overview of changes to the research design, summarized key findings and progress to date, and presented new data and information for three of the research questions. **This Draft Comprehensive Report provides a summary to date of Best Practice literature, as well as data compiled related to justice system contact for individuals not booked during COVID-19, the needs of those at risk for justice system contact and the services available locally to address them.**

Due to significant data limitations, it was not possible to develop reliable cost estimates of community-based alternatives to incarceration relative to the cost of jail. Because of these limitations, a cost analysis could not be included in this report.

Although the initial research design outlined a methodology for estimating the cost of providing community-based services compared with the cost of incarceration (SOW 3.9), some agencies involved in these services were unable to provide full cost data, making a comprehensive analysis of the cost of providing these alternatives impossible. In addition to these data availability obstacles, the following limitations would have undercut the reliability and usefulness of cost estimates derived from the available data:

- Per the methodology, only individuals booked on one of nine low-level charges were eligible to be included in the cost analysis. The data did not allow for an analysis of whether individuals booked on one of these nine

charges also committed more serious offenses over the sampling period, nor did it show whether individuals may have avoided future offenses given proper interventions. Therefore, it was neither possible to credibly determine the full average jail cost of individuals who were booked on the nine charges, nor future cost savings.

- Criminal history, the ability to afford bail, the assessed clinical need for particular services, and other factors that could affect incarceration time, sentencing recommendations, or eligibility or appropriateness for alternatives were not able to be included in the analysis.

- Outcomes for individuals who received an intervention versus those who did not, including the cost of receiving the program or an alternative, could not be compared. Relatedly, recidivism data for individuals receiving each alternative was not available, meaning that an analysis of longer-term cost savings was not possible.

What Do We Know About Individuals Not Booked During COVID-19 and Their Continued Contact with the Justice System?

- A total of 11,904 individuals were arrested or cited across the San Diego region between April 1, 2020, and March 31, 2021, and not booked into jail for one of five misdemeanor-level drug use/possession charges or four misdemeanor-level public disorder charges.

- The total number of arrests/citations for these nine types of offenses (excluding any cases that contained other types of offenses) was 19,068.

- Around nine in ten (91%) of all contacts were for drug-related offenses and 9% were for public disorder offenses, which reflects at least in part booking criteria.

- Most of the individuals arrested or cited and not booked were male, almost half were White/Caucasian, and the median age was 36.0.

- A comparison of where these arrests/citations occurred revealed that there was an overrepresentation in Central, East Suburban, and North County West, compared to the population.

- Over three-quarters (77%) of the 11,904 individuals with justice-system contact during COVID-19 also had contact in the one-year ***prior*** to that instant offense (that did not result in a booking). More than one-fourth of these individuals had six or more contacts. The Final Report will include additional information regarding the nature of these offenses.

- Over half (55%) of the 11,904 individuals with justice-system contact during COVID-19 also had contact in the one-year ***after*** that instant offense (that did not result in a booking). The Final Report will include additional information regarding the nature of these offenses.

What Do We Know About the Needs of the Population At-Risk for Incarceration, How Well These Needs are Being Met, and Where Gaps and Barriers Exist?

- The most prominent need for individuals at-risk of incarceration are those related to basic needs, including having affordable housing and being able to obtain basic necessities. Additional needs for those with a history of incarceration often include mental health treatment, substance abuse treatment, and employment/vocational training.

- Across different data sources, it appears that as few as one-third of individuals with a history of incarceration who needed mental health services received it. Similar or even smaller percentages reported receiving housing navigation services, assistance paying for basic necessities, or vocational/job skill support.

- Even when individuals receive referrals to service, high percentages may not engage, especially in substance abuse treatment; additionally, some do not think they need the service or find it helpful.

- Around two in three individuals with a prior history of incarceration reported barriers to receiving services, including the ability to get to the program when it was operating, paying for it, long waiting lists or challenging enrollment procedures or criteria, and even gaining knowledge on available services.

- Service providers themselves also face barriers to meeting clients' needs, including hiring, training, and retaining qualified staff, as well as securing stable funding and being able to meet contracting and reporting outcomes.

What Does Best Practice Research Indicate May be Areas for Further Investment by the County of San Diego?

- Community response teams serving to divert low-level, nonviolent offenders from contact with law enforcement are effective at reducing crime and increasing connections to needed programs and services.

- When law enforcement contact cannot be avoided, law enforcement-led diversion to needed programs and services can be an effective means of beginning to meet the criminogenic needs of at-risk individuals.

- Collaborative Courts work. Providing education about programming and offering incentives to encourage participation in these courts as a sentencing alternative may help increase the number of eligible individuals who participate in these alternatives.

- Wraparound reentry services that begin prior to an individual's release from incarceration help facilitate successful reintegration into society and reduce the risk of recidivism.

- Programs that pair jail in-reach, comprehensive needs assessments, and the use of peer counselors with lived experience of incarceration can help connect individuals with services upon release and ease the transition back into the community. Drawing on the lived experience of peer counselors and ensuring that they are representative of the target population contributes to culturally competent service provision.

- Providing warm hand-offs to healthcare providers in the community and utilizing community health workers with lived experience can reduce barriers to accessing needed medical care upon release from incarceration, increasing the chances of a successful reentry.

Take Aways from This Report

- Over half (55%) of those not booked during COVID-19 for a low-level drug and/or public disorder offense had continued law enforcement contact in the year following. Understanding more about these individuals with frequent contact and how the County can best address underlying factors related to this contact will be a component of the Final Report.

- The greatest need for services appears to be in those areas that also have the lowest median income. Focus should be placed on ensuring needed services are located where individuals live and are easy to access.

- While the location of services is important, other factors are important to ensure accessibility, including reliable transportation, hours of operation, and difficulty that may exist related to enrollment. The importance of ensuring warm hand-offs and case management and advocacy cannot be underestimated. This is especially true for those who may have physical or mental disabilities and other factors that may be barriers to accessing services.

- No one agency can meet all an individual's needs. The importance of strong collaboration, communication, sharing of data/information, and warm hand-

offs cannot be emphasized enough. The County is in a unique position to facilitate the sharing of client information, case management, and warm hand-offs between agencies to support a strong network of care that can effectively engage clients.

- Obstacles to interagency data sharing hinder systematic efforts to determine the type, level, and distribution of needs in the region, making it more difficult to coordinate an effective response to meet those needs through services. The County should continue its efforts to facilitate data sharing across agencies and jurisdictions. An example of a well-integrated data sharing platform can be found in the City of Denver's Open Data Catalog, a publicly available data portal that stores county- and city-level data across multiple domains, including law enforcement and public health.

- Being able to be self-sufficient is an important goal, and one that is dependent on being able to earn a livable wage. As such, the importance of education, job training and other employment assistance in this area cannot be underestimated.

- Providing culturally competent services and utilizing peer mentors is important to facilitate engagement, especially when Black and Hispanic individuals are overrepresented among the population of formerly incarcerated, compared to their proportion of the San Diego County population. Drawing on the lived experience of peer counselors and ensuring that they are representative of the target population contributes to culturally competent service provision.

Introduction and Project Background

On October 19, 2021, the San Diego County Board of Supervisors directed County staff to issue a Request for Proposals (RFP) entitled "A Data-Driven Approach to Protecting Public Safety, Improving and Expanding Rehabilitative Treatment and Services, and Advancing Equity through Alternatives to Incarceration: Building on Lessons Learned during the COVID-19 Pandemic." As noted in this Board item, "mass incarceration disproportionately impacts the poor, homeless, mentally ill, and people of color and does not make us safer."

The Criminal Justice Research Division (CJRD) of SANDAG responded to this RFP and signed a contract with the County of San Diego on January 21, 2022, to serve as the independent contractor on this effort. In this role, SANDAG is analyzing data and seeking community input to identify the primary drivers of reduced incarceration rates during COVID-19, disaggregating the populations affected, analyzing outcomes associated with these short-term changes in incarceration policy, and recommending policy changes that will reduce jail populations safely and permanently, with the overarching goal of better protecting public safety with alternatives to incarceration.

On March 15, 2022, SANDAG staff presented on the Preliminary Report for the project to the San Diego County Board of Supervisors, which included an overview of the goals, methodologies, and timeline. The Initial Interim Report was later presented to the Board of Supervisors on May 24, 2022. This Initial Interim Report provided an overview of community outreach efforts; described policy drivers of decreased incarceration rates and how the incarcerated population changed during the pandemic; and presented recent crime statistics for the region. A Second Interim Report, which focused on the results of the ATI Community Survey that was conducted in Spring 2022 and four Community Forums that were held in June and July, was completed on July 29, 2022 and a Third Interim Report was completed on October 14, 2022 that provided an overview of changes to the research design, summarized key findings and progress to date, and presented new data and information for three of the research questions.

All information related to this project is posted to www.SANDAG.org/ATIStudy. Between February 23, 2022, and November 30, 2022, there have been 12,057 page views, up from 2,801 as of April 30, 2022.

Justice System Contact of Those Not Incarcerated During COVID-19

What type of contact and for what types of offenses (including if serious or violent) did individuals (as described in SOW 3.6) not detained during COVID-19 due to policy changes have with law enforcement in the community (e.g., citations, arrests, bookings), compared to an equitable, matched control group? (SOW 3.5.6)

As described in 3.5.6, SANDAG was asked to "determine the rate at which populations who were not incarcerated due to booking changes driven by the Public Health emergency committed new crimes or were returned to custody, using a comparison group defined by the Contractor and approved by the COR." As described in the Third Interim Report, this question was revised to better understand the level and type of justice system contact of individuals who had contact (misdemeanor-level arrest or citation) with local law enforcement between April 1, 2020, and March 31, 2021 for select drug use and possession (HS 11350A-Possession of a controlled substance, HS 11357-Possession of marijuana, HS 11377A-Methamphetamine and drug possession, HS 11550A-Under the influence of a controlled substance, HS 11364-Possession of drug paraphernalia) and/or public conduct charges (PC 415-Disturbing the peace, PC 602-Trespassing, PC 647(e)-Illegal lodging, PC 647(f)-Public intoxication) but who were not booked into jail as a result of this contact.[1]

To generate a representative sample of data for analysis, an inverse matching methodology was applied to Automated Regional Justice Information System (ARJIS) data between April 1, 2020, and March 31, 2021, to filter out observations where an individual was arrested or cited for one or more of these misdemeanor-level charges and then later booked into jail. To ensure that this population included only those individuals who were arrested for these charges but not booked into a detention facility, ARJIS data were cross-referenced with San Diego County Sheriff's Jail Information Management System (JIMS) data from the Multi-Agency Interface (MAI), using an individual's presence in the JIMS data as the core exclusion criteria from the ARJIS data. To SANDAG's knowledge, this is the first time that these two large datasets have been linked in such a way.

Because there is no single variable in both datasets on which to match data, the chosen sampling strategy came with some minor methodological tradeoffs but minimized the risk of unintentionally including ineligible individuals in the sample (i.e., individuals who were booked into a detention facility on those charges). To create the final data frame, any individual from the ARJIS data who was also present

[1] The select drug-related charges are Health and Safety (HS) violations, and the select public conduct charges are Penal Code (PC) violations. This notation will be used to refer to these violations throughout the report.

in the JIMS data during the April 1, 2020, to March 31, 2021, time frame was excluded by matching on five key demographic variables: first name, last name, date of birth, sex, and date of arrest. The total number of observations upon applying these filters was 11,904,[2] which represents the entire population of individuals arrested or cited for the specified violations between April 1, 2020, and March 31, 2021, but who were not booked.

To better understand the type, frequency, and timing of justice system contacts for individuals arrested or cited, but not booked on the nine predefined charges, recorded contacts are being analyzed for each individual one year prior to and one year following their pandemic-period offense. For example, if an individual was arrested on June 12, 2020, on one of the specified drug possession or public conduct charges, his/her/their criminal activity was analyzed back to June 12, 2019, and forward to June 12, 2021. Points of analysis include frequency and location of agency contact, charge type and level, and time between contacts (i.e., the time between a COVID-19 period arrest and an individual's first post-COVID-19 arrest). In addition to these descriptive statistics, sub-analyses based on key demographic characteristics, such as race/ethnicity, age group, and ZIP code are being conducted. While this analysis is still in process, a summary of information to date is provided here.

Population Characteristics

11,904 individuals were arrested or cited **19,068** times during the one-year sampling period for a drug use/possession and/or public conduct charge.

Between April 1, 2020, and March 31, 2021, a total of 11,904 individuals were arrested or cited but not booked into jail for one or more of the drug use/possession and/or public conduct charges. Among these unique individuals, there were 19,068 contacts with law enforcement that resulted in an arrest or citation, but that did not ultimately result in a booking. Examining the characteristics and criminal activity of these individuals allows for a more complete understanding of the types of individuals being arrested/cited and released for these types of offenses, as well as of the effects of pandemic-era policy changes on crime patterns for this population of lower-level offenders. As Table 1 shows, over three-quarters (76%) of these individuals were male, the median age was 36.0, just under half were White/Caucasian (46%) and 33% were Hispanic/Latino.[3]

[2] Although the original revised plan was to sample 300 to 400 individuals arrested or cited but not booked on any of the nine charges during the pandemic period, SANDAG researchers were able to identify the entire population of individuals that fit these criteria.

[3] It should be acknowledged that these statistics do not necessarily allow for a full understanding of who in general *commits* these types of offenses, as the decision whether to book or cite and release is largely left to the discretion of the arresting officer. Rather, this analysis focuses only on those arrested or cited but not booked on these charges.

The majority (**91%**) of law enforcement contacts that did not result in booking were for drug-related offenses, as opposed to public conduct.

An analysis of the activity of the population during this time period indicated that a vast majority (91%) of arrests and citations that did not result in jail bookings were for narcotics-related charges. Of these, a majority were related to drug possession. The most frequent charge recorded was HS 11377(A) (possession of methamphetamine and other narcotics), followed by HS 11364 (possession of drug paraphernalia), HS 11550(A) (under the influence of a controlled substance), and HS 11350(A) (possession of a controlled substance). Relative to drug possession charges, public conduct charges among the population were relatively low, comprising roughly 9% of total contacts.

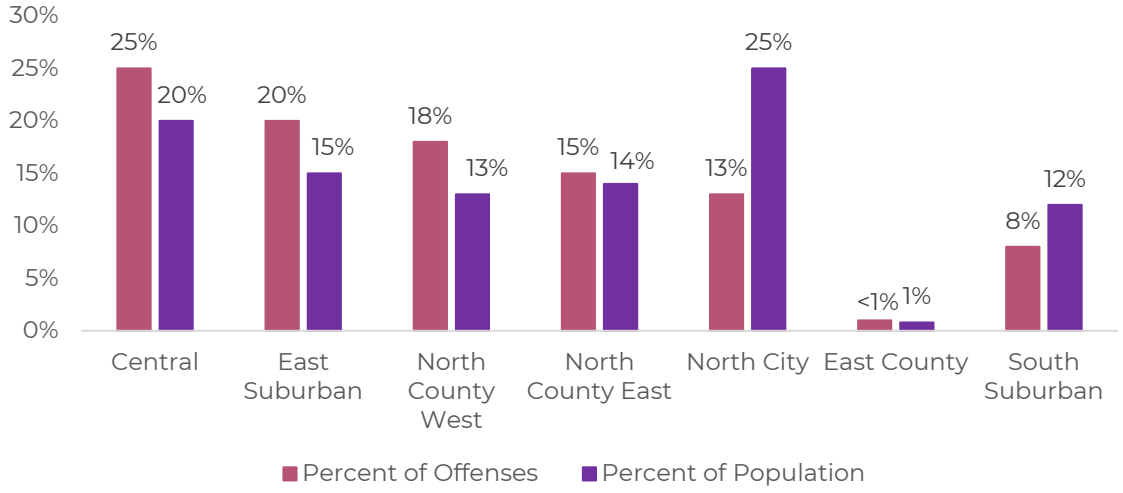
Table 1
CHARACTERISTICS OF INDIVIDUALS AND CONTACTS WITH LAW ENFORCEMENT CONTACT WHO WERE NOT BOOKED DURING COVID-19 FOR A MISDEMEANOR-LEVEL DRUG OR PUBLIC CONDUCT OFFENSE

INDIVIDUAL CHARACTERISTICS	
Sex	
Male	76%
Female	24%
Race	
White/Caucasian	46%
Hispanic/ Latino	33%
Black/African-American	15%
Asian/Pacific Islander	2%
Other	2%
Age	
Median	36.0
Mean	38.2 (18-88)
TOTAL	**11,904**
CONTACT CHARACTERISTICS	
Violation Type	
Methamphetamine and Drug Possession (HS 11377A)	37%
Possession of Drug Paraphernalia (HS 11364)	22%
Under the Influence of a Controlled Substance (HS 11550A)	18%
Possession of Controlled Substance (HS 11350A)	13%
Trespassing (PC 602)	7%
Illegal Lodging (PC 647e)	2%
Public Intoxication (PC 647f)	<1%
Disturbing the Peace (PC 415)	<1%
Possession of Marijuana (HS 11357)	<1%
TOTAL	**19,068**

NOTE: Percentages may not equal 100 due to rounding.
SOURCES: ARJIS; MAI; SANDAG

SANDAG analyzed the number of contacts that occurred during the pandemic period by major statistical area (MSA)[4] and compared it to the most recent SANDAG population estimates for the same area. As Figure 1 shows, a greater percentage of contacts occurred in the Central, East Suburban, and North County West MSAs, compared to the population, while a smaller percentage occurred in the North City and South Suburban MSAs.

Figure 1
PERCENT OF THE POPULATION AND DRUG/PUBLIC DISORDER CONTACTS REPORTED IN EACH OF THE COUNTY'S MAJOR STATISTICAL AREAS



NOTE: Percentages may not equal 100 due to rounding.
SOURCES: SANDAG, 2020 Annual Population Estimates, Retrieved: December 12, 2022; ARJIS; MAI; SANDAG

Justice System Contact One Year Prior to Instant Offense

Three in **four** individuals with justice system contact that did not result in a booking also had contact in the one-year prior to this instant offense.

Among the 11,904 individuals arrested or cited but not booked on eligible offenses during COVID-19, 7,600 (77%) individuals had a recorded law enforcement contact in the one year prior to their instant offense, while 4,304 (23%) did not (Table 2). Among these 7,600 individuals with a pre-pandemic law enforcement contact, there were 36,785 law enforcement contacts in the year prior to their instant offense. Of those who had law enforcement contact in the one year prior to their pandemic-period offense, there was a median of 3.0 contacts (mean 4.8) per person, with a range from 1 to 110. Further, as Figure 2 shows, around one in four had six or more contacts and around one in ten had ten or more.

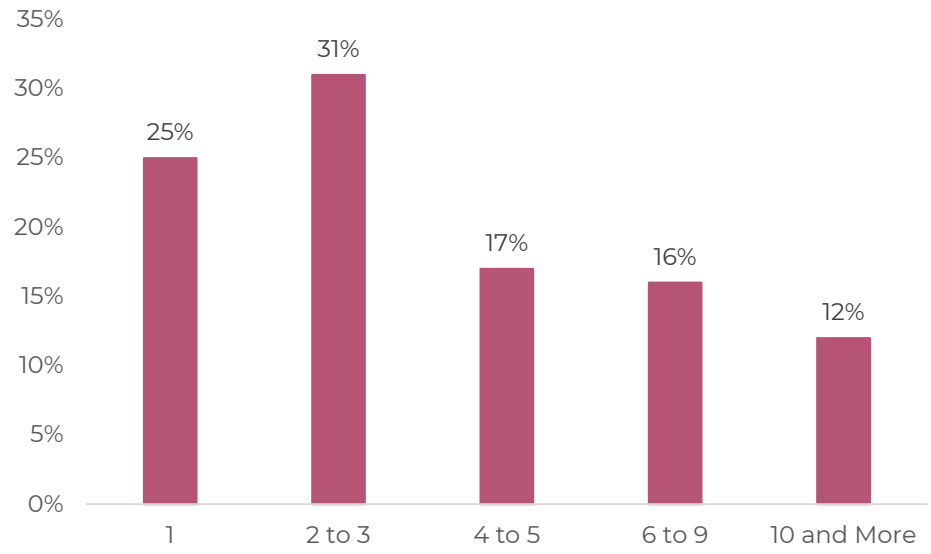
[4] There are seven Major Statistical Areas (MSA) in San Diego County, all of which describe different geographical areas of the County. To view these MSAs on a map, please visit https://sdgis.sandag.org/

These numbers indicate that while one in four of these individuals may not have a history of continued contact, the majority do, many of whom have underlying needs that may need to be address. The final report will build upon this preliminary analysis and examine what types of offenses this group of individuals tended to commit and, for those with repeat contacts, whether the type of offense generally remained the same or varied across contacts.

Table 2
HISTORY OF LAW ENFORCEMENT CONTACT FOR ANY CHARGE IN THE ONE YEAR PRIOR TO THE DRUG AND/OR PUBLIC DISORDER CONTACT DURING THE COVID-19 PERIOD

Contacts (Arrests/Citations)	
Percent with contact in one-year prior	77%
Median/person	3.0 (1-110)
Mean/person	4.8
TOTAL CONTACTS	**7,600**
SOURCE: ARJIS; MAI; SANDAG	

Figure 2
NUMBER OF CONTACTS INDIVIDUALS NOT BOOKED DURING COVID-19 HAD IN THE ONE YEAR PRIOR TO THEIR IDENTIFYING CONTACT FOR ANY TYPE OF OFFENSE



TOTAL = 7,600

NOTE: Percentages do not equal 100 due to rounding.SOURCE: ARJIS; MAI; SANDAG

Justice System Contact One Year After Instant Offense

Over half (**55%**) of individuals who were not booked for a drug or public disorder offense during COVID-19 had continued law enforcement contact in the one-year following.

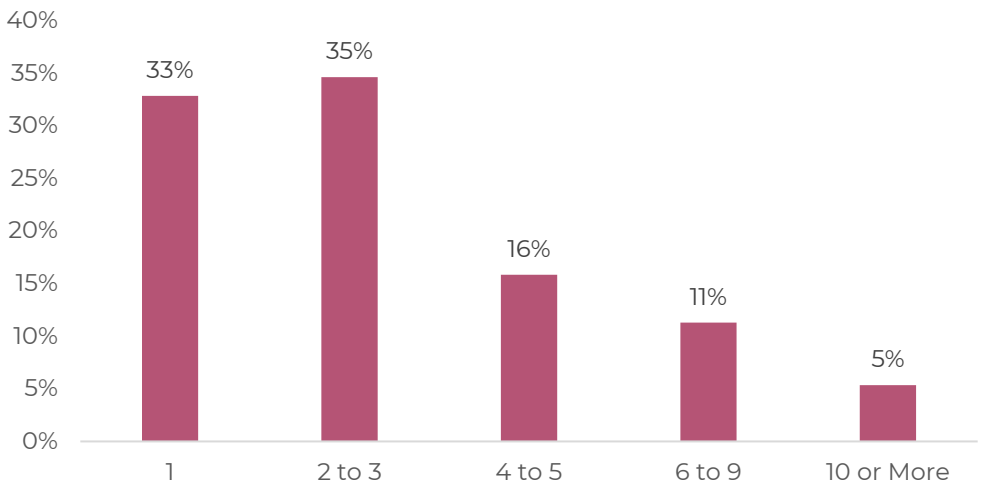
When looking at the one year following the COVID-19 instant offense, over half (55%, 6,604 of 11,904) of the individuals not booked had some type of law enforcement contact. As Table 3 shows, relative to the pre-pandemic period, this population had lower rates of law enforcement contacts in the form of arrests and citations. Among individuals with post-pandemic offenses, there were 22,829 law enforcement contacts in the one year following the instant offense. For those who had repeat contacts, the frequency of these contacts declined from the pre-pandemic period to a median of 2 (mean 3.5). As Figure 3 shows, one-third (33%) of these individuals only had one additional contact with law enforcement in the follow-up period, over half had two to five, just over 1 in 10 had six to nine, and just 1 in 20 had ten or more. It is possible that this lower rate of continued contact could reflect either changed behavior on the part of the individuals, or alternatively, a different pattern of response from law enforcement that could reflect ongoing changes from the pandemic. A full analysis of these data that will be presented in the Final Report will include information on the types of offenses that were committed, where they were committed, and predictors of continued contact with the justice system.

Table 3
LAW ENFORCEMENT CONTACT FOR ANY CHARGE IN THE ONE YEAR FOLLOWING THE DRUG AND/OR PUBLIC DISORDER CONTACT DURING THE COVID-19 PERIOD

Contacts (Arrests/Citations)	
Percent with contact in one-year after	55%
Median/person	2.0 (1-151)
Mean/person	3.5
TOTAL CONTACTS	**6,604**

SOURCE: ARJIS; MAI; SANDAG

Figure 3
DISTRIBUTION OF NUMBER OF CONTACTS, POST-PANDEMIC PERIOD



TOTAL = 6,604

SOURCE: ARJIS; MAI; SANDAG

Needs, Services, Gaps, and Barriers

What rehabilitative and restitutive program needs does this population have and how do needs vary by other characteristics? (SOW 3.7.6)

What County-funded services are available, what type of services do they provide, and where are they located? (SOW 3.7.5)

What are the gaps in services and facilities for justice involved individuals who are unhoused or homeless, face substance use challenges, struggle with mental and behavioral health needs, are youth or young adult offenders, or are otherwise strong candidates for diversion programs and alternatives to incarceration? What are barriers and limitations to receiving services? (SOW 3.7.5)

A key part of this study is to provide information regarding the needs of those at-risk of incarceration, understand what services are available to meet those needs, and identify gaps and barriers that may exist that prevent an individual from being able to receive services that are available. When considering these data, it is important to note that a variety of different data sources, as shown in Tables 4 and 14 were used to answer these questions. Each of the sources provided information collected in different ways (e.g., self-report, assessed) and with different populations, some of whom reached out to the entity in search of services, and some of whom were referred. In addition, an individual not identifying a need does not necessarily mean that need does not exist, and it is important to remember that every person is a unique individual with needs, risks, and strengths and any attempt to suggest otherwise is an oversimplification of the human condition. As such, this analysis is more qualitative in nature and common themes are noted as appropriate, with a summary provided at the end of this section regarding key takeaways for further discussion and possible action.

Table 4 SOURCES OF NEED DATA IN THE SAN DIEGO REGION FOR THE ATI STUDY			
Data Source	**Population**	**Time Period**	**Data Description**
2-1-1	General population that calls 2-1-1	FY 22	Needs by type and ZIP code
District Attorney's CARE Community Center	Individuals served by the CARE Community Center	October 2017-August 2022	Aggregate needs data by race, gender, trauma, and history of incarceration
Department of Homeless Solutions and Equitable Communities	Individuals with housing needs leaving Sheriff's detention facilities	November 2019-April 2022, depending on referral source	De-identified data including demographics and need for mental health or substance use disorder treatment
Behavioral Health Services	Individuals with a justice system referral who received County-funded mental health or substance use treatment	FY 21	De-identified data including demographics and where in the region services were received
Proposition 47 Evaluation	Low-level offenders served through Proposition 47-funded programs	2017-2021	Self-reported needs
ATI Community Survey	Community Survey respondents who indicated they had been incarcerated	2022	Self-reported needs with the ability to examine by self-reported gender, age, race/ethnicity, and ZIP code
ATI Service Provider Survey	Service provider survey	2022	Perceived needs of adult clients they serve
Substance Abuse Monitoring Study	Adults booked into local detention facilities	2020	Self-reported needs related to mental health and housing instability, drug use test results
Probation Community Resource Directory	Individuals under Probation Supervision	FY 21 & 22	Aggregate data describing what services individuals were referred to, which reflects need
SOURCE: SANDAG			

Needs

2-1-1 – General Population

In many ways, 2-1-1 provides an ideal starting point for understanding the type and distribution of needs throughout the County, due to its status as a central operator connecting people in need to resources in the community that meet those needs. The nonprofit organization, 2-1-1, provides 24/7 connection to over 6,000 services and resources that are regularly updated. The data shared with SANDAG include information on both the total number of reported needs, broken down by category and reported by ZIP code. 2-1-1 does not disaggregate data by justice system involvement, but its data provide helpful context for mapping needs among vulnerable populations across the County who could theoretically become involved with the system if their needs are not addressed and met.

During FY 2022 (July 1, 2021-June 30, 2022), 2-1-1 served 290,765 clients and assessed 582,186 needs, representing an average of approximately two assessed needs per client. Understanding the demographic determinants behind needs and service referrals is necessary to gain a more nuanced understanding of what subpopulations tend to have more needs than others and where they are located. This is also necessary information for assessing whether there are gaps in service provision among high-need populations and high-need locations within the county.

As shown in Table 5, a majority of 2-1-1 callers were female (68%), just over two in five (41%) described themselves as Hispanic/Latino, and almost three-fifths (58%) were between the ages of 30 and 59. The majority (59%) of individuals who called reported having 12 or fewer years of formal education, around two in five (39%) reported they were unemployed (and looking for work), and another 17% said they were disabled and unable to work. Not shown, 7% reported they were a veteran.

The number one need of 2-1-1 clients is related to housing.

The top four categories of needs that were self-reported and categorized by 2-1-1 were housing (26%), health care (15%)[5], utilities (13%), and income support and employment (11%) (Figure 4). The fifth need, reported by less than one in ten (6%) of those who called, was criminal justice/legal assistance (not shown).

Figure 4
TOP FOUR NEED CATEGORIES REPORTED TO 2-1-1

SOURCES: 2-1-1; SANDAG

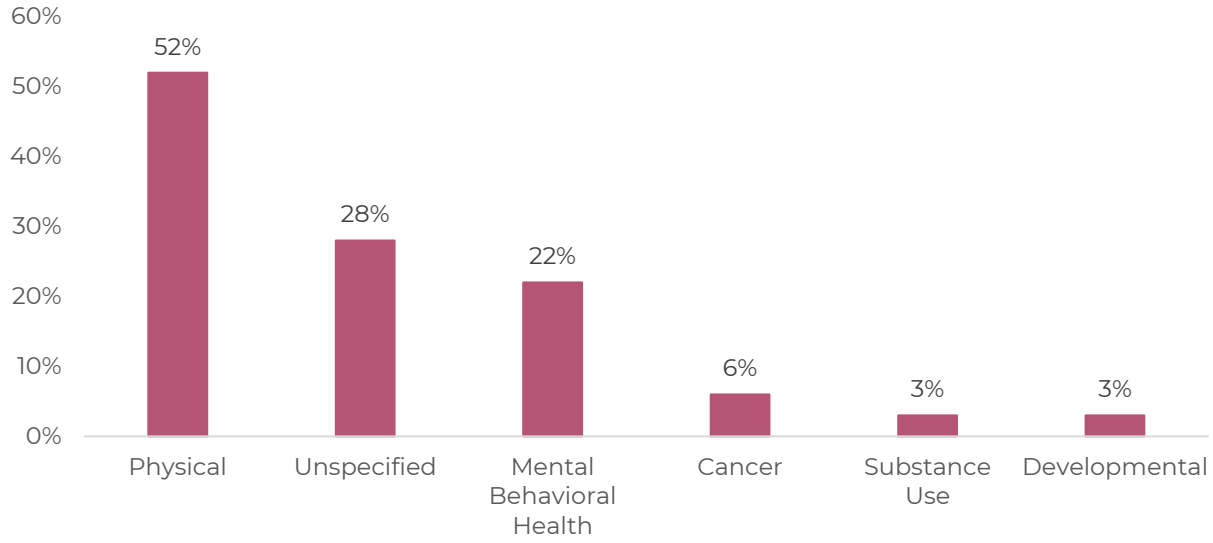
[5] Due to the ongoing COVID-19 pandemic and the data obtained through 2-1-1, COVID-related needs can be assumed to make up a significant proportion of these reported needs. For example, there were 25,980 referrals to County COVID-19 testing sites alone, among other COVID-related needs. Though health care is clearly a significant need and gaps certainly exist, these data should be considered with the effects of COVID-19 in mind.

Table 5 FY 22 2-1-1 CLIENT CHARACTERISTICS	
Gender	
Male	32%
Female	68%
Race	
Hispanic/Latino	41%
White/Caucasian	29%
Black/African-American	14%
Other	7%
Asian/ Pacific Islander	5%
Bi-Racial/Multi-Racial	3%
Alaska Native/Native Indian	1%
Age	
Under 20	1%
20-29	15%
30-39	22%
40-49	18%
50-59	18%
60-69	15%
70-79	7%
80-89	2%
90 and older	<1%
Employment Status	
Unemployed	39%
Disabled/Unable to Work	17%
Full-time	16%
Part-time	13%
Retired	11%
Other employment	4%
Education	
Less than high school	22%
High school or equivalent	37%
Some college	25%
Associate degree	5%
Bachelor's degree	7%
Post-Bachelor's degree	3%
TOTAL	**290,765**
NOTE: Percentages may not equal 100 due to rounding. *SOURCES: 2-1-1; SANDAG*	

2-1-1 also captures specific information regarding clients' health concerns and health insurance status. According to the data provided, just over half (53%) (not shown) of clients reported having a health concern (even if it was not a top need they were calling about), which most often was physical (52%), but also included mental behavioral health (22%) (Figure 5). The majority (88%) of clients who called reported

they had health insurance, with the most common type being Medi-Cal (66%) (not shown).

Figure 5
MEDICAL CONCERNS REPORTED BY 2-1-1 CLIENTS IN FY 22

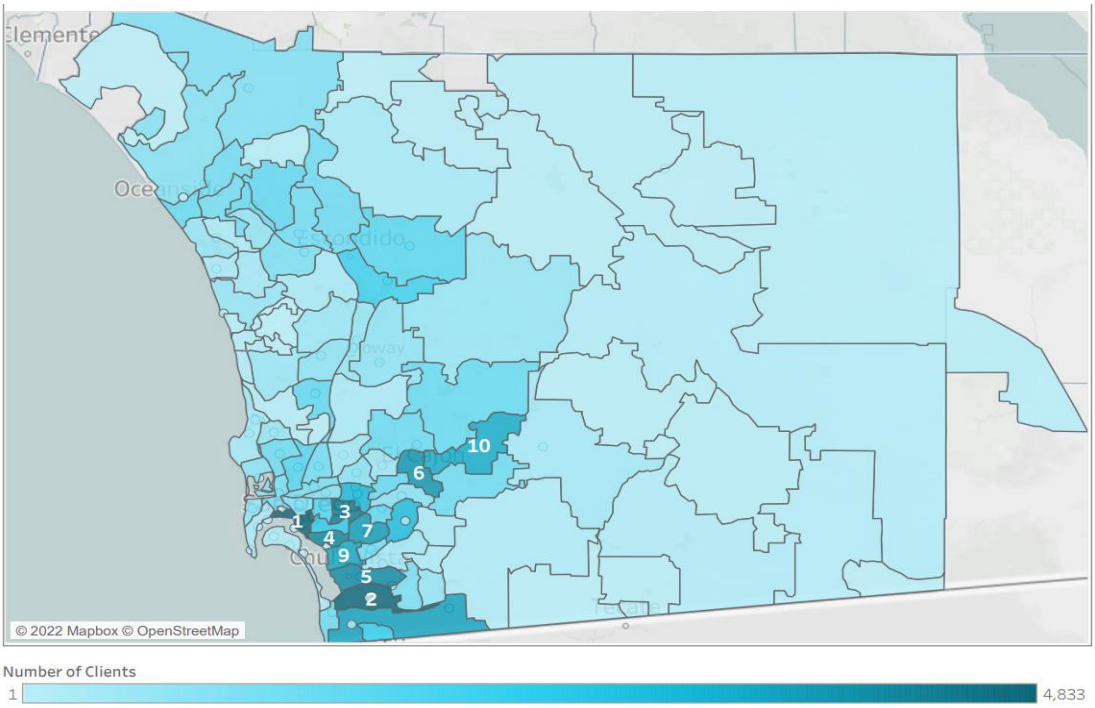


NOTE: Percentages based on multiple responses.
SOURCES: 2-1-1; SANDAG

Clients with reported needs were clustered by geographic area, with large proportions of clients in downtown San Diego, Chula Vista, City Heights, Logan Heights, and El Cajon (Figure 6). Whether client needs were reported was also clearly linked to socioeconomic indicators. Using median household income per ZIP code as a proxy for socioeconomic status, SANDAG conducted analyses of the relationship between income and the number of needs had and referrals made. Statistical tests confirmed a significant negative correlation (r=-0.43) between median household income and the number of needs reported, indicating that increases in income are negatively correlated with the number of needs per household. Put differently, with every $1,000 increase in median household income, there is a 3% decrease in the number of needs reported per household, signifying a strong relationship between a household's socioeconomic status and contacting 2-1-1 to report needs.[6] These numbers suggest that the uneven distribution of needs throughout the County can at least be partially understood by socioeconomic disparities, which should be considered when evaluating service availability and gaps in these services in areas where they are most needed.

[6] Negative binomial regression testing the statistical relationship between median household income and the number of needs reported indicated a statistically significant ($p<0.001$) relationship between the two variables.

Figure 6
DISTRIBUTION OF 2-1-1 NEEDS REPORTED BY ZIP CODE



SOURCES: 2-1-1; SANDAG
NOTE: The ten ZIP codes with the greatest number of needs include 92101 (Downtown San Diego), 91911 (Chula Vista), 92105 (City Heights San Diego), 92113 (Logan Heights San Diego), 91910 (Chula Vista), 92020 (El Cajon), 92114 (Encanto San Diego), 92154 (Otay Mesa San Diego), 91950 (National City), and 92021 (El Cajon).

District Attorney's CARE Center – Previously Incarcerated Community Members

The second source of needs data was provided by the San Diego County District Attorney's CARE (Community, Action, Resource, Engagement) Community Center. The CARE Center provides individuals (primarily in National City and Southeast San Diego) with evidence-based prevention and intervention support services to help improve their quality of life, reduce crime and recidivism, and promote public safety.

3 in **4** CARE Center clients who are formerly incarcerated report a history of trauma.

The CARE Center provided a summary of their data for this analysis for the period of October 2017 through August 2022. During this time period, a total of 1,136 assessments were completed by CARE Center staff, half (50%) of which were conducted with formerly incarcerated individuals. As Table 6 shows, over half of these individuals were male (55%), almost three-quarters were Black/African-

American or Hispanic/Latino (70%) and a similar amount (73%) had experienced traumatic events (and most said they were still affected by them), and almost three in five were unemployed and looking for work (58%).

Table 6
CHARACTERISTICS OF CARE CENTER CLIENTS WHO ARE FORMERLY INCARCERATED

Gender	
Male	55%
Female	45%
Race	
Black/African-American	35%
Hispanic/Latino	35%
White/Caucasian	20%
American Indian/Alaska Native	3%
Asian/Pacific Islander	3%
Other	5%
Employment Status	
Unemployed and looking for work	58%
Employed	23%
Unemployed and not looking	17%
Other	3%
Traumatic Event History	
Ever	73%
Still Affected	76%
TOTAL	**569**

NOTE: Percentages may not equal 100 due to rounding.
SOURCES: CARE Center; SANDAG

Employment assistance and help paying for basic necessities were most frequent needs of CARE Center clients.

In terms of the most frequently identified needs of these formerly incarcerated CARE Center clients, the most common included employment counseling or training (21%), food/nutrition services (20%), mental health care (14%), and housing services (12%) (Table 7).

Table 7 NEEDS OF CARE CENTER CLIENTS WHO ARE FORMERLY INCARCERATED	
Employment counseling or training	21%
Food/nutrition services	20%
Mental health care	14%
Housing services	12%
Medical care	10%
Health coverage and insurance support	9%
Education support	7%
Childcare services	4%
Drug abuse counseling/treatment	1%
Government ID support	1%
TOTAL	**569**
NOTE: Percentages do not equal 100 due to rounding. *SOURCES: CARE Center; SANDAG*	

Department of Homeless Solutions and Equitable Communities – Housing Unstable Individuals Leaving Detention Facilities

The third source of information regarding needs was provided by the Office of Homeless Solutions, a division of the Department of Homeless Solutions and Equitable Communities (HSEC). The results from the data provided by the HSEC are presented in an aggregated format, but there were individuals from three different Community Care Coordination (C3) programs[7]: the original Community Care Coordination (C3) program, which focused on homeless clients with a serious mental illness and other complex needs; the veteran focused C3 program; and a C3 program dedicated to complex health issues. The sample from the C3 programs included de-identified data on needs and referrals for 255 homeless individuals released from jail (between November 2019 and April 2022), with demographic breakdowns by age group, race/ethnicity, and gender. As Table 8 shows, 78% of these individuals were male, just under two-fifths (37%) were between the ages of 35 and 44, and the majority described their race as White/Caucasian (61%).

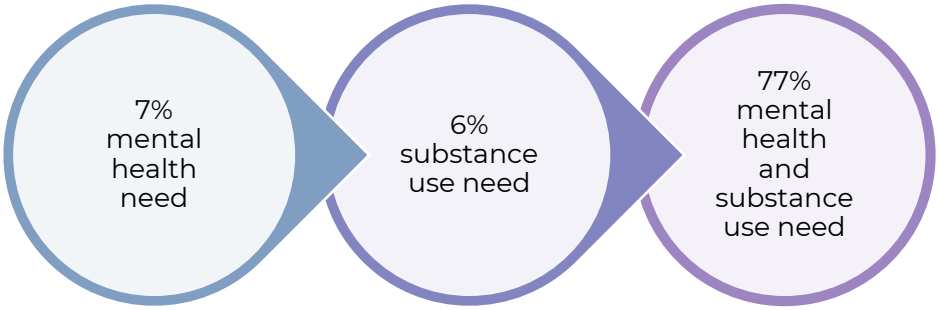
[7] The goal of C3 programs is to provide intensive case management and peer support to coordinate medical and behavioral healthcare, community services, and housing assistance for individuals to promote better outcomes.

Table 8 CHARACTERISTICS OF HSEC COMMUNITY CARE COORDINATION CLIENTS	
Gender	
Male	78%
Female	22%
Age	
18-24	4%
25-34	22%
35-44	37%
45-54	18%
55 and older	19%
Race	
White/Caucasian	61%
Black/African-American	28%
Asian/Pacific Islander	4%
Multi-Racial	3%
Native American	<1%
Other	4%
TOTAL	**255**
NOTE: Percentages may not equal 100 due to rounding. *SOURCES: HSEC; SANDAG*	

Data were also provided regarding whether an individual was assessed as having a mental health and/or substance use disorder (SUD) need. Over three-fourths (77%) were identified as having both a mental health and substance use need, while 7% had only a mental health need and 6% had only a SUD need (Figure 7).

Most C3 clients have needs related to both mental health and substance use.

Figure 7
MENTAL HEALTH AND SUBSTANCE USE NEEDS OF HOUSING UNSTABLE FORMERLY INCARCERATED INDIVIDUALS



SOURCES: HSEC; SANDAG

Behavioral Health Services – Individuals with a Justice System Referral

Behavioral Health Services (BHS) provided the fourth source of needs information through intake records for justice-involved individuals who received a BHS mental health or substance use disorder referral during FY 2021. The population included in these data is comprised of individuals referred to BHS from the justice system (e.g., Drug Court or probation supervision), although some individuals captured in the data were self-referred for treatment. The data includes a breakdown of BHS clients referred for both mental health and substance use disorder treatment by demographic characteristics.[8]

As Table 9 shows, the characteristics of BHS clients referred for mental health and substance use disorders were somewhat similar as a majority of clients in both groups were male (70% and 74%, respectively), within the age range of 25 to 44 (53% and 68%, respectively), and White (39% and 39%, respectively). The most notable difference in the characteristics of BHS mental health and SUD clients is seen in their home region. Geographically, a greater proportion of clients with mental health needs were described as living in the Central or North City areas of the County, while

[8] It should also be noted that some duplicates may be present in the data, as an individual could have started two different treatment periods within the data reporting window and therefore was counted twice. As this is aggregated and de-identified data, duplicates were not able to be identified.

over one-third of those with a substance use disorder were described as having an unknown address or living outside the County.

Table 9
CHARACTERISTICS OF JUSTICE-INVOLVED BHS CLIENTS

	Clients with Mental Health Need	Clients with SUD Need
Gender		
Male	70%	74%
Female	30%	26%
Age		
<18	4%	2%
18-24	11%	9%
25-34	29%	40%
35-44	24%	28%
45-54	17%	14%
55 and older	17%	7%
Race		
White/Caucasian	39%	39%
Hispanic/Latino	34%	40%
Black/African-American	17%	10%
Asian/Pacific Islander	4%	3%
Other	3%	6%
Unknown	2%	0%
Native American	1%	1%
Region of San Diego County		
Central	33%	16%
North City	17%	5%
East Suburban/East	15%	11%
South Suburban	12%	10%
North West	10%	12%
North East	10%	8%
Outside of SD or Unknown	3%	38%
TOTAL	**21,922**	**5,993**

NOTE: Percentages may not equal 100 due to rounding. These data represent unique counts of MH and SUDS clients who had open assignment to services in FY 21-22. Although a client may have multiple assignments during the fiscal year, each client was only counted once for the purpose of reporting demographic characteristics. Demographic information is reported for most recent assignment
SOURCES: BHS; SANDAG

Proposition 47 Evaluation – Low-Level Offenders with Substance Use/Mental Health Issues

The fifth source of data for the needs analysis comes from a recent evaluation SANDAG completed for the County of San Diego that was aimed at providing services to individuals who had justice system contact for Proposition 47-related offenses[9] and were provided services through one of two programs – Community Based Services and Recidivism Reduction (CoSRR) and San Diego Misdemeanants At-Risk Track (S.M.A.R.T.). While each program offered a slightly different approach to intake and service delivery, both were voluntary and aimed at reducing recidivism of chronic, low-level misdemeanor offenders with substance use disorder and mental health challenges. S.M.A.R.T. was also focused on clients who were homeless.

The top needs of Prop 47-funded programs included substance use, housing, and transportation.

As Table 10 shows, the top needs for these individuals included housing and substance use treatment, which is to be expected given the focus of both programs. For CoSRR clients, the need for transportation assistance and training on employment skills were also frequently noted. For S.M.A.R.T. clients, there was also a high need for transportation and a medical home[10]. Overall, CoSRR clients reported a mean of 6.5 needs and S.M.A.R.T. clients a mean of 7.1.

Table 10
SELF-REPORTED NEEDS OF COSRR AND S.M.A.R.T CLIENTS

	CoSRR	S.M.A.R.T.
Substance use	99%	99%
Housing	81%	99%
Transportation	72%	98%
Employment skills	66%	59%
Public benefits	49%	75%
Mental health treatment	47%	81%
Physical health	44%	69%
Job skills	33%	46%
Family services	31%	21%
Medical home	31%	83%
Education skills	31%	15%
Vocational skills	29%	32%
Civil/legal assistance	27%	36%
TOTAL	**248**	**98-127**

NOTE: Percentages based on multiple responses.
SOURCES: San Diego County Proposition 47 Grant Final Evaluation Report, 2021; SANDAG

[9] As part of Proposition 47, certain property-and drug-related offenses were reduced from felonies to misdemeanors.
[10] A medical home is a team of providers that manage an individual's care collaboratively.

ATI Community Survey – Community Survey of Current and Formerly Incarcerated Individuals and Family Members

The sixth source for the needs analysis was previously presented in the Second Interim report for this study and is included here as one of the key data sources for this research question. Overall, community survey respondents reported a mean of 4.0 significant needs and 5.9 needs that were described as significant or somewhat of a need. Twenty-nine percent (29%) failed to describe any significant needs and 21% indicated not having any needs at all (not shown).

79% of incarcerated individuals reported having unmet needs at the time of their most recent incarceration and the average number of needs respondents reported having was almost **6**.

As Table 11 shows, between 25% and 58% described having a significant need, with the most common including employment assistance (58%), housing navigation (56%) and help paying for basic necessities (55%). The items most often described as "not a need" included anger management therapy (53%), mental health treatment (41%), and substance abuse treatment (39%).

Table 11
SELF-REPORTED NEEDS OF ATI COMMUNITY SURVEY RESPONDENTS AT THE TIME OF THEIR MOST RECENT INCARCERATION

	Significant Need	Somewhat of a Need	Not a Need
Employment assistance	58%	16%	26%
Housing navigation	56%	17%	26%
Help paying for basic necessities	55%	21%	25%
Transportation assistance	46%	22%	32%
Medical health care	44%	21%	34%
Help obtaining documentation	43%	21%	36%
Substance abuse treatment	41%	19%	39%
Peer mentorship	40%	28%	32%
Education services	39%	26%	35%
Mental health treatment	36%	23%	41%
Anger management therapy	25%	22%	53%
TOTAL	**339-356**		

NOTE: Percentages based on multiple responses.
SOURCE: SANDAG ATI Community Survey, 2022

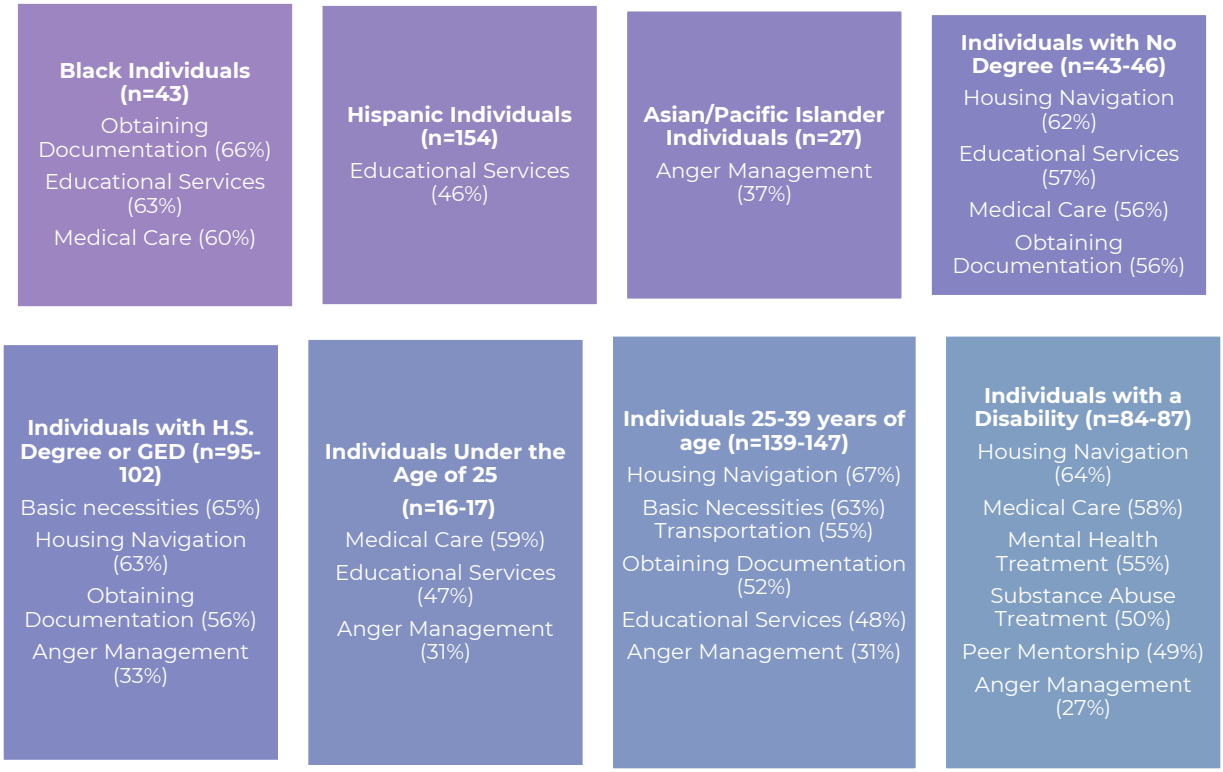
Younger individuals, those who identify as **Black**, and those with a **disability** had the greatest number of needs at the time of incarceration, on average.

Additional analyses were conducted to better understand if the number of needs varied by any individual characteristic and three were found to be significantly related, as Table 12 shows. Specifically, individuals who identified as White, not having a disability, and being 40 years of age and older reported having fewer significant needs and needs overall, compared to other races, those with a disability, and those 39 years of age and younger.

Table 12 MEAN NUMBER OF SIGNIFICANT AND ANY NEED BY INDIVIDUAL CHARACTERSTIC		
	Number of Significant Needs	**Number of Needs at All**
Race*		
White/Caucasian (n=147)	3.8	6.2
Black/African-American (n=47)	5.8	8.1
Asian/Pacific Islander (n=28)	4.8	7.1
Native American (n=6)	5.8	8.5
Other (n=88)	4.5	6.4
Disability*		
Yes (n=92)	5.4	7.8
No (n=265)	4.1	6.2
Age*		
Under 25 (n=17)	4.9	6.4
25 to 39 (n=159)	5.1	7.3
40 and older (n=173)	3.8	6.1
**Significant at p < .05.* *SOURCE: SANDAG ATI Community Survey, 2022*		

While the need for employment services did not vary by an individual's age, race, education level, or having a disability, several other needs did. Figure 8 shows individuals who were significantly more likely to report a need (significant or somewhat) for several types of services. When interpreting this information, it is important to remember that this does not mean that every individual described with this characteristic had this need and that others who do not have this characteristic do not have this need, but rather, this group was more likely to have the need on average. The number of individuals in a particular group could also be relatively small, so generalizations should be made with caution.

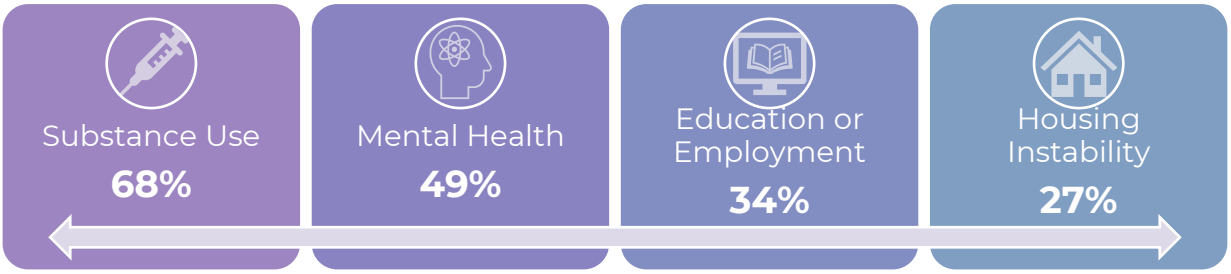
Figure 8
INDIVIDUALS MOST LIKELY TO REPORT A SIGNIFICANT NEED FOR THIS TYPE OF SERVICE*



**Significant at p < .05.*
SOURCE: SANDAG ATI Community Survey, 2022

In addition, just over one-third (34%) of community survey respondents responded affirmatively when asked if anyone in their family had been incarcerated as an adult. When these individuals were asked to describe what underlying needs their family member(s) had that may have contributed to justice system involvement (that could have been addressed with services in the community prior to incarceration), the most common answer was substance use treatment (68%), followed by mental health treatment (49%), education/employment (34%), and housing instability (27%); 15% said they were not aware of any underlying needs (Figure 9). Four percent noted other underlying needs which included a traumatic childhood (7), personal issues (7), discrimination (5), financial troubles (4), medical issues (3), other addictions (1), and victimization (1) (not shown).

Figure 9
FAMILY MEMBERS' PERCEPTION OF INCARCERATED FAMILY MEMBER'S UNDERLYING NEEDS



NOTE: Percentages based on multiple responses.
SOURCE: SANDAG ATI Community Survey, 2022

ATI Service Provider Survey – Adult Clients for Services

Based on a recommendation made by the ATI Advisory Group, SANDAG created and distributed (September 23, 2022, to October 7, 2022) a brief Service Provider survey, which is the seventh source of need data. This survey was distributed through a variety of methods including the Criminal Justice Clearinghouse and ATI email lists, the ATI Advisory Group, ATI Working Group, and the Reentry Roundtable and a total of 55 surveys were returned. One of the four survey questions asked what service providers perceived to be the greatest needs of their adult clients. As seen in Table 13, service providers perceived some of the same needs previously described as the most significant, including housing, mental health treatment, employment, substance use treatment, and transportation. They were also likely to mention the need for case management and advocacy.

Service providers also rated housing, employment, and transportation as top client needs.

Table 13 SERVICE PROVIDERS' PERCEPTION OF THE GREATEST NEEDS OF JUSTICE-INVOLVED ADULTS SEEKING SERVICES			
	Significant Need	**Somewhat of a Need**	**Not a Need**
Housing navigation/affordable housing	87%	13%	0%
Mental health treatment	82%	15%	4%
Employment	74%	19%	7%
Substance abuse treatment	70%	26%	4%
Case management/advocacy	65%	24%	11%
Transportation assistance	63%	33%	4%
Paying for necessities	55%	42%	4%
Obtaining documentation	54%	31%	15%
Education services	49%	40%	11%
Anger management	44%	37%	19%
Peer mentorship	43%	43%	15%
TOTAL	**52-55**		
NOTE: Percentages may not equal 100 due to rounding. *SOURCE: SANDAG, 2022*			

Substance Abuse Monitoring Study

As described in the Initial Interim Report, data from SANDAG's Substance Abuse Monitoring (SAM) study was also a source of need information for this study component. As part of SAM, individuals booked within the past 48 hours are asked to complete an anonymous and confidential interview and also provide a urine sample for drug testing (that cannot be tied back to them).

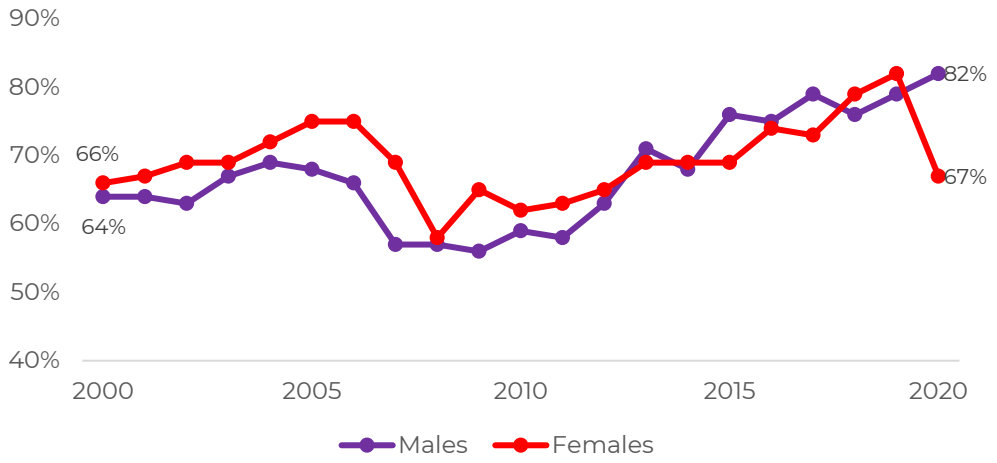
Majority of individuals booked into jail are positive for at least one drug.

As Figure 10 shows, the majority of both male and female arrestees booked into jail test positive for at least one drug (marijuana, methamphetamine (meth), opiates, cocaine/crack, or PCP), with 82% of the sample of adult males booked positive in 2020, up from 79% in 2019, compared to 67% of the adult females (down from 82% in 2019). The most common drug for adult arrestees is meth, with around one in every two adult arrestees positive for it in 2020 (Figure 11).

Additional analyses by the level of the highest booking and type of charge reveals that there is no significant difference in the percent of arrestees positive for any drug in 2020, a pattern that is consistent from prior years (not shown). Specifically, 80% of those booked for a felony in 2020 that were interviewed were positive for any drug, compared to 71% of those booked for a misdemeanor. In addition, as Figure 12 shows, across the type of charge, 72% to 83% of those interviewed in local jails were positive for any drug; these differences were not statistically significant.

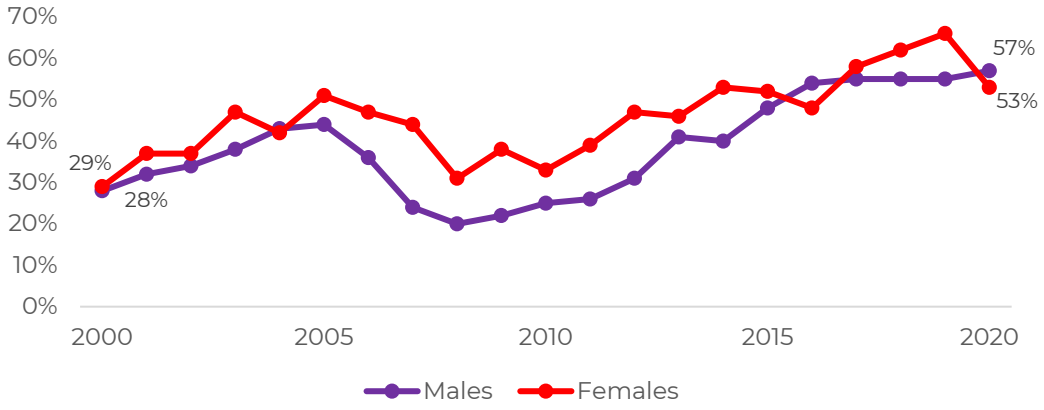
Finally, there was no significant difference in drug use by an individual's race/ethnicity, with the percent positive for any drug varying from 75% to 84% (Figure 13).

Figure 10
PERCENT OF ADULT MALES AND FEMALES POSITIVE FOR ANY DRUG AT BOOKING AS PART OF THE SAM PROJECT



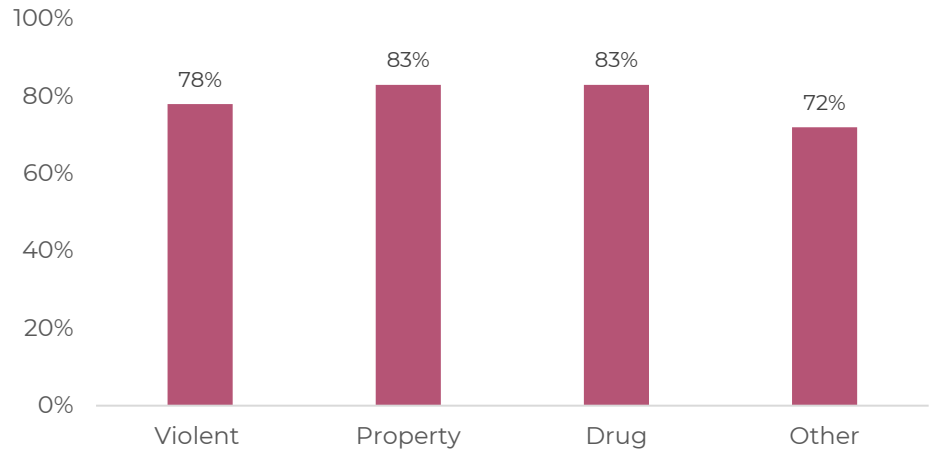
SOURCE: SANDAG

Figure 11
PERCENT OF ADULT MALES AND FEMALES POSITIVE FOR METH AT BOOKING AS PART OF THE SAM PROJECT



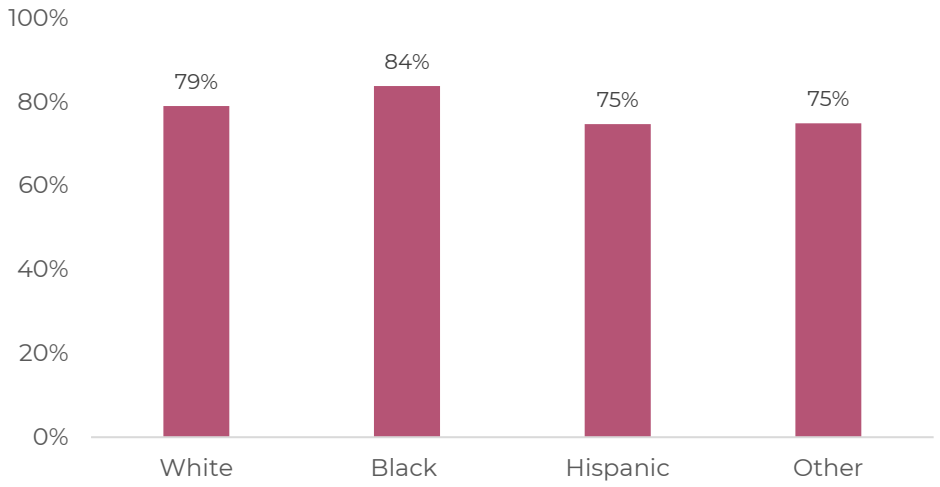
SOURCE: SANDAG

Figure 12
PERCENT OF ADULTS POSITIVE FOR ANY OR MULTIPLE DRUGS AT BOOKING BY TYPE OF HIGHEST CHARGE AS PART OF THE SAM PROJECT, 2020



SOURCE: SANDAG

Figure 13
PERCENT OF ADULTS POSITIVE FOR ANY OR MULTIPLE DRUGS AT BOOKING BY RACE/ETHNICITY AS PART OF THE SAM PROJECT, 2020

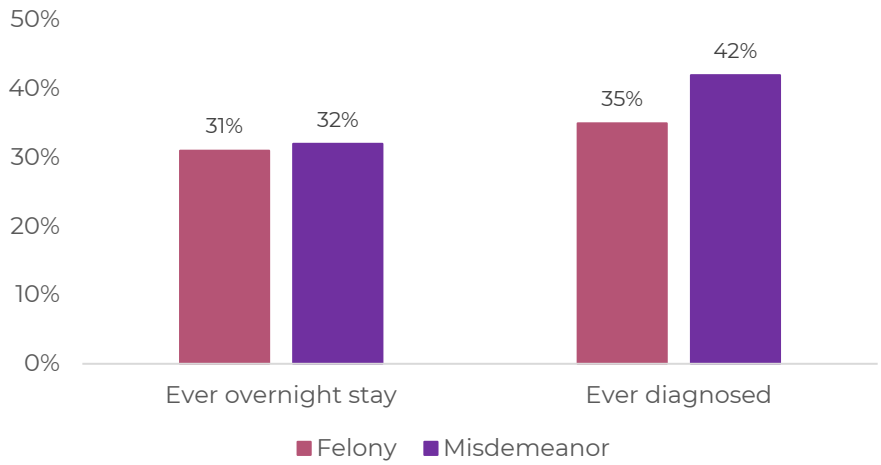


SOURCE: SANDAG

Individuals interviewed as part of the SAM project are asked if they have ever stayed overnight in a mental health facility and if they have ever had a mental health diagnosis. In 2020, around one in three adult arrestees responded affirmatively to these questions (31% had ever stayed overnight and 37% had a mental health diagnosis, overall) (not shown). There was no significant difference in either measure by the level (felony/misdemeanor) of the highest charge (Figure 14), but there was by type of charge for the variable "ever having an overnight stay". Specifically, those with the highest charge for a drug offense were least likely to report this having occurred and those with a violent offense most likely to say it occurred (Figure 15). There was also no significant difference by the individual's race/ethnicity for either mental health indicator (Figure 16).

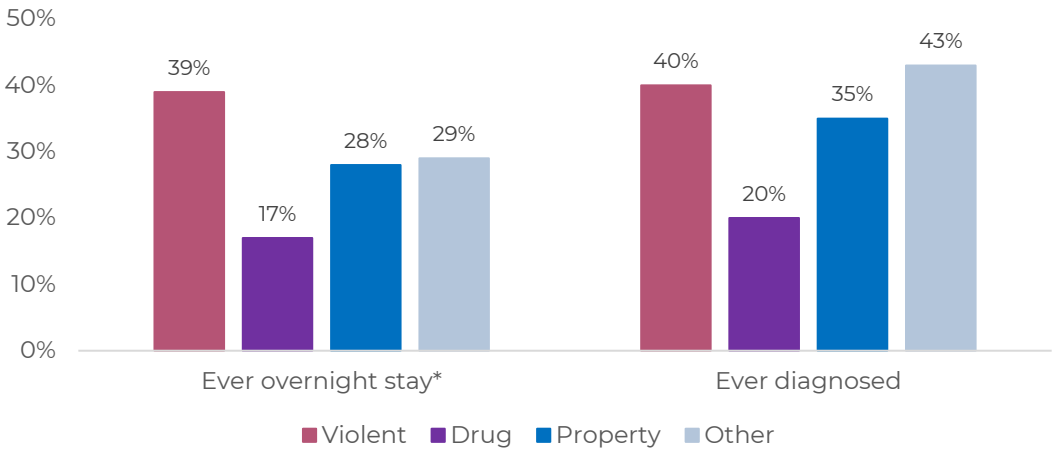
Around **2** in **5** misdemeanants booked into jail in 2020 reported having ever received a mental health diagnosis.

Figure 14
PERCENT OF ADULTS WITH A MENTAL HEALTH HISTORY BY LEVEL OF HIGHEST CHARGE AS PART OF THE SAM PROJECT, 2020



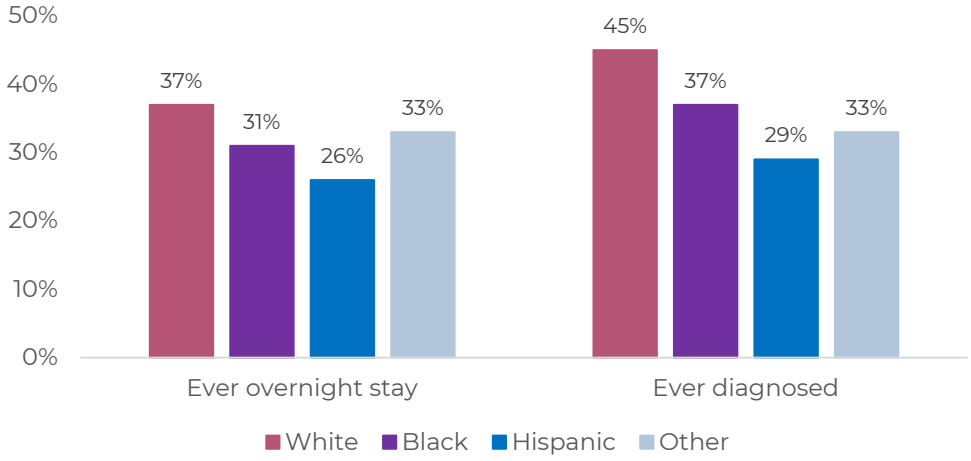
SOURCE: SANDAG

Figure 15
PERCENT OF ADULTS WITH A MENTAL HEALTH HISTORY BY TYPE OF HIGHEST CHARGE, AS PART OF THE SAM PROJECT, 2020



**Significant at p < .05.*
SOURCE: SANDAG

Figure 16
PERCENT OF ADULTS WITH A MENTAL HEALTH HISTORY BY RACE/ETHNICITY, AS PART OF THE SAM PROJECT, 2020



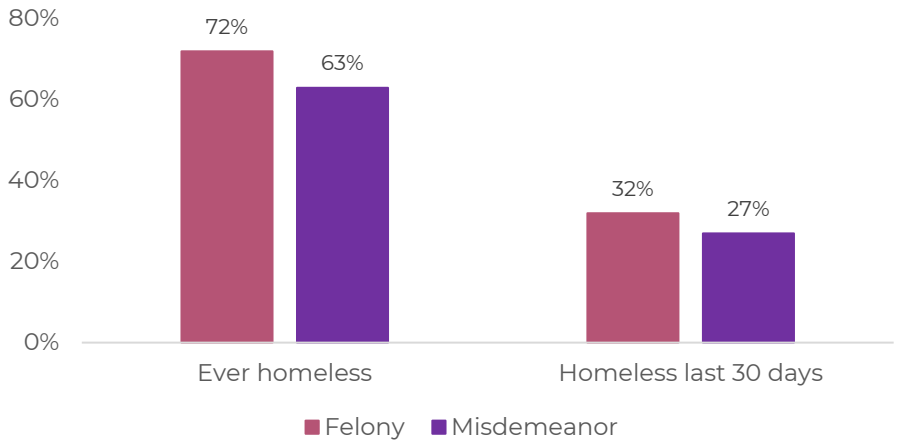
SOURCE: SANDAG

More than **three-fifths** of misdemeanants booked into jail reported ever being homeless in 2020.

Individuals interviewed as part of the SAM project are also asked if they have ever been homeless, as well as if they have been primarily homeless in the past 30 days. Individuals are able to determine for themselves if they would describe themselves as homeless. In 2020, 70% of those interviewed reported having ever been homeless and 31% said they were primarily homeless in the 30 days prior to their arrest (and booking).

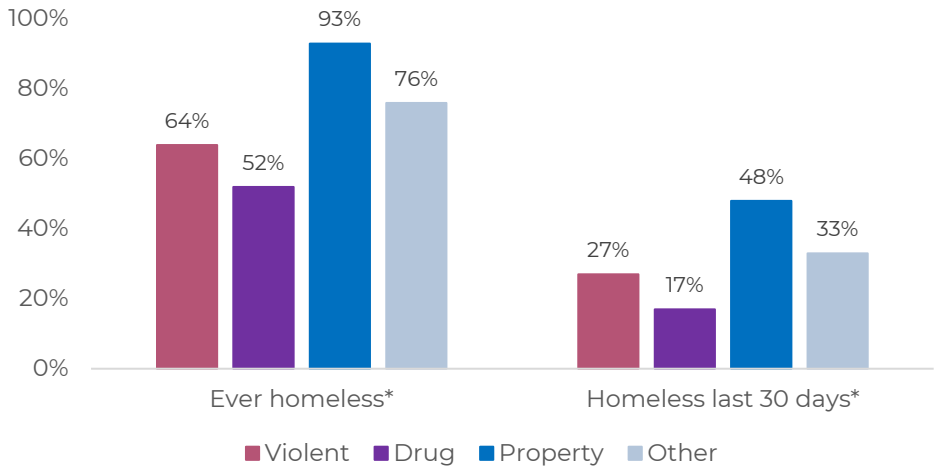
As the following series of figures show, while there was no statistically significant difference by booking charge level or race on either of these variables (Figures 17 and 18), there was by highest booking charge type. Specifically, those booked with a highest charge for a drug offense were the least likely to report ever being homeless and being homeless recently, and those booked for the most serious offense for a property offense were the most likely (Figure 19).

Figure 17
PERCENT OF ADULTS WITH A HISTORY OF HOUSING INSTABILITY BY HIGHEST BOOKING LEVEL, SAM PROJECT, 2020



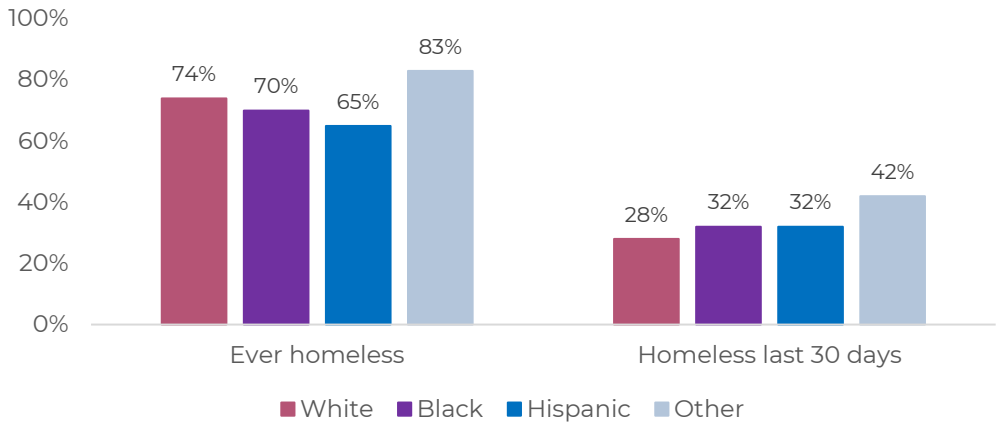
SOURCE: SANDAG

Figure 18
PERCENT OF ADULTS WITH A HISTORY OF HOUSING INSTABILITY BY HIGHEST BOOKING TYPE, SAM PROJECT, 2020



**Significant at p < .05.*
SOURCE: SANDAG

Figure 19
PERCENT OF ADULTS WITH A HISTORY OF HOUSING INSTABILITY BY RACE/ETHNICITY, SAM PROJECT, 2020



SOURCE: SANDAG

Probation Community Resource Directory – Individuals Under Probation Supervision

The Probation Department began developing the Community Resource Directory (CRD) in 2008 to provide a comprehensive resource directory of adult and juvenile services that allows probation officers to be aware of departmentally approved programs to which clients on supervision can be referred. All agencies who have an interest in serving probationers can submit applications to be included in the CRD using an online portal that is available on the Probation Department's website. A data summary regarding the types of referrals made in the CRD for FY 21 and 22 was provided to SANDAG for inclusion in this needs assessment and serves as the final data source.

According to Probation, during this time period, 4,991 referrals were made using the CRD for 2,131 unique adult clients, with 1,188 receiving more than one referral. The most common referrals were made to substance abuse treatment (42%), employment/vocational (18%), and mental health (12%) (Figure 20).

Figure 20
MOST FREQUENT SERVICE REFERRALS MADE TO ADULTS ON PROBATION

SOURCES: San Diego County Probation Department; SANDAG

Services

Following the analysis of needs previously described, the next analysis describes the services that were provided to individuals with needs. A variety of sources (Table 14) were also used to document the services that are available for individuals in San Diego County. For two of these, data were compiled from where referrals were provided (2-1-1 and HSEC), one (Probation's CRD) list of referral sources was provided, and for the final two (Prop 47 and ATI Community Survey), self-reported data on services received was analyzed; data from BHS will be provided for the final report. While the original intention was to focus on County-funded services, the Working Group recommended that all possible services be included to better understand where gaps may exist. When considering this information, it is important to note that this analysis most likely underrepresents services that are available because there are numerous community groups providing services that are not part of the referral networks that were accessed here. In addition, documenting the location of where services are provided was not possible because an entity may have one physical address, but provide services at other locations. Finally, this summary does

not include any analysis regarding the effectiveness of the services or if they are provided with fidelity.

Table 14
SOURCES OF SERVICE DATA IN THE SAN DIEGO REGION FOR THE ATI STUDY

Data Source	Population	Time Period	Data Description
2-1-1	General population that calls 2-1-1	FY 2022	Referrals provided by ZIP code, agency, service type, and total referrals
Department of Homeless Solutions and Equitable Communities	Individuals with housing needs leaving Sheriff's detention facilities	November 2019-April 2022, depending on referral source	De-identified data shared for analysis regarding who received what type of referrals
Behavioral Health Services	Individuals with a justice system referral that received County-funded mental health or substance use treatment	FY 2021	Data to be added for final report
Proposition 47 Evaluation	Low-level offenders served through Proposition 47-funded programs	2017-2021	Self-reported receipt of services
ATI Community Survey	Community Survey respondents who indicated they had been incarcerated	2022	Self-reported receipt of service by self-reported gender, age, race/ethnicity, and ZIP code
Probation Community Resource Directory	Individuals under Probation Supervision	FY 2022	Aggregate data for 72 service providers by type of service

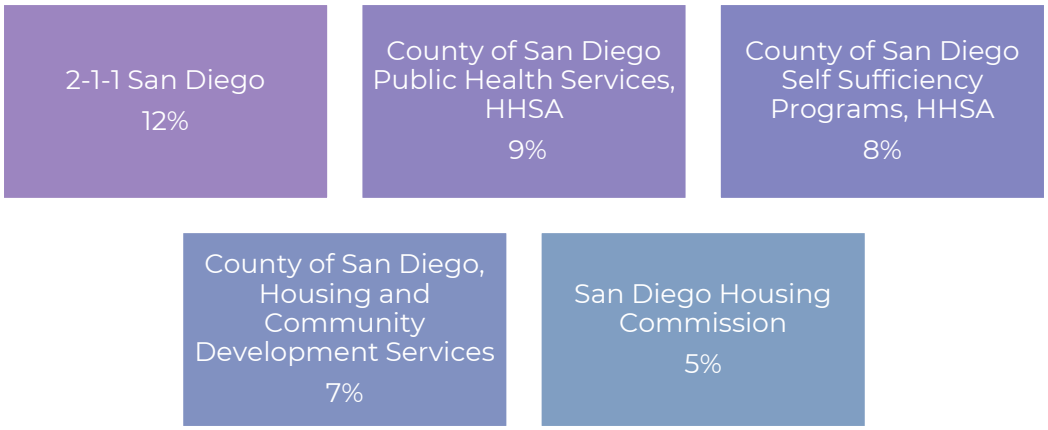
SOURCE: SANDAG

2-1-1 – Referrals and Services

2-1-1 provided data for this analysis that included the number of referrals made, as well as to the number of agencies and for what types of services. Overall, a total of 419,652 referrals were made to the 290,765 clients previously described, which equates to 1.4 referrals per individual. These referrals were provided to 1,179 unique agencies and 4,593 unique services. As Table 15 shows, six of the top eight referrals by service name (that represented 2% or greater of all referrals) related to housing or meeting basic necessities. As Figure 21 shows, the five agencies most often referred to received almost two in every five referrals in FY 22 and three of these were departments within the County of San Diego.

Table 15 TOP EIGHT REFERRALS BY AGENCY AND SERVICE NAME FOR FY 22 2-1-1 CLIENTS	
County of San Diego: COVID-19 Testing Sites	6%
2-1-1 San Diego: CalFresh Enrollment Services	5%
County of San Diego: ACCESS Customer Service Center and Self Service	5%
2-1-1 San Diego: VITA	3%
County of San Diego: Security Deposit Assistance Program	2%
County of San Diego: Housing Resource Directory	2%
San Diego Housing Commission: Housing Stability Assistance Program	2%
San Diego Housing Commission: Affordable Housing Resource Guide	2%
SOURCES: 2-1-1; SANDAG	

Figure 21
TOP FIVE AGENCIES 2-1-1 CLIENTS WERE REFERRED TO IN FY 22



SOURCES: 2-1-1; SANDAG

Department of Homeless Solutions and Equitable Communities – Referrals

In addition to providing assessment data, the Department of Homeless Solutions and Equitable Communities (HSEC) included information on the rate of connection to various services for those receiving C3 services. A majority of those with an assessed mental health need (72%) were successfully connected with mental health services, but the rate of connection with SUDs-related services was significantly lower (46%) (Figure 22). This number could be low for a number of reasons, including the possibility that individuals connected to services were not ready or willing to engage in treatment. However, the data do not include information on successful completion of treatment or on reasons for failed uptake, so this is speculative.

Figure 22

PROPORTION OF HSEC CLIENTS WHO RECEIVED MENTAL HEALTH OR SUBSTANCE USE DISORDER TREATMENT IN FY 21

SOURCES: Department of Homeless Solutions and Equitable Communities; SANDAG

Proposition 47 Evaluation – Receipt of Needed Services

As described in the previous section, SANDAG's evaluation of the County of San Diego's state-funded Prop 47 programs also provides a window into how well the needs of low-level offenders with underlying substance use and/or mental health issues may be met. As Table 16 shows, the majority of CoSRR clients received substance abuse treatment and transportation, while a much smaller percent (34% to 8%) received the other services, including public benefits, which was a need for just under half (49%) of clients.

As Table 17 shows, the Prop 47-funded S.M.A.R.T. program prioritized the provision of substance abuse treatment and transportation, in addition to providing housing. However, fewer than one in three clients were connected to only other highly-rated needs (mental health, public benefits, job skills). These data further indicate that one program cannot meet all of an individual's needs and highlights the importance of collaboration, communication, and warm hand-offs.

Table 16 PERCENT OF COSRR CLIENTS WHO WERE REFERRED OR CONNECTED TO A SERVICE AS PART OF THE PROP 47 EVALUATION			
	Need at Intake	**Referred**	**Connected**
Substance abuse treatment	99%	100%	100%
Transportation	72%	--	67%
Mental health	57%	44%	25%
Public benefits	49%	45%	34%
Job skills	33%	17%	13%
Educational	31%	17%	12%
Medical home	31%	20%	16%
Family support	31%	9%	7%
Vocational	29%	17%	12%
Civil/legal	27%	11%	8%
TOTAL	**248**	**253**	**253**
NOTE: Percentages based on multiple responses. *SOURCE: SANDAG Proposition 47 Final Report*			

Table 17 PERCENT OF S.M.A.R.T. CLIENTS WHO WERE REFERRED OR CONNECTED TO A SERVICE AS PART OF THE PROP 47 EVALUATION			
	Need at Intake	**Referred**	**Connected**
Substance abuse treatment	99%	100%	100%
Transportation	98%	--	100%
Medical home	83%	99%	79%
Mental health	81%	95%	29%
Public benefits	75%	48%	25%
Job skills	46%	26%	9%
Vocational	32%	25%	4%
Civil/legal	32%	2%	4%
Family support	21%	3%	1%
Educational	15%	4%	5%
TOTAL	**98-127**	**135**	**135**
NOTE: Percentages based on multiple responses. *SOURCE: SANDAG Proposition 47 Final Report*			

ATI Community Survey – Receipt of Needed Services

As part of the ATI Community Survey, previously/currently incarcerated individuals were also asked if they had received any of these types of services while they were incarcerated, in the community, or both. Table 18 presents an analysis of what percent of individuals received a service (regardless of where) by whether they had indicated a significant need, somewhat of a need, or that it was not a need at all. Some notable results from this analysis include:

- The two services with the greatest number of individuals indicating a significant need – employment assistance and housing navigation – were received by the smallest percentage of individuals (35% and 27% respectively).

- Help paying for basic necessities was the third most frequently cited significant need and was received by only 39% of individuals.

- The service most often provided to those with a significant need was substance abuse treatment, and this was still only received by just under three in every five individuals (59%).

Services to meet the two most common needs (employment assistance and housing navigation) were received by around **one-third or fewer** of survey respondents.

- Between 11% and 27% of individuals who said they did not have a need for a service indicated they had received it anyway. This could represent a misalignment in service delivery where an individual's needs are not taken into consideration to the degree they could be, or alternatively, that individuals have needs they are not aware of.

- To better understand where services were provided, Table 19 presents the percent of individuals who reported they received a particular service in custody or the community. It should be noted that individuals could have said they received services in both. As this table shows, with the exception of educational services and anger management therapy, individuals were more likely to report they received a particular service in the community, as opposed to in custody. Of those clients who reported receiving a service, between 32% and 70% reported receiving it in custody, while 59% to 83% reported receiving it in the community.

When asked to describe how helpful the service they received was, the greatest percentage described the peer mentorship and help obtaining documentation as "very helpful" (Table 20). Employment assistance, which was one of the top five identified needs was "very helpful" to almost three in five (57%) but was also among the five rated by 16% to 17% (the greatest percentages) as being "not very helpful." The other four services rated as "not very helpful" included substance abuse treatment, transportation assistance (also a top five need), education services, and anger management.

Table 18
PERCENT OF SURVEY RESPONDENTS WHO RECEIVED A SERVICE BY THEIR SELF-REPORTED LEVEL OF NEED*

	Significant Need	Somewhat of a Need	Not a Need
	(Number in parentheses represents the number that indicated that need)		
Substance abuse treatment	59% (142)	60% (63)	25% (135)
Medical health care	58% (150)	54% (72)	27% (119)
Mental health treatment	52% (117)	51% (75)	14% (140)
Help obtaining documentation	48% (139)	45% (65)	16% (121)
Education services	44% (135)	46% (90)	22% (118)
Transportation assistance	34% (158)	35% (75)	14% (109)
Help paying for necessities	39% (189)	37% (71)	18% (87)
Peer mentorship	38% (133)	29% (96)	14% (108)
Anger management therapy	37% (82)	38% (72)	13% (180)
Employment assistance	35% (203)	36% (56)	15% (89)
Housing navigation	27% (196)	37% (60)	11% (92)

**Significant at p < .05.*
NOTE: Percentages based on multiple responses.
SOURCE: SANDAG ATI Community Survey, 2022

Table 19
WHERE INDIVIDUALS RECEIVED SERVICES

	Custody	Community
	(Number in parentheses represents the number that indicated that received the service)	
Educational services (131)	70%	59%
Anger management therapy (85)	66%	59%
Mental health treatment (125)	60%	70%
Medical care (167)	59%	71%
Housing navigation (87)	56%	69%
Substance abuse treatment (164)	54%	74%
Peer mentorship (98)	54%	70%
Employment assistance (107)	44%	76%
Help obtaining documentation (119)	45%	70%
Transportation assistance (99)	40%	80%
Help paying for necessities (121)	32%	83%

SOURCE: SANDAG ATI Community Survey, 2022

Table 20 HOW HELPFUL SERVICES RECEIVED WERE			
	Very Helpful	**Somewhat Helpful**	**Not Very Helpful**
Peer mentorship	64%	27%	9%
Help obtaining documentation	60%	32%	8%
Medical health care	57%	36%	7%
Employment assistance	57%	27%	16%
Help paying for necessities	56%	34%	10%
Substance abuse treatment	55%	30%	16%
Transportation assistance	53%	31%	17%
Housing navigation	51%	37%	12%
Mental health treatment	50%	37%	13%
Education services	50%	34%	16%
Anger management therapy	44%	40%	16%
TOTAL	**81-161**		
SOURCE: SANDAG ATI Community Survey, 2022			

Probation Community Resource Directory – Service Provider List

The final data source regarding service availability comes from Probation's CRD, which was previously described in the needs section. As of August 23, 2022, there were 72 providers that serve adult clients registered in the CRD. According to Probation, 69% of these identified at least one program serving clients in the Central region, 60% in the South region, 58% in North Inland, 56% in North Coastal, and 54% in the East region.

As Table 21 shows, providers in the CRD identified 24 program service areas, with the most common being substance abuse treatment, housing, and counseling. It is interesting to note how small many of these percentages are, and also that many of the needs most often mentioned, including help obtaining basic necessities, are not provided by most providers. When interpreting this information, it is important to note that these service categories are self-identified and do not indicate capacity levels.

Table 21 PROGRAM SERVICES FOR ADULT CLIENTS IN PROBATION'S CRD	
Substance abuse treatment	17%
Housing	11%
Counseling	9%
Other	7%
Employment/vocational	7%
Parenting	6%
Mental health	6%
Anger management	5%
Domestic violence	5%
Sex offenses	4%
Education	4%
Child abuse	3%
Driving under the influence	3%
Mentoring	3%
Crime prevention	2%
Health	1%
Life skills	1%
Self-help	1%
Traffic	1%
Reconciliation and restoration	1%
Financial/income	1%
Victim assistance	1%
Stalking	1%
Substance abuse education	1%
SOURCES: San Diego County Probation Department; SANDAG	

Gaps and Barriers

Three sources of information were used to identify gaps and barriers to receiving services – the ATI Community Survey, ATI Community Forums, and ATI Service Provider Survey.

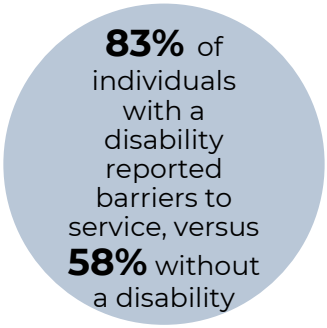
ATI Community Survey

As part of the community survey, individuals who had previously been or were currently incarcerated were asked if there had been any barriers to receiving services they had sought in the community and almost two-thirds (65%) responded affirmatively. Additional analyses revealed that respondents' age, primary language spoken, gender, and race/ethnicity were not significantly correlated with experiencing barriers, but having a disability was, as Figure 23 shows.

When further probed regarding what barriers to receiving services they faced, the three most common reasons (Figure 24) included that the service was not easy to get to, that it was too hard to find out about what services were available, and that

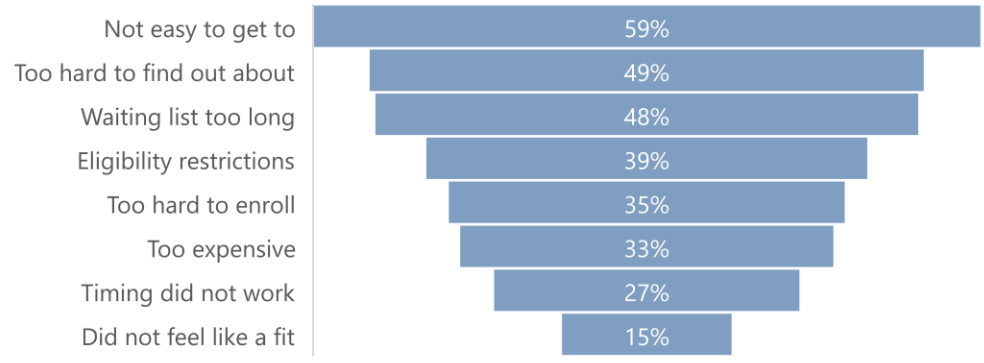
the waiting list was too long. Others also noted that there were restrictions for who the service would take, it was too hard to enroll, it was too expensive, the timing or availability did not work for the individual, and it didn't feel like the right fit for the individual. Other responses not included in the list of possible barriers were noted by 17 individuals (9%) and included other logistical issues (9), lack of mentorship or follow-up (5), the perception of bias on the part of the program (2), and substance use (1) (not shown).

Figure 23
INDIVIDUALS WITH A DISABILITY MORE LIKELY TO REPORT BARRIERS TO RECEIVING SERVICES IN THE COMMUNITY*



**Significant at p < .05.*
NOTE: Seventy individuals with a disability answered the question about barriers, as did 187 without a disability.
SOURCE: SANDAG ATI Community Survey, 2022

Figure 24
BARRIERS TO RECEIVING SERVICES IN THE COMMUNITY



NOTE: Percentages based on multiple responses.
SOURCE: SANDAG ATI Community Survey, 2022

Additional analyses were conducted to determine if any needs were significant predictors of a particular barrier being noted. As Figure 24 shows, services not being easy to get to was the most frequently reported barrier. The accessibility of services was reported as a barrier by individuals in eight of the eleven possible needs, with the only needs not associated with this barrier being housing navigation, substance abuse treatment, and mental health services. Those with a self-reported need for housing navigation were significantly more likely to report program eligibility criteria as a barrier, as well as long wait lists. Those with a self-reported need for mental health treatment were significantly more likely to report that it was too expensive or too hard to find out about. Finally, cost and timing were cited as barriers to medical health care, difficulty finding out about services was cited as a barrier for paying for basic necessities and long waiting lists were cited as a barrier for employment assistance.

The most common barrier for most service needs is being **difficult to get to**.

ATI Community Forums

Four virtual ATI Community Forums were held via ZOOM between June 23, 2022, and July 7, 2022. These forums were recorded (in English for all four and in Spanish for all but the first) and are available on the SANDAG website. An estimated 145 individuals attended these forums, not including SANDAG staff. Over half of the forum discussion related in some way to gaps and barriers to receiving support services before, during, and after incarceration, especially about availability and efficacy. A good amount of the discussions was also focused on structural concerns regarding behavioral health and other services, as well as limited funding and resources. A common sentiment that was expressed was that improved resources, communication, and innovation could effectively and safely reduce the incarcerated population. Some of the opinions shared regarding service provision included:

- Programs such as Mobile Crisis Response Teams (MCRT) are promising, but under-resourced;
- Waitlists are too long;
- Services need to be tailored to meet an individual's need and staff need to be effectively trained to provide these services;
- Services are fragmented, rather than connected or offered in a continuum, and there is a need for more supportive hand-offs and better communication between providers;
- Service providers should be better paid to ensure their retention;
- The County should consider offering individuals in need incentives to engage in behavioral health treatment;
- The provision of housing and vocational skills training is essential;
- There is a need to conduct behavioral health assessments at the time of incarceration; and

- There is a need to provide more services during incarceration, including peer support and vocational support.

Figure 25
SELF-REPORTED NEEDS MOST OFTEN ASSOCIATED WITH A PERCEIVED BARRIER TO RECEIVING COMMUNITY SERVICES

SOURCE: SANDAG ATI Community Survey, 2022

ATI Service Provider Survey

Service providers surveyed as part of this project were asked their perception of the greatest barriers for adult clients seeking services, as well as the greatest barriers that the service providers themselves may face. As Table 22 shows, service providers, similar to community members surveyed who reported a history of incarceration, most often cited long waiting lists and services not being available when needed. They also were more likely to say that the timing of the service did not work, compared to those who were formerly incarcerated, but less likely to say it was hard to find out about the programming.

Table 22
SERVICE PROVIDERS PERCEPTION OF THE GREATEST BARRIERS TO THE JUSTICE-INVOLVED POPULATION RECEIVING SERVICES

	Significant Barrier	Somewhat of a Barrier	Not a Barrier
Long waitlists	64%	32%	4%
Services aren't available when needed	60%	25%	15%
Transportation assistance	59%	34%	8%
Too expensive	49%	23%	28%
Eligibility restrictions	31%	50%	19%
Unaware of available services	26%	56%	19%
Difficulty enrolling	26%	57%	18%
Lack necessities needed for stable enrollment	14%	2%	84%
TOTAL	**50-54**		

NOTE: Percentages may not equal 100 due to rounding.
SOURCE: SANDAG

In another question, service providers were asked to identify what barriers service providers themselves may face that limit their ability to meet the needs of clients. As Table 23 shows, the greatest barriers pertained to staffing and funding, including retaining and hiring staff, and obtaining reliable funding that does not include restrictions or complex contracting requirements. Mention was also made regarding coordination across service providers, including data sharing and warm hand-offs.

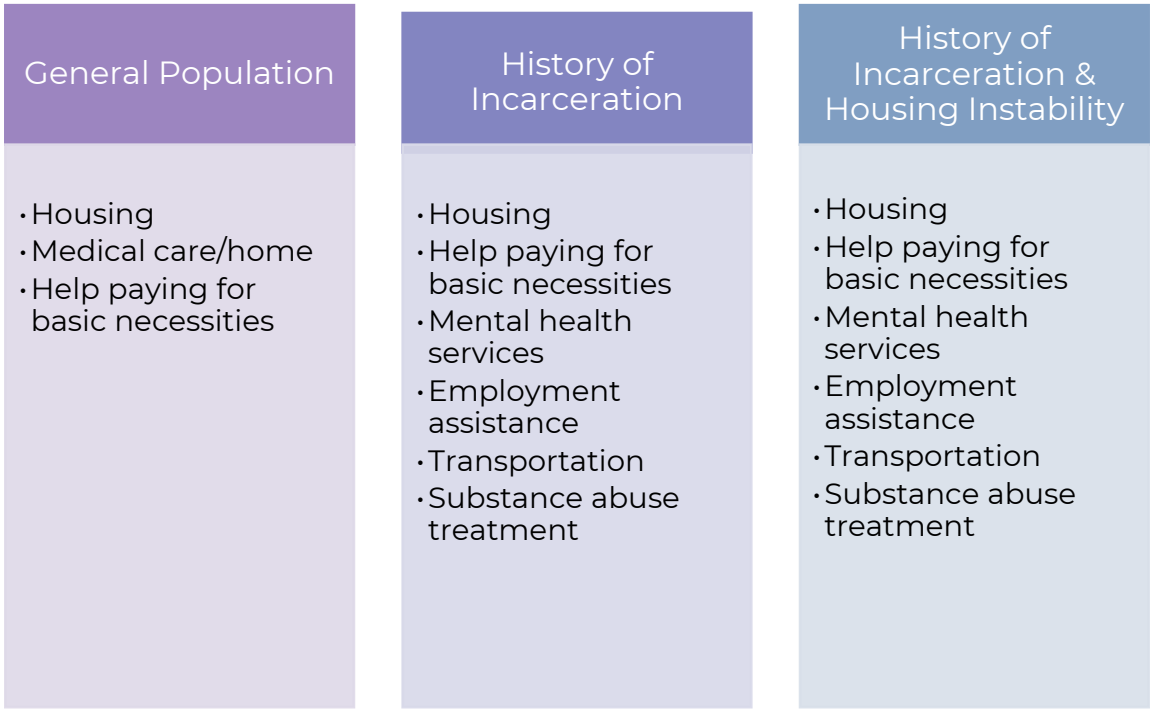
Table 23 SERVICE PROVIDERS PERCEPTION OF THEIR GREATEST INTERNAL BARRIERS			
	Significant Barrier	**Somewhat of a Barrier**	**Not a Barrier**
Retaining staff	55%	29%	16%
Hiring staff	47%	33%	20%
Obtaining reliable funding	46%	34%	20%
Restrictions on funding use	44%	42%	15%
Contract requirements for funding	41%	39%	20%
Long waitlists	39%	37%	25%
Reporting requirements from funders	27%	47%	27%
Inability to do warm hand-offs	24%	41%	35%
Unrealistic funding outcome measures	22%	42%	36%
Inadequate information from referrals	19%	48%	33%
Retaining clients	17%	46%	37%
Receiving client referrals	15%	43%	42%
Inability to access client data	14%	41%	45%
Engaging clients	11%	51%	38%
Workload management	7%	0%	93%
TOTAL	**45-53**		
NOTE: Percentages may not equal 100 due to rounding. *SOURCE: SANDAG*			

Take Aways

As Figure 26 shows, a variety of different needs were reported across the population groups that were considered, from the general population to those under probation supervision. Some of the most common include housing, transportation, ability to pay for basic necessities, and medical care. Other often reported needs relate to training and assistance to obtain employment and address underlying issues that may make employment challenging, including mental health and substance use issues.

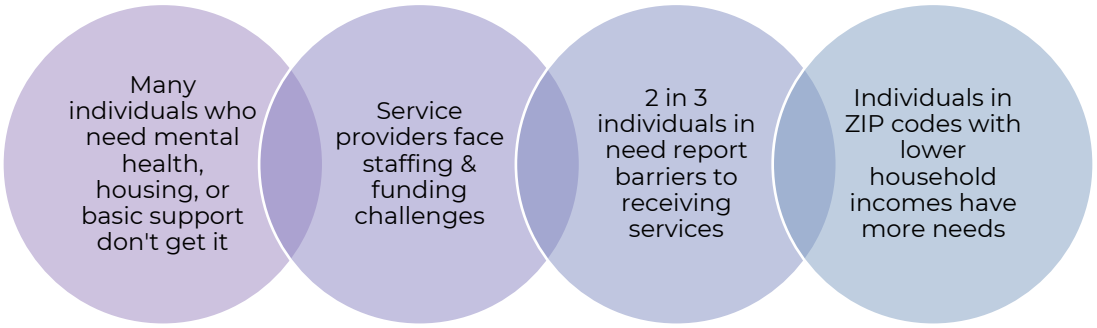
In terms of how well the needs of at-risk individuals are being met, it appears that while there are over 1,000 service providers in the County, there is definitely room for improvement, as reflected by the fact that across datasets, sizeable proportions appeared to not receive needed services and the majority of individuals with a history of incarceration reported facing barriers to receiving services (Figure 27). Every individual is unique and one agency cannot meet all of an individual's needs, from addressing past trauma, meeting basic needs, and helping to heal addictions. Service providers have their own challenges in terms of staffing and funding and multiple barriers for clients exist, which are more challenging for some than others. With the role the County plays in terms of connecting individuals to services, it has the opportunity to strengthen connections and information sharing to facilitate service provision across different populations.

Figure 26
SUMMARY OF NEEDS OF SAN DIEGO COUNTY RESIDENTS



NOTE: General population data from 2-1-1; History of Incarceration data from CARE Center, ATI Community Survey, BHS, ATI Service Provider Survey, CRD, and the SAM program; History of Incarceration and Housing Instability from HSEC and Prop 47 evaluation.
SOURCE: SANDAG

Figure 27
SUMMARY OF SERVICE GAPS AND BARRIERS FOR THOSE AT RISK OF INCARCERATION



SOURCE: SANDAG

While the final report for this project will provide more detailed recommendations based on the entirety of the analyses conducted for this effort, the following are put forth now for initial consideration.

- While the location of services is important, other factors are important to ensure accessibility, including reliable transportation, hours of operation, and difficulties that may exist related to enrollment. The importance of ensuring warm hand-offs and case management and advocacy cannot be underestimated. This is especially true for those who may have physical or mental disabilities and other factors that may be barriers to accessing services.

- No one agency can meet all of an individual's needs. The importance of strong collaboration, communication, sharing of data/information, and warm hand-offs cannot be emphasized enough. The County is in a unique position to facilitate the sharing of client information, case management, and warm hand-offs between agencies to support a strong network of care that can effectively engage clients.

- The greatest need for services appears to be in those areas that also have the lowest median income (e.g., Central, South, and East San Diego County). Focus should be placed on ensuring needed services are located where individuals live and are easy to access.

- Being able to be self-sufficient is an important goal, and one that is dependent on being able to earn a livable wage. As such, the importance of job training and other assistance in this area cannot be underestimated.

- Providing culturally competent services and utilizing peer mentors is important to facilitate engagement, especially when Black and Hispanic individuals are overrepresented among the population of formerly incarcerated, compared to their proportion of the San Diego County population.

Best Practice Literature Review

What has been found to be successful in terms of reducing the incarcerated population and addressing their underlying needs? What services and programs have been identified as best-practice or promising in reducing criminal justice involvement? What strategies are most effective for engaging clients who are resistant to services? What effective programs or practices in San Diego County can be expanded or started to support alternatives to incarceration? (SOW 3.7.1, 3.7.2, 3.7.3, 3.7.7, and 3.7.8)

There is a wealth of research addressing what works and what doesn't in reducing justice system involvement. This research has shaped a collective understanding of best practices for achieving outcomes of reduced recidivism and justice system contact. In the context of alternatives to incarceration, there are several lessons and best practices that should be considered to help frame the discussion of how to advance alternatives to incarceration within San Diego County. Seeing what has worked elsewhere and why it has worked is paramount to designing and implementing similar programs that will both reduce system involvement for low-level offenders and advance equity for vulnerable populations while also improving public safety.

This section provides a review of evidence-based best practices for reducing the size of the incarcerated population and addressing unmet needs that could lead to system involvement (SOW 3.7.1, 3.7.2, 3.7.3, 3.7.7, 3.7.8). As a part of this effort, the following points are addressed by incorporating evidence from peer-reviewed and policy-based research on best practices:

- What types of services, programs, and general approaches have been identified as best practices in reducing criminal justice system involvement and recidivism?
- What are effective strategies for increasing uptake of services among individuals resistant to participation?
- What are effective programs and services within San Diego County that might be expanded or initiated to support and advance alternatives to incarceration in accordance with best practices?

Although the review of relevant literature and evidence has been as comprehensive as possible, this is not an exhaustive accounting of all best practices, and there will likely be more best practices generated or existing best practices modified as additional evidence is gathered. However, the best practices highlighted here provide a representation of what is currently considered by experts and practitioners to be best practice in alternatives to incarceration that are supported by evidence and data.

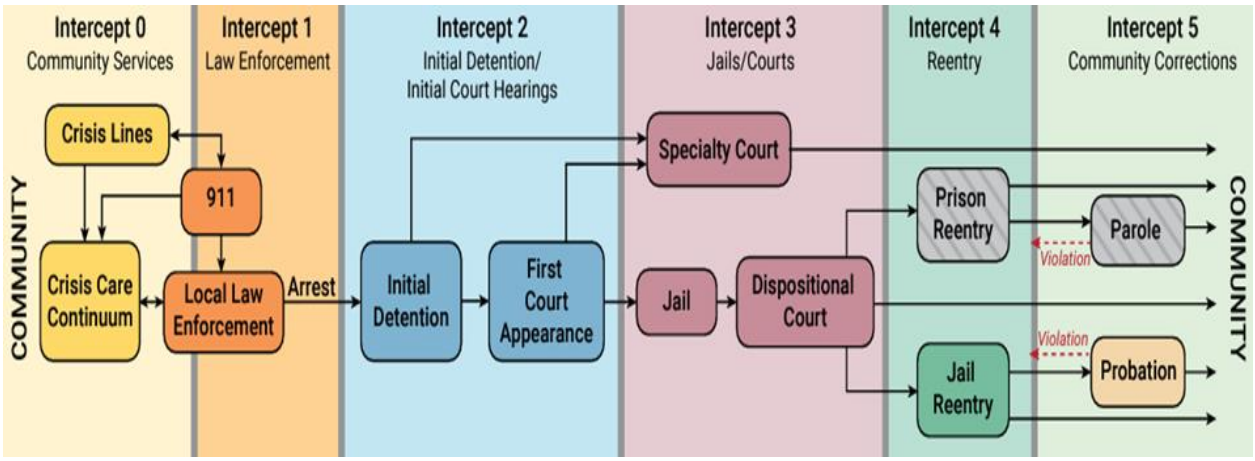
Best Practices and the Sequential Intercept Model

Available evidence on best practices is examined through the prism of the Sequential Intercept Model. The Sequential Intercept Model (SIM) is a conceptual roadmap that situates different potential needs-based interventions along multiple intercepts, or points at which an individual may either come into contact with the justice system or become further involved in the system after initial contact with law enforcement. Initially developed by public health experts to address the criminalization of individuals suffering from mental illness and potential interventions that could be made as an alternative to justice system contact, the SIM has been adapted to consider alternatives to incarceration for people with other unaddressed criminogenic needs, including substance abuse disorders and housing instability. The SIM outlines six distinct points of interception along a continuum from preemptive community services to post-reentry community corrections, with different programs and services situated at each intercept to address needs of individuals at that stage (Munetz & Griffin, 2006). The SIM is a helpful framework for considering whether existing programs need to be expanded or redesigned or if new programs need to be implemented.[11]

Best practices are organized by which intercept such practices fall under. Where applicable, existing services and programs in San Diego County that follow these best practices are highlighted. In highlighting potential examples of these best practices in the County, SANDAG is not endorsing the program; rather, it is meant to illustrate what certain best practices can look like in a program-specific context.

Figure 28
THE SEQUENTIAL INTERCEPT MODEL

[11] SANDAG acknowledges and seeks to build upon the extensive sequential intercept mapping, recommendations, and ongoing work undertaken by the Office of the District Attorney to address mental health and homelessness within San Diego County. SDCDA's first report from February 2019 outlines the work of local stakeholders in mapping the intersection between housing instability, mental health, and substance use among the county's justice-involved population, and includes a set of recommendations which have begun to be addressed since the report's publication. A follow-up report published by SDCDA in March 2022 focuses specifically on homelessness, outlining a three-point plan to address housing instability as it relates to the criminal justice system and justice-involved population.



Source: SAMHSA

Methodology and Selection Criteria

To identify best practices[12] that constitute successful alternatives to incarceration and are backed by evidence, an extensive review of the academic and policy literature on alternatives to incarceration was conducted. Academic sources consulted included peer-reviewed journals focused on research relevant to criminal justice and behavior, as well as public health and public policy.[13] Relevant policy research conducted by think tanks such as the RAND Corporation, UrbanLabs, and the Vera Institute for Justice was also reviewed. Additionally, 120 practices and programs associated with those practices evaluated by the National Institute of Justice as being either "promising" or "effective" based on evidence from meta-analyses were reviewed. The Alternatives to Incarceration (ATI) Advisory and Working Groups also provided feedback and input regarding best practices and some of their suggestions have been incorporated here. Due to the broad scope addressed by this research and in recognition that not all best practices cited in the literature can be evaluated, practices that meet the following criteria are highlighted:

- The intention and effect of the practice is to reduce system involvement, whether through diversion at the point of first system contact or through reduced recidivism; and

[12] As a note on terminology, this report considers a best practice to be a general approach or type of programming aimed at achieving a specific goal—for example, increasing access to crisis diversion options at intercepts 0-1 would be a practice. Programs are specific applications of practices—for example, San Diego's Mobile Crisis Response Teams (MCRTs) would be a program that would fall under the aforementioned practice.
[13] Examples of journals searched in the course of this research include the *Journal of Criminal Justice, Criminology and Public Policy, Criminology and Behavior,* and the *American Journal of Public Health.*

- The practice addresses unmet criminogenic needs.

Best practices are outlined along the intercept model. Prior to discussing these best practices, main goals are outlined at each intercept. The discussion of each best practice highlighted includes existing literature and evidence supporting its efficacy, as well as the goals of and populations targeted by each practice. Programs currently operating in San Diego County that exemplify these best practices that the authors are aware of at the time of writing are highlighted. Where these do not exist, examples from outside of San Diego County are provided. A summary table outlining the main practices and associated programs is provided at the end of this section, with links to program pages included where available. Please note that programs listed in this table are examples, rather than an exhaustive list of all available programs.

The Six Key Criminogenic Needs

1. Substance use
2. Antisocial cognition
3. Antisocial associates
4. Family and marital relations
5. Employment
6. Leisure and recreational activity

In thinking about best practices as they are located along the SIM, it is helpful to apply knowledge on more general best practices regarding program design based on evidence from the literature. This is especially true in thinking about programs and service models that target criminogenic needs. A wealth of research has shown that the effectiveness of correctional treatment programs can be directly linked to the number of criminogenic needs that they address, relative to non-criminogenic needs such as underlying mental illness or self-esteem issues (Andrews & Bonta, 1998; Andrews et al., 1990; Lowenkamp, Latessa, & Smith, 2006). In their influential study, Andrews and Bonta identified the following six needs as the most important in reducing criminal offenses: substance use, antisocial cognition, antisocial associates, family and marital relations, employment, and leisure and recreational activity. Their study focused on probationers who were treated with an intervention over the course of 12 months and found that there were significant reductions in offending for those who received interventions that 1) reduced their interactions with criminally-involved family members, 2) improved work performance, and 3) reduced alcohol use. Programs that addressed these needs (antisocial associates, employment, and substance use) were the most markedly effective in reducing recidivism (Andrews & Bonta, 1998). Though conducted twenty years ago, these findings have been replicated in other studies and have led to a general consensus in the field regarding which needs are most likely to lead to criminal activity.

The identification of criminogenic needs facilitated the development of the risk-need-responsivity model, a framework for identifying high-risk offenders based on criminogenic needs in a way that directly addresses these needs (Latessa et al., 2020). According to this model, the most effective treatments at rehabilitating offenders target multiple criminogenic needs simultaneously. A meta-analysis of studies that evaluated multiple programs aimed at reducing recidivism found that interventions targeting four to six criminogenic needs had a strong effect on reducing recidivism rates, while interventions targeting only one to three of those needs resulted in a minor increase in recidivism rates (Gendreau et al., 2002). In addition to ensuring that programs identify the correct people and the correct needs, it is also important to ensure fidelity to the program model—how well an intervention targets offenders matters greatly in determining its effectiveness.[14]

Table 24 provides a summary of the best practices reviewed for this report, as well as examples of programs that fall under that best practice. This table is not comprehensive, but rather gives an overview of the breadth of approaches to alternatives to incarceration reviewed.

The Importance of Fidelity in Program Implementation

Fidelity to the program model in design and implementation is of the utmost importance in ensuring that the goals of the intervention are met. In this context, fidelity refers to the extent to which a program's key components are implemented as they were intended. There is a large body of research that shows that well-designed programs that are not implemented with fidelity—or that deviate from their design during program delivery—are less likely to achieve their intended effects (Fixsen, 2005). In thinking about best practices in alternatives to incarceration, ensuring program fidelity is key to ensuring that these alternatives are effective in reducing recidivism and in rehabilitating former offenders in the longer term. Process and impact evaluation are necessary tools to ensure that programs are consistently implemented with fidelity to their original design.

Intercepts 0-1: Community Services and Law Enforcement

Intercepts 0 and 1 within the SIM apply to individuals up to and including their first contact with law enforcement, but prior to initial booking into jail.

[14] Some methods of conducting risk and needs assessments have been criticized for their potential to introduce and perpetuate racial bias in scoring an individual's risk level, especially those tools that rely on computerized methods and algorithms to calculate a risk score (Raynor and Lewis 2011, DiBenedetto 2019). With this in mind, it is important to ensure that tools intended to help rehabilitate individuals with criminal histories do not create more harm by providing racially-biased assessments that are then used to create treatment plans or determine sentencing outcomes.

Alternatives to incarceration at Intercepts 0-1 should address unmet needs in the community while reducing unnecessary justice system and law enforcement contact.

Intercept 0 within the SIM encompasses programs and services provided to individuals who are at increased risk of system involvement. Successful programs administered at this intercept would both address unmet needs for the at-risk individual while also preventing unnecessary initial contact with the justice system. Programs and services at this level—for example, crisis response teams—are therefore primarily community-based and attempt to divert individuals with certain unmet needs from moving further along the continuum of system involvement. In short, these services are primarily geared towards preventing initial justice system contact by addressing needs *before* a crime has been committed. There is a growing body of evidence that non-law enforcement interventions for at-risk populations can address underlying criminogenic needs of individuals in crisis, while also reducing crime and arrest rates (Dee & Pyne, 2022). When designed and implemented properly, programs that divert at-risk individuals to needed services who might otherwise have encountered law enforcement can be highly effective in preventing these individuals from becoming unnecessarily involved with the criminal justice system.

Table 24
SUMMARY OF BEST PRACTICES AND EXAMPLE PROGRAMS REVIEWED BY SEQUENTIAL MODEL INTERCEPTS

Best Practices	Example Programs	Local Programs
Intercept 0-1		
Community-level crisis response and diversion	STAR CAHOOTS	Mobile Crisis Response Teams (MCRT)
Law enforcement-assisted crisis response and diversion	LEAD Pinellas SafeHarbor PAD	Psychiatric Emergency Response Team (PERT)
Alternative treatment options for substance use offenders	Sobering services centers (Houston Recovery Center) Narcotics Arrest Diversion Program	McAlister Institute Inebriate Reception Center PC1000

Intercept 2-3		
Behavioral interventions to reduce failure to appear	North Carolina Court Appearance Project	
Collaborative courts	Drug Court (STOP Drug Court) DUI Court Transitional-age youth courts	Drug Court Homeless Court Behavioral Health Court Veterans Court
Correctional therapeutic communities	Incarceration-based therapeutic communities	Amity In-Prison Therapeutic Community Veterans Moving Forward
Educational and vocational programs	Inside Out Prison Exchange Program Goucher Prison Education Partnership	
Intercept 4-5		
Comprehensive Reentry Services	Allegheny County Jail-Based Reentry Specialist Program Anti-Recidivism Coalition	Second Chance
Warm hand-offs to post-release services	Project Kinship	
Wraparound healthcare services	CHIOC Transitions Clinics	SD Transitions Clinics (La Maestra Community Health Centers and Family Health Centers of San Diego)
SOURCE: SANDAG		

Intercept 1 within the SIM encompasses programs and services provided to individuals at the point of first contact with law enforcement. Programs and services at this level generally involve community-based organizations and public-private partnerships but are often offered in tandem with law enforcement response. For low-level offenders who do not otherwise pose an imminent threat to public safety and who would benefit from receiving needed services, diversion through services at intercepts 0-1 may not only rehabilitate them by addressing unmet needs but may also prevent further justice system or law enforcement contact by addressing potentially criminogenic tendencies before they lead to additional or more serious criminal behavior. In addition to the rehabilitative and public safety benefits of these practices, cost savings may also be realized: economic analysis has shown that every dollar spent on treatment reduces criminal justice costs by seven dollars (Etner et al. 2006).

Following is a discussion of best practices and programs that have shown promise in diverting nonviolent low-level offenders from incarceration while also linking at-risk individuals with needed services.

Community-level Crisis Response and Diversion

Individuals experiencing an acute crisis, such as a mental health emergency or substance use issue, are frequently referred to and intercepted by law enforcement. There is evidence that local law enforcement nationwide spend a disproportionate amount of time responding to these low-priority calls, draining substantial time and resources away from higher-priority calls (Irwin & Pearl, 2020). In recognition of the high incidence of calls related to these issues, most of which involve nonviolent, low-level offenders, municipalities throughout the United States have begun exploring and implementing crisis response programs that reduce law enforcement's role in handling these crisis situations and involve experts that specialize in working with these at-risk populations. In addition to freeing up police resources for more urgent emergency situations and reducing jail populations, pre-arrest diversion programs at intercepts 0 and 1 exemplify a care-first approach that emphasizes addressing criminogenic needs before these unmet needs lead to unnecessary law enforcement contact and/or incarceration.

There are three general models that these types of programs fall under: community response, crisis intervention teams (CIT), and co-response. The **community response model** removes law enforcement from crisis response entirely by first having a team of non-law enforcement first responders triage and send a team of health and social services practitioners (Dee & Pyne 2022; Irwin & Pearl 2020). **Crisis intervention teams** train law enforcement officers to respond to individuals experiencing crises and connect them with the appropriate services (Compton et al., 2008). The **co-response model** involves a paired response by law enforcement and mental health practitioners (Puntis et al., 2018; Shapiro et al., 2015). Not only has the latter service model been found to be cost-effective, but there is evidence that programs following this model are effective in reducing arrests and crime as well. A recent evaluation of the STAR program in Denver found that this model reduced targeted crimes by 34% in areas where it operated, relative to precincts in which the program had not been rolled out. The **STAR program,** based upon Oregon's **CAHOOTS** (Crisis Assistance Helping Out on the Streets) community diversion program, is a mobile crisis response program that sends a paramedic and a mental health clinician in a van to calls where the individual in distress 1) does not pose an imminent threat to others and 2) meets certain screening criteria related to mental health, substance use, or other related issues. 911 dispatchers are trained to triage low-level calls and dispatch a STAR team when the call meets certain criteria[15], freeing up police to respond to higher priority criminal calls. However, police can call STAR to assist in

[15] In order for a call to be eligible for STAR response, the dispatcher must be able to categorize it based on one of the following codes: calls for assistance, intoxication, suicidal series, welfare checks, indecent exposure, trespassing of an unwanted person, and syringe disposal (Denver Justice Project). At the same time, the incident must clearly exclude more serious criminal activity or the threat of violence.

crisis response when they need assistance. Contrary to concerns that lower police response rates to low-priority calls might have the effect of increasing crime, the results of the STAR evaluation showed that at the same time there was a significant reduction in STAR-related offenses reported, there was no appreciable increase in more serious crimes (Dee & Pyne, 2022). At the same time, the matched comparison group—which included police officers trained in crisis intervention response—did not see the same decrease in low-level crime relative to the precincts in which the STAR program was operational. This finding led researchers to the tentative conclusion that the STAR community response model might be comparatively more effective than the crisis intervention team model.

San Diego's **Mobile Crisis Response Team** program (MCRTs) has not been formally evaluated, but is worth noting as a locally implemented community response model. All law enforcement dispatch 911 call centers receive, screen, and refer directly to MCRT (excepting the city of San Diego). Law enforcement center referrals to MCRT were initiated in the summer of 2022. When an MCRT-eligible call is identified, a van with behavioral health clinicians and peer support specialists are sent to respond. Most of these calls involve individuals experiencing some sort of substance abuse or mental health related crisis that may otherwise have been addressed by law enforcement. Rather than facing incarceration, these individuals can be diverted and connected to needed service and treatment in the community. In addition to diverting individuals in crisis from incarceration and justice system involvement, MCRTs can either directly provide services that meet immediate needs, such as crisis intervention for individuals experiencing a mental health crisis, or connect individuals to services in the community that meet needs, such as housing instability, substance use treatment, or employment services support. There is a growing body of evidence that community response models are effective in both reducing system contact for at-risk individuals while also reducing the incidence of lower-level crime.

Law Enforcement-Assisted Crisis Response and Diversion Programs

Crisis intervention teams are a useful model in situations where police are called and the suspect has committed a low-level offense. Law enforcement-led crisis response and intervention teams have historically been considered the gold standard for police encounters with individuals suffering from mental illness (Peterson & Densley, 2018). As of 2020, roughly 17% of all law enforcement agencies nationwide were operating some sort of crisis intervention team (CIT Center at the University of Memphis, 2020). Crisis intervention teams, or CITs, send police officers trained in crisis intervention and response to respond to low-level calls, with the idea that successful CITs will both de-escalate the situation and refer the individual to needed programs and services. Co-response model programs are similar in that they involve law enforcement officers, but they also dispatch a clinician or other type of health or crisis expert to assist law enforcement in responding to calls involving low-level offenses committed by individuals experiencing a crisis. Where possible, these individuals are diverted from arrest and incarceration and redirected toward needed

programs and services that aim to address underlying needs. Evidence shows that these programs are at least moderately effective in improving public safety outcomes and in connecting at-risk individuals with needed services. At the same time, the success of these models is largely dependent upon proper program design and implementation (Chunghyeon et al., 2021). For example, a program that emphasizes regular interaction and collaboration between law enforcement and mental health clinicians might be more effective than a program that includes minimal training for law enforcement on the principles of crisis response and intervention among people with mental illness (Bailey et al., 2018).

San Diego's **Psychiatric Emergency Response Team (PERT)** pairs law enforcement officers with behavioral health experts in responses to calls involving individuals experiencing a mental health or psychiatric crisis. PERT specializes in aiding individuals experiencing a mental health crisis to which law enforcement is responding and sends a licensed behavioral health clinician alongside a uniformed officer to de-escalate crisis situations, divert individuals from mental health crisis-related hospitalizations and arrests, and connect them to the required level of mental health care. In FY 2019-2020, 47% of PERT-assisted calls resulted in a diversion away from law enforcement. However, this specific program has not been formally evaluated, therefore, the full scale of its impact is difficult to ascertain given currently available evidence.

Seattle's Law Enforcement Assisted Diversion program (LEAD), the first established pre-booking diversion program in the U.S., targets low-level drug and prostitution offenders for diversion from jail and toward needed case management resources and services. Individuals may be referred to LEAD through law enforcement, community-based organizations, or via calls from concerned community members. The program involves a coalition of law enforcement, behavioral health providers, legal services, and community groups. Through the LEAD program, Seattle Police Department officers are able to divert eligible individuals away from prosecution and incarceration either at the point of arrest or prior to arrest, as long as these individuals are suspected of low-level drug and prostitution violations or are considered to be at risk of committing future violations as a result of behavioral health issues or chronic income instability. However, individuals are ineligible if they were previously involved in drug or mental health collaborative courts within King County, as this could lead to a duplication of services received. Once an officer determines that an individual is LEAD-eligible and the individual indicates that they are amenable to diversion, they are referred to a case manager for an intake assessment, at which point they are referred to legal services or other needed services. Crucially, services are provided as long as case managers determine that they are necessary, and there is no fixed end date for individuals referred to services through LEAD. Prosecutors and law enforcement have the ability to monitor participants' progress through the LEAD program to ensure that services are being received as intended. In the event that diverted individuals fail to complete intake within an agreed-upon time period, prosecutors are able to revoke LEAD

eligibility and file charges; otherwise, charges are not filed. Additionally, prosecutors have full discretion over the handling of charges unrelated to the charge leading to LEAD diversion.

Recently, the LEAD program has expanded its services in partnership with the King County Behavioral Health and Recovery Division (BHRD) and others to build a continuum of diversion programs for individuals in the county who have a history of repeat cycling through legal competency services. This expanded continuum of programs adds to LEAD services intensive mental health services and both interim and permanent housing supports through designated contracting partners.

Continuously operational since 2011, studies have shown high effectiveness of the LEAD model: one study showed that those who were involved in the LEAD program were 60% less likely to recidivate in a six-month period than those who had not been involved with LEAD (Collins et al., 2017). Metrics for client outcomes and cost effectiveness have been similarly promising: LEAD participants were significantly more likely to have obtained needed services such as housing, access to income, and employment than non-LEAD participants. Furthermore, costs associated with LEAD participation were lower than those for standard law enforcement contacts over time (Clifasefi et al., 2016; Collins et al., 2019). Seattle's LEAD program is the flagship program of the nationwide Law Enforcement Assisted Diversions Bureau, a colloquium of programs that follow similar diversion and service provision models. The model has been implemented elsewhere in the U.S. and continues to see success in diverting individuals from custody and directing them to needed services.

A potentially promising program at this intercept highlighted at the request of the ATI Working Group is the **Pinellas Safe Harbor** program in Pinellas County, Florida. This program provides one example of a law enforcement-assisted jail diversion program specifically designed for non-violent homeless offenders. Rather than being incarcerated for ordinance violations or low-level non-violent offenses, homeless individuals transported by law enforcement can be taken to an emergency homeless shelter administered by the Pinellas County Sheriff's Office in partnership with third-party contractors and community organizations. Individuals entering the facility via law enforcement-led diversion are not charged. Homeless individuals may also enter Pinellas via self-referral, or upon exiting jail. The facility has a capacity of 470 and regularly operates at an average of 300 individuals at a time. Individuals housed at Safe Harbor are provided three hot meals a day and can access clothing donations, as well as to do their own laundry on-site. When needed, transportation is provided to employment-related appointments or medical services and the facility is strategically located close to a public transportation stop. Additionally, the shelter has a medical clinic onsite, where patients can receive basic healthcare and referrals to medical, dental, and mental health services. Various treatment groups, such as Alcoholics Anonymous and Narcotics Anonymous, are available for individuals at the shelter. Case management, legal, and longer-term substance use services are also available. Onsite social workers provide needs assessment and referrals to services;

the public defender's office can assist with ordinance violations; and a third-party contractor provides substance use needs evaluations and recovery services.

Alternative Treatment Options for Substance Use Offenders

Similar to law enforcement-led crisis response programs, law enforcement-led diversion programs for low-level alcohol and other drug offenses have shown promise in increasing uptake of needed services for individuals suffering from substance use disorders and reducing recidivism for substance-related offenses. A general consensus exists among researchers that punitive approaches to drug use do not stem longer-term use (Hayhurst et al., 2015). At the same time, a growing body of evidence indicates that properly addressing substance use issues through proactive treatment can improve health outcomes and reduce substance-related arrest and incarceration.

Sobering services centers provide an example of an alternative treatment option for individuals picked up on low-level charges who are under the influence of alcohol or drugs. Though public intoxication charges are low-level misdemeanors, the downstream consequences of an arrest for these charges can have the counterintuitive effect of criminalizing individuals in such a way that involves them in the criminal justice system and affects other aspects of their lives negatively (Boruchowitz et al., 2009). Rather than taking these individuals to jail, law enforcement transports the individual to a sobering services center, where they receive onsite treatment, a bed, and are given time to regain sobriety prior to exiting the center. When clients are receptive to the possibility of further services and treatment, clinicians may then refer individuals to additional services and continued care. Sobering services centers have been evaluated in multiple contexts and have demonstrated efficacy in both reducing incarceration for low-level offenders with acute alcohol intoxication and in connecting individuals in need with treatment. Given the classification of substance use issues as a significant criminogenic need (Andrews & Bonta, 1996) and its frequent co-occurrence with mental health issues and other criminogenic needs (Bonta et al., 2014; Ogloff et al., 2004), services that effectively target this issue are important in effectively reducing criminal activity related to substance use issues. Implementation and expansion of sobering services also could have the effect of reducing the amount of time law enforcement and emergency services spend transporting and processing low-level offenders under the influence of substances, freeing up more time and resources to address more pressing emergencies and more serious crime.

As of July 2022, there were nearly 40 sobering services centers across the U.S. in at least 13 states.[16] As of the time of writing, there were two sobering services centers operating in San Diego County. Administered in collaboration with the McAlister Institute for Treatment and Education, the County's sobering services centers in

[16] This directory from the National Sobering Collaborative outlines all existing locations.

Oceanside and central San Diego are available for law enforcement dropoffs. However, the Oceanside center has subsequently closed due to insufficient usage.

It is worth examining successful sobering services models elsewhere to gain a better understanding of what could be expanded or implemented in San Diego County. An evaluation of the **Houston Recovery Center's** sobering center services program found strong early support for sobering services centers as an effective public health intervention that doubles as a tool for reducing jail overcrowding. In recognition of the high amount of public intoxication-related arrests occurring within the growing metropolitan area under its jurisdiction, the Houston Police Department partnered in 2013 with the Houston Recovery Center to provide sobering services to individuals brought in on low-level public intoxication charges. The center provides a place to stay for 4-6 hours for individuals under the influence of alcohol picked up by law enforcement and is open 24 hours a day, seven days a week. Though law enforcement may transport individuals in need of the center's services, they may also be transported by hospitals and emergency departments, as well as referred from public spaces like colleges and airports. The center also accepts community walk-ins. The center is staffed by emergency medical technicians (EMTs), who provide monitoring for clients under their care. Crucially, the center's staff is composed primarily of state-certified peer recovery support specialists, individuals who have been in recovery for at least two years and are able to conduct needs assessments and refer to services if needed and desired by the client.[17] Individuals with three or more sobering center admissions are automatically referred to the center's affiliate treatment program, Partners in Recovery (PIR), whose flagship program pairs clients with a case manager and peer support recovery specialist for an 18-month treatment period (Jarvis et al., 2019). The program was designed for chronic clients (three or more sobering center admissions) who qualify as low-income and are uninsured. Over a five-year period, public intoxication jail admissions in Houston decreased by 95%, from 15,357 at the beginning of the evaluation period in 2012 to 835 at the end of the period in 2017 (Jarvis et al., 2019). A majority (77%) of clients during this period were admitted once or twice, while 23% were frequent users (three or more admissions). Almost half (48%) of clients either accepted a referral to outside treatment services, requested housing assistance, or enrolled in treatment upon their discharge from the sobering center (Jarvis et al., 2019). Over this time period, the PIR enrolled 849 clients, a number which included 23% of the sobering center's frequent clients. In addition to the promising results of Houston's sobering center rollout, there is substantial evidence in the literature that sobering services are a cost-effective alternative to emergency department services (Marshall et al., 2020).

There are other unique aspects of the Houston sobering services program worth highlighting as possible extensions of sobering services work currently being done in San Diego County. In addition to providing detox services and connection to longer-

[17] Peer recovery support specialists may either refer clients to community health services for treatment or to the center's treatment partner, Partners in Recovery.

term treatment, the Houston Recovery Center conducts jail in-reach to establish connections with incarcerated individuals with substance issues prior to their release. With the cooperation of the Harris County Sheriff's Office, recovery center staff interview inmates who have been pre-screened for substance issues and determined to be interested in receiving services upon release. During these interviews, staff help prepare inmates to enter a PIR substance use treatment program immediately upon re-entry into the community. The comprehensive treatment approach espoused by the Houston model not only provides diversion opportunities at the point of law enforcement contact, but also facilitates successful re-entries through service provision and connection to treatment upon release.

Drug arrest diversion programs represent an additional avenue of alternative treatment options for non-violent offenders facing substance use challenges. An evaluation of individuals involved in Chicago's **Narcotics Arrest Diversion Program (NADP)**, the largest opioid arrest diversion program in the U.S., indicated there were improvements along key metrics for participants compared to individuals in a matched control group. There was a significant increase in connections with substance use counselors, and the probability of being released without criminal charges also increased. Most strikingly, re-arrest rates fell significantly, with a 15% drop in the probability of a drug charge re-arrest. There was also a 17% decrease in the probability of being arrested on violent charges compared to the control group (Arora & Bencsik, 2021). In addition to improving public safety outcomes and reducing the amount of time officers spend policing low-level drug crime, treatment outcomes indicate success connecting individuals to needed substance use services—80% of those diverted through NADP begin treatment, and 52% of these individuals remained in treatment 30 days post-diversion (UrbanLabs Crime Lab, 2022).

Chicago's program applies only to suspects arrested on low-level drug possession charges—if an individual commits a violent offense in conjunction with the drug possession offense, or if they have been arrested on violent offenses in the previous ten years, they are ineligible for diversion under this program.[18] The program provides individuals who have been arrested and determined to be eligible for drug diversion with the option to pursue substance use treatment. If they consent to receive treatment, they then speak with an in-precinct substance use counselor, who then conducts a needs assessment and refers them to treatment services.[19] Once the referral has been made, transportation is provided directly to the service center, and the individual is released without charge. After release, there is no

[18] Chicago mayor Lori Lightfoot authorized the expansion of eligibility criteria in recognition of the effects of the opioid epidemic and in an effort to expand access to treatment as an alternative to incarceration. Whereas previous eligibility criteria limited the program to individuals who had been arrested for possession of 1 gram or less of heroin or cocaine, the new criteria allows for any person arrested for possession of 2 grams or less of any controlled substance, including fentanyl (source: Office of the Mayor, City of Chicago).
[19] Though the focus of the NADP is connecting individuals with substance use treatment programming, program representatives may also connect them with other services, such as housing.

further possibility of being arrested or charged for the same offense.[20] Chicago's program was piloted in 2018, and is one of only a few such programs currently operational in large cities (population > 1 million) in the US.[21] As more favorable evidence regarding its positive impact on reducing recidivism and increasing connections to de-addiction treatment accrues, it is possible that such programs will expand as alternatives to incarceration for low-level opioid possession offenses.

The NADP diversion model differs from what is currently available in San Diego through **PC 1000.** This pre-plea diversion program in California provides an alternative for offenders arrested for simple drug possession or under the influence charges and allows these individuals to have their charges dismissed if they complete diversion.[22] This program requires participants to attend a drug education program or a drug treatment based on their assessed need. If the individual completes diversion, the case is dismissed without sentencing. Unlike NADP, referrals cannot be made prior to a court appearance, and dismissal of charges is contingent upon successful completion of diversion. Though there are consequences for individuals who are referred to PC1000 but do not complete recommended treatment, the barriers to entry and engagement in treatment services are substantially lower with the NADP model than they are with PC1000.

In expanding alternatives to incarceration, it is important to prioritize programs that address criminogenic needs not only for the reduction of crime, but for the rehabilitation of individuals in need. Doing so has the dual effect of connecting individuals to needed treatment while also mitigating the public safety threat posed by individuals whose needs are not being met. Ultimately, successful interventions at intercepts 0 and 1 will divert individuals from first-instance arrest or incarceration and redirect them to programs and services that directly target criminogenic needs.

Intercepts 2-3: Initial Detention, Court Hearings, and Jails/Prisons

[20] The program contracts with an organization called Thresholds, which provides housing and employment services in addition to recovery and substance use disorder treatment.
[21] The only other such programs in large cities exist in Los Angeles, Philadelphia, and Phoenix (Arora and Bencsik 2021).

[22] There are a number of additional eligibility criteria for PC1000 that should be noted. The individual must not have been convicted for any offenses related to controlled substances other than the offenses included in the statute, and the offense cannot have involved a crime of violence or threat of violence. Additionally, individuals with felony convictions within the previous five years or with a contemporaneous narcotics-related violation not included in the statute are ineligible for PC1000 diversion.

By the time an individual has reached intercept 2, they have already been initially detained and charged and are facing their first court appearance. Alternatives to incarceration at intercept 2, initial court hearings and/or detention, include programs and services that divert individuals to community-based treatment at the point of initial intake, booking, or at the first court hearing. Alternatives to incarceration at intercept 3, jails and courts, are typically intended to provide community-based services through either the jails or courts that serve to rehabilitate offenders and prevent recidivism. The primary goal of programs at intercepts 2 and 3 is to provide eligible individuals with alternative means of repaying their debt for the offense committed while offering an opportunity for community service or some other form of rehabilitation that can occur either inside or outside of custody. These programs, broadly speaking, involve pre-trial services and alternative sentencing for certain low-level offenses, as well as corrections-based programs that address criminogenic needs. Additionally, best practices for reducing procedural missteps that lead to increased incarceration rates and system involvement—for example, reducing failure to appear—should be considered at this intercept.

Alternatives to incarceration at Intercepts 2-3 should provide diversion to rehabilitative programs and services where possible. When incarceration cannot be avoided, programs and services should be targeted based on the needs of the individual, with a focus on facilitating successful community reentry.

Evidence shows that the means and extent to which an individual interfaces with the criminal justice system at these intercepts can be determinative of their future trajectory within and contact with the criminal justice system. Such research suggests that jail should be used only for those who need more intensive supervision than is possible by alternative, community-based methods (Latessa et al., 2020). In studies of the effects of non-prosecution for misdemeanor crimes (Agan et al., 2021) and deferred prosecution for felonies (Mueller-Smith & Schnepel, 2020), recidivism was found to be reduced by 50-58% as a result of diversion (Arora & Bencsik, 2021,). In addition to reducing recidivism, a systematic review of the literature found that jail diversion programs increase service utilization (Lange, Rehm, & Popova, 2011). All jail diversion programs are not created equal, however: a multi-site study of jail diversion programs for individuals with mental illness confirmed that connection with treatment services that address criminogenic needs are necessary to maximize the success of diversion programs. In addition to targeting criminogenic needs and treating mental health issues, participants should have stable housing throughout the duration of their participation in programs for maximum efficacy (Case et al., 2009). Increasing diversion opportunities and ensuring that these opportunities include connection to treatment and vital services is tantamount to effective program and intervention design along intercepts 2 and 3.

Reducing Failure to Appear

One aspect of the criminal justice system that is often missed in discussing alternatives to incarceration at intercepts 2-3 is the effect of high rates of failure to appear (FTA). One study in New York City found that nearly 41% of more than 300,000 cases resulting from tickets for low-level offenses resulted in costly arrest warrants being issued (Cooke et al., 2018). Any discussion of best practices in providing alternatives to incarceration along intercepts 2-3 would benefit from discussing 1) the effects of FTAs, and 2) interventions that can reduce FTA rates and thus remove the necessity of diversion for those individuals who fail to appear for their court date.

A study looking at effective behavioral interventions in reducing FTA found that two main things reduced FTA (Cooke et al., 2018). First, **redesigning summons forms** to make the most relevant information—for example, the summons date and the consequences of failing to appear on or respond by that date—appear at the top reduced FTA by 13%. The new form included court date and location at the top, as well as a bolded display clearly outlining the consequences of FTA. When scaled system-wide within the study area (New York City), this form redesign resulted in roughly 17,000 fewer arrest warrants being issued per year. The second and most effective intervention was **pre-appearance reminder text messages**—receiving any pre-court message was found to reduce FTA by 21%. Certain messages, however, were found to be more effective than others. The most effective in reducing FTA included information both on the logistics of the appearance and a note on the consequences of FTA, and receipt of three of these combination messages prior to the appearance date reduced FTA by 26%. Additionally, the researchers examined whether the timing of messages contributed to their level of effectiveness, finding that while receiving post-FTA messages reduced open warrants by 32%, the gold standard remained sending a series of pre-appearance messages that both reminded recipients of their appearance date and location, as well as of the consequences of FTA.

An additional example of a promising FTA reduction program is the **North Carolina Court Appearance Project**. Supported by the Pew Charitable Trusts and the University of North Carolina School of Government Criminal Justice Innovation Lab. The goal of the initiative was to devise evidence-based strategies to improve court appearance rates, reduce FTA, and develop better responses post-FTA. Prior to the program's implementation, one in six (17%) of all criminal cases in the state had at least one missed court appearance. In the counties where data were analyzed, the most common reason for jail booking was FTA for misdemeanor court dates, leading to significant repercussions and downstream consequences for those jailed. However, an analysis of geographic data indicated that individuals in certain ZIP codes had higher nonappearance rates than those in other areas, suggesting that policy differences and barriers to transportation in different jurisdictions exist. In addition to finding evidence that automated text message reminders are an effective solution to reduce FTA rates, the study found that reducing barriers to transportation were important for those who had problems getting to court; in

addition to advertising and providing transportation options for individuals on the day of their appearance date, increasing remote appearance options also reduced FTA (North Carolina Court Appearance Project, 2022). These behavioral and logistical interventions supported by the data to reduce FTA rates are simple and low-cost relative to the financial implications and downstream consequences of unnecessary system involvement resulting from FTA charges.

Reducing FTA is an effective alternative to incarceration for individuals who have committed low-level misdemeanor offenses who may not have otherwise faced jail or prison time without the FTA charge, but what about alternatives to incarceration for others? In recognition of the evidence indicating that avoiding jail time among those who can receive adequate rehabilitation outside of custody is best practice for individuals that do not require more intensive supervision, the following pages examine best practices for individuals at intercepts 2-3 at the point of and following sentencing. These best practices therefore include sentencing alternatives that occur outside of custody, as well as rehabilitative programs that occur while in-custody that are designed to both mitigate the criminogenic effects of being incarcerated and to rehabilitate in advance of re-entry.

Collaborative Courts

Collaborative courts are alternative courts that emphasize rehabilitation as a condition of sentencing and address criminogenic needs such as substance use. There are several types of collaborative courts that provide sentencing alternatives for non-violent offenders, including drug courts, driving while intoxicated (DWI) courts, and mental health courts. One collaborative court type that has been consistently supported by research as being especially effective is the drug court, and the expansion of this model throughout the country in the last decade underscores this effectiveness—estimates put the current number of adult drug courts at 1,300, with multiple hundreds of thousands served (National Drug Court Institute). As the goal of drug courts is rehabilitation of drug offenders for successful community re-entry, coordinated and supervised treatment are a central feature of the model.

A prominent meta-analysis of existing studies showed that, in addition to providing needed treatment to individuals who may not otherwise receive it, participation in drug courts can reduce recidivism by between 8% and 13% (Mitchell et al., 2012). Program evaluations of specific drug courts have found substantial evidence of the efficacy of these models. The **Multnomah County (OR) Sanctions Treatment Opportunities Progress (STOP) Drug Court program**, for instance, has been evaluated by multiple sources and was found to be effective in both reducing recidivism and improving drug treatment outcomes. Established in 1991, the STOP program is the second-oldest drug court in the country. The program is designed for first-time drug offenders and follows a post plea model, wherein the defendant—if determined to be eligible—pleads guilty and is required to complete a 12-month, court-supervised treatment program. After successful completion of the program,

the defendant's charges can be dropped and they are eligible to apply for expungement from their record. The program has three phases, with frequency of counseling sessions decreasing as the participant progresses through these phases. The program also features what is called the STOP clock, which counts down the days until successful completion of the program. The clock is stopped if the participant fails to fulfill any of the requirements and is resumed once they do fulfill those requirements. Findings regarding the effectiveness of the model were striking, with reductions in conviction and arrest rates and increases in positive adjustment scores, indicating rehabilitative progress. Over a two-year evaluation period, participants were found to be 61% less likely to be re-arrested and 57% less likely to be re-convicted (Finigan, 1998). The program has since been replaced by the Treatment First program for low-to medium-risk offenders, with STOP being reserved for only the highest-risk offenders.

Correctional Therapeutic Communities

The therapeutic community (TC) model is one that has gained increasing attention for its emphasis on treatment and rehabilitation, as well as for its effectiveness in reducing recidivism (Mitchell et al., 2007; Mitchell, Wilson, & MacKenzie, 2012). A TC is a residential treatment program that emphasizes cognitive behavioral interventions within a community of individuals seeking the same goal of recovery (National Institute on Drug Abuse). Originally developed to help individuals suffering from substance use disorders recover and rehabilitate, TCs have been adapted to treat individuals with other issues, including co-occurring psychiatric disorders and chronic homelessness (De Leon, 2000; De Leon, 2010).

As designed, TCs target multiple criminogenic needs simultaneously, including antisocial attitudes and associations and substance use issues. A core characteristic of the TC model is its emphasis on cohabitation and community-building among individuals seeking recovery, as well as isolation from previous associates who engage in the harmful behavior (De Leon & Wexler, 2009; Vanderplasschen et al., 2013). These communities are frequently self-sustaining, with profits from work performed by members of the TC being recycled back into the continued operation of the TC. TC members live together, work together, and engage in cognitive-behavioral and substance use treatment together, encouraging prosocial attitudes and behavior while also building life skills and tools to control negative thoughts and impulses. TCs have seen success not only in rehabilitating individuals with substance use issues but in changing the behaviors that would lead these individuals to re-offend.

When incarceration cannot be avoided, in-custody treatment options are an imperative for enabling rehabilitation and preventing recidivism upon release from jail or prison. In addition to reducing instances of prison misconduct that could lengthen incarceration times, the implementation of effective treatment programs has been found to increase the likelihood of a successful re-entry (French & Gendreau, 2006). A program model with a high degree of documented success is

the incarceration-based therapeutic community, a TC that exists within the context of a jail or prison. Therapeutic community-based programs based in jails and prisons are funded by the Bureau of Justice Assistance, and as is the case for many participants in TCs outside of correctional settings, participants in incarceration-based TC programs frequently suffer from substance use issues. Although nearly 75% of all correctional facilities offer some form of substance use treatment program, the type of program and the way in which it is implemented can make the difference between a successful intervention and an unsuccessful one (Latessa, 2020; Stephan, 2008). For example, there is limited support for the efficacy of drug education programs (Pearson & Lipton, 1999), while there is substantial support for treatment-based therapeutic community models (Mitchell et al., 2007). The efficacy of these programs is underscored by the continued operation and expansion of residential substance abuse treatment (RSAT) programs. These programs are expected to follow some basic implementation principles. First, they should isolate participants from the general jail or prison population to reduce the likelihood of negative influence from non-participant peers. Second, they should occur near the end of the participant's jail or prison sentence so that they can be released into the community upon completion of the program. Third, they should address other needs, such as cognitive and vocational skills, in addition to targeting substance use needs.

The **Amity In-Prison Therapeutic Community**, founded in San Diego and originally based at the Richard J. Donovan Correctional Facility, was one of the original examples of a successful incarceration-based TC. A three-phase voluntary program, Amity's correctional TC requires participants to reside in a dedicated separate housing unit within the facility for the final 9 to 12 months of their sentence. The first phase of the program includes comprehensive needs assessments and treatment planning, and during this time participants are typically assigned to an in-prison job that facilitates the maintenance of the TC. A unique feature of the TC at phase one is the encounter group, peer-led discussion circles where TC participants discuss their and their peers progress within the program, as well as highlight any negative attitudes or behaviors that need to be addressed. Phase two, the longest phase of the program, includes counseling sessions that emphasize prosocial behaviors and coping skills. Phase three, the re-entry phase, focuses on preparation for community reentry and training in decision-making skills necessary for success. The program includes what are called "lifer mentors," peer counselors who have previously struggled with substance addiction and have been incarcerated themselves. These peer support mentors are trained and supervised by Amity program staff, and are available to counsel participants 24 hours a day. They also work with participants to develop re-entry plans prior to their release from prison.

Studies of the effects of participation in Amity examined recidivism rates at two years, three years, and five years after release. The researchers found that recidivism rates for program participants (43%) were significantly lower than those of non-participants (67%), though no statistically significant difference in hard drug use was

found and these reductions in recidivism rates disappeared three years post-program (Wexler et al., 1999a; Wexler et al., 1999b). An additional study looking at outcomes five years post-release found statistically significant differences in recidivism rates between program participants (76%) and non-participants (83%) (Prendergast et al., 2004).

The general success of the Amity model has facilitated its growth and expansion to include post-release TC programs and additional wraparound reentry services, both inside and outside San Diego County. For example, participants in the Amity In-Prison TC program are also given the option to participate in the **Vista Ranch TC** upon re-entry, a residential TC that serves up to 60 male parolees and that includes wraparound re-entry services and continued substance use treatment.

An additional example of a successful program that involves housing individuals in an incarceration-based community with therapeutic elements is the San Diego Sheriff's **Veterans Moving Forward (VMF)** program. VMF provides incarcerated veterans an opportunity to prepare for successful reentry by fostering peer connections with other veterans and counselors with lived experience in a veterans-only housing unit. While in residence in the unit, veterans receive mandatory rehabilitative programming and receive one-on-one services through a VMF Counselor, who can facilitate connections to needed resources and services upon reentry. A SANDAG-led evaluation of the VMF program found that program participants had fewer rule violations and were less likely to be convicted of a new offense within one year of release (SANDAG 2019).

Education and Vocational Programming

When offered in tandem with cognitive behavioral and substance use treatment programs, education and vocational skills-based training programs can increase the likelihood of successful re-entry by targeting education and employment-based criminogenic needs (Latessa, 2020). One meta-analysis of such programs found that participation in vocational programs reduced recidivism rates by 13%, while educational program participation reduced the same by 5% (Aos, Miller, & Drake, 2006). Participation in correctional industries programs, or programs where inmates produce goods or provide services for use by the general public while incarcerated, was found to be associated with an 8% reduction in recidivism (Aos, Miller, & Drake, 2006). However, completion status matters in determining how effective such programs are in improving outcomes: in a study of correctional education and vocational programs in Ohio state prisons, researchers found that there was no detectible effect on recidivism rates for participants who started but did not complete such programs; on the other hand, improved outcomes were seen among those who completed college classes or earned a GED as a result of program participation (Pompoco et al., 2017).

Improved educational outcomes while incarcerated have been found to be linked with better employment and recidivism outcomes post-release. For example, one

study found that earning a GED or equivalent degree significantly increased the likelihood of finding post-release employment (Duwe &Clark, 2014). Earning a college degree increased the number of hours worked post-release, indicating more stable employment opportunities, and also reduced recidivism (Duwe &Clark, 2014). One example of a successful correctional educational program that has been implemented widely, the **Inside Out Prison Exchange Program,** brings college students into correctional settings on a weekly basis to take courses alongside inmates. At the end of the semester, participants receive college credit for successful completion of the course (Latessa, 2020). Based in Philadelphia at Temple University's Department of Criminal Justice, the program has expanded globally and currently offers programming in around 200 jails and prisons; however, the program has never been implemented in San Diego County correctional settings. Program offerings have expanded in recent years to include free virtual college courses offered to both traditional college students and formerly incarcerated individuals. The **Goucher Prison Education Partnership** (GPEP) program offers a different model for correctional education. Operating since 2012, the program is administered by Goucher College and offers college courses and tutoring in two Maryland state prisons. Participants can earn college credits that they can use to enhance employment opportunities upon release, and those who complete enough courses to graduate receive a degree in American Studies from Goucher. GPEP alumni can also receive post-release assistance applying to Goucher or other institutions to finish their degrees.

Intercept 4-5: Reentry and Community Corrections

After an individual's release from custody, additional programs and services are needed to facilitate successful reentry and to prevent recidivism. Intercept 4 within the SIM applies to individuals in the leadup to their release from custody and reentry into the community. Programs and services at this stage relate broadly to reentry planning. Services provided at this intercept should focus not only on recidivism risk assessment but should also consider the needs of the individual being released in devising a comprehensive reentry plan. Intercept 5 shares the general focus of intercept 4, on successful community reentry, while also focusing on community supervision and addressing unmet needs of individuals after their release to reduce recidivism.

Alternatives to incarceration at Intercepts 4-5 should facilitate successful community reentry through comprehensive reentry planning and ensuring that needs are met upon release from incarceration.

The stakes of unsuccessful reentry are high and the challenges faced by individuals upon reentry are significant. One study that followed parolees over time found that, among the population studied, more than two-thirds were re-arrested within nine years of release, and the majority of this two-thirds was re-arrested within three years (Alper, Durose, & Markman, 2018). Reducing barriers to needed programs and

services and designing programs that reduce the risk of recidivism is paramount to ensuring successful reentry.

In considering best practices along these intercepts, it is important to keep two main points in mind. First, the needs of the population being released from jail are significantly greater and more complex than those of the general population. In addition to the high risk posed by unaddressed criminogenic needs such as antisocial attitudes and behaviors and criminal associates waiting for individuals upon their release, those released have significant housing, substance use, mental health, educational, and employment needs relative to others. It is estimated that among those reentering society after incarceration in the United States, 10% have a history of homelessness; 70% have a history of substance use disorders; most are nearly four times as likely as the general population to have mental health issues; and 40% do not have a GED or high school diploma (Latessa et al., 2020; National Reentry Resource Center). Second, successful reentry must proactively consider these needs and plan accordingly, ensuring that ready connection to services is available immediately upon and following release.

Comprehensive Reentry Services

The most effective outreach programs would ideally also include jail in-reach and the provision of wraparound reentry planning that begins prior to an individual's release from custody. One meta-analysis of 53 studies found that participation in adult reentry programs was associated with a roughly 6% decrease in recidivism, even when considering different adult reentry program model types (Ndrecka, 2014). The evaluated programs included pre-release outreach and reentry planning and provided supervision and resources after reentry that would address assessed needs.

The **Allegheny County Jail-Based Reentry Specialist Program** is one program that has seen significant success. The program, first established in 2010, is a two-stage program that combines pre-release in-reach and reentry planning over at least five months at the end of the incarceration period, with up to one year of supportive services post-release. Eligible participants are those assessed as being medium- to high-risk and who are returning to the community following at least three months in jail. Enrollment occurs on a rolling basis, with the Allegheny County Jail receiving a weekly list of all offenders and determining eligibility at the time of each review. During the first (in-jail) phase of the program, participants are placed in the Re-Entry Pod, a structured living environment that includes classes and re-entry services in the jail's Re-Entry Center. A comprehensive needs assessment is conducted at this stage, with coordinated vocational, educational, and/or behavioral health services provided based on the results of their risk and needs assessment. The service plan is shared with the court, and participants meet biweekly with the Jail Service Coordinator to monitor progress throughout the duration of phase one. The post-release phase, phase two, includes regular supervision by a Reentry Probation Officer and four Reentry Specialists, comprising a five-person team dedicated to regular monitoring and assistance to individuals upon release. A peer-reviewed study of the

effects of participation in the program found a significant reduction in re-arrest rates among program participants compared to the control group, with participants seeing a 10% chance of re-arrest versus a 34% chance for the control group (Willison, Bieler, & Kim, 2014).

The **Anti-Recidivism Coalition (ARC)** provides multiple programs that include wraparound reentry planning and supportive services upon release from custody. Founded in 2013, the ARC's main goal is to reduce incarceration rates throughout California by providing support for current and former inmates and advocating for policy change. The ARC's flagship jail in-reach program, the Hope and Redemption Team (HART), sends formerly incarcerated individuals, known as ARC Life Coaches, into California Department of Corrections and Rehabilitation facilities to assist inmates with rehabilitation and reentry. HART is currently operational in 31 California institutions, including San Diego's Richard J. Donovan Correctional Facility, where they offer three workshops led by life coaches that focus on rehabilitating former gang members, preparing inmates for parole board hearings, and mentoring youth offenders. Peer mentorship by individuals with lived experience is a core part of the ARC model, with roughly 80% of its staff being formerly incarcerated. Additional supportive services include therapeutic programs that assist inmates in building relationships, gaining vocational skills through training programs, and providing housing at its two housing sites. Relatedly, the ARC provides free transportation from correctional facilities to safe housing through its network of formerly incarcerated drivers, who double as reentry counselors and can provide follow-up support to those helped. Recipients of ARC services are also able to receive mentorship in becoming ARC members themselves, thereby contributing to the development of prosocial behaviors post-release and providing a network of noncriminal associates.

There are some existing programs in San Diego County that offer comprehensive reentry services. The Amity Foundation programs, discussed previously in this section, also offer wraparound reentry services that combine jail in-reach, incarceration-based therapeutic communities and reentry planning, and voluntary post-release therapeutic communities. Participants of the organization's incarceration-based therapeutic community are supported through the reentry stage and may continue receiving services post-reentry at Vista Ranch (located in Vista), a residential therapeutic community that provides sober living and supportive services. The Second Chance program offers its collaborative court, Reentry Court, for nonviolent offenders which provides various services and case management to assist with successful reentry. Second Chance also offers Transitional Housing for Reentry Court and recently released people under community supervision, as well as other funded adult reentry programs and Job Readiness Training with employment services. Additionally, the Neighborhood House Association's (NHA) Project In-Reach (PIR) and Project In-Reach Ministry (PIRM) programs have offered comprehensive reentry services since 2012 and 2019, respectively, to incarcerated individuals with serious mental illness and/or substance use issues in the main San Diego detention facilities. Individuals served through NHA's In-Reach and Reentry programs are

connected with clinical case managers prior to their release from detention and receive a variety of services as needed and at no cost to them. PIR's and PIRM's comprehensive care coordination services include clinical assessments, education on and treatment for mental health and substance use issues, and connection to a wide variety of resources in the community upon release. The programs also provide transportation to services, short-term emergency housing assistance, counseling, faith-based services, peer support services, group services, employment support services, and nursing services.

Warm Hand-Offs for Post-Release Care and Services

Immediate reentry services can provide formerly incarcerated individuals with the resources and connections to services needed immediately upon release from custody. Orange County, California's, **Project Kinship (PK)** provides a variety of programs and services to help enable successful community reentry. PK emphasizes employing peer navigators with lived experience who can relate directly to incarcerated individuals, combining the experience of these individuals with clinical expertise among its team of case managers, mental health clinicians, and substance use counselors. Among other services, PK's two reentry programs, **PK Cares** and the **Community Support and Recovery Center (CSRC),** places a team of its staff outside Orange County's Intake Release Center (IRC) to ensure that they make first contact with individuals upon their release from detention. The aim of PK's reentry programs is to provide immediate support and connection to services to those individuals it comes into contact with, including assistance with basic needs, connection to emergency shelter or housing support, and substance use and mental health support. In addition to triaging formerly incarcerated individuals' needs immediately upon their release, PK conducts jail in-reach with its peer navigators and case managers to help prepare individuals for release through providing intensive case management services and treatment for those who need it. PK's reentry programs are funded in partnership with Orange County's Correctional Health Services.

Pre-Release Community Healthcare Coordination

Given the high incidence of co-occurring health issues among individuals affected by incarceration, reentry services that emphasize connection to and provision of healthcare are vitally important to successful reentry. Project Kinship's **Community Health Initiative of Orange County** (CHIOC) partners with the Orange County Sheriff's Department to conduct outreach in all county detention facilities, including high security facilities like Theo Lacy. During this outreach, CHIOC enrolls incarceration-affected individuals to receive medical assistance upon release through virtual case management and aids individuals with getting to medical appointments.

The **transitions clinic** model, which has been scaled to 48 health systems nationwide as of 2022—including two locations in San Diego—provides a culturally competent and whole-health approach to meeting healthcare needs among

individuals returning to the community after incarceration. The Transitions Clinic Network (TCN) model emphasizes a peer-to-peer approach, employing community health workers (CHWs) with lived experience and a history of incarceration as an integral part of a patient's medical team. TCN sites serve as the medical center for individuals returning from incarceration and are based primarily in neighborhoods disproportionately affected by incarceration and the health disparities that high incarceration rates perpetuate. In addition to providing patient-centered care within the community, TCN clinics leverage connections with correctional partners in order to ensure continuity of care between release and after reentry. TCN centers also facilitate navigation of health and social services and provide mentorship for individuals struggling with reentry. There is robust data indicating the effectiveness of the TCN model across a wide variety of metrics. A randomized controlled trial (RCT) at the flagship TCN site in San Francisco found that individuals who received a TCN intervention had emergency room utilization rates at 51% less than patients in basic primary care (Wang et al., 2012). A study of individuals treated at the TCN site in New Haven, Connecticut found that the TCN model both reduced patients' preventable hospitalizations by half and shortened hospitalizations (Wang et al., 2019). In addition to improving health outcomes, those treated through TCN sites had 25 fewer incarceration days in their first-year post-release compared to a matched control group (Wang et al., 2019). There is also evidence that the use of CHWs increases uptake of medical services among those contacted, with the rate of attendance at the first medical appointment post-release increasing from 30% to 70% for those who had met with a CHW with lived experience prior to their release from custody (Santa Clara Valley Medical Center, 2015).

Next Steps

The most promising ATI practices and program models tend to have two major elements in common. First, they address criminogenic needs that lead an individual to engage in criminal behavior in the first place, such as antisocial attitudes, substance use issues, struggles with employment, and cognitive errors. Second, they target individuals based on their needs and risk profiles, and tailor programming to meet those needs and mitigate risks of re-offending. This section has provided an inventory of existing best practices along each intercept within the sequential intercept model and is based on a comprehensive review of the peer-reviewed and policy literature regarding recidivism reduction and the rehabilitation of incarcerated and formerly incarcerated individuals.

In the coming months, additional best practice research will be conducted with the aim of being able to devise data-driven, evidence-based recommendations regarding alternatives to incarceration in which the County may confidently invest. Some areas of focus that will be researched in the coming months and included in the final report are the following:

- International programs and practices that have been proven to reduce recidivism and/or increase connection to services;

- A comprehensive accounting of local programs and services that constitute best practices seen elsewhere;

- A discussion of the types of programs and services with buy-in from multiple justice partners and stakeholders.

Public Comments

The following comments are verbatim as shared by community members who chose to leave a comment through a form on the study's website. These comments are being added here so the voices of the public can be heard directly. Please note that no editing has occurred in these comments.

Date	Comment	Commenter Name
October 25, 2022	Thank you for your willingness to see improvements for people who residually show signs of an absence of supports and resources and are not able to identify or even express these needs. I would like to see peer supports to raise awareness in crisis stabilization at the court level. Both my sons demonstrated these needs in the courts before sentencing but because nothing was established to identify how to help them at this level, the status quo is to throw them away! There should be a process that researches ones need for mental health treatment before being sentenced by a judge. NAMI has actualized this info in a form called "Inmate Medical Information Form" to be faxed in to the court appointed facility highlighting the significance of this communication.	Cheryl Canson

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