



Administration of Justice Policy Committee
CSAC Legislative Conference
Wednesday, May 16, 2018 — 2:15 p.m. – 3:45 p.m.
Sacramento Convention Center, Room 307
Sacramento, California 95814

Supervisor Alfredo Pedroza, Napa County, Chair
Supervisor Kelly Long, Ventura County, Vice Chair

- 2:15 p.m. **I. Welcome and Introductions**
Supervisor Alfredo Pedroza, Napa County, Chair
Supervisor Kelly Long, Ventura County, Vice Chair
- 2:20 p.m. **II. A Coordinated Response to Mental Health in the Criminal Justice System**
Jackie Lacey, District Attorney, Los Angeles County
- 2:45 p.m. **III. Managing Mentally Ill Offenders in the Criminal Justice System: Best Practices**
Sheriff Dean Growdon, Lassen County
Dave Mitchell, Deputy Director, Probation Department, Los Angeles County
Kelli Weaver, LCSW Division Manager, Department of Health and Human Services, Division of Behavioral Health Services, Sacramento County
- 3:15 p.m. **IV. Mental Health Courts in California: A Judge's Perspective**
Judge Larry Brown, Mental Health Court, Sacramento County
- 3:35 p.m. **V. Legislative Update**
Jessica Devencenzi, Legislative Representative
Stanicia Boatner, Legislative Analyst
- 3:45 p.m. **VI. Adjournment**

ATTACHMENTS

Attachment One Mental Health Advisory Board Report a
Blueprint for Change: Executive Summary

Attachment Two Managing Mentally Ill Offenders in the Criminal
Justice System: Best Practices

Attachment Three Mental Health Courts in California: A Judge's
Perspective

Mental Health Advisory Board Report a Blueprint for Change: Executive
Summary

Attachment One

Entire Report can be found at:

<http://da.lacounty.gov/sites/default/files/policies/Mental-Health-Report-072915.pdf>

EXECUTIVE SUMMARY

Statement of Purpose

The Criminal Justice Mental Health Advisory Board was convened to safely divert non-violent mentally ill offenders from the jail, into community treatment options. This is an ambitious, long-term goal which will take time and fiscal resources to fully effectuate.

Mental health diversion is not a jail reduction plan. There will always be the need for mental health treatment to take place in the jail, since offenders at all levels of the criminal justice continuum can find themselves afflicted by mental illness, including those charged with serious crimes, violent crimes and even the ultimate crime of murder.

Criminal Justice Mental Health Advisory Board and Working Groups

Over the past year, the Advisory Board has made significant progress in assessing mental health resources and identifying strengths, weaknesses and priorities for improvement. Local stakeholders participated in a “Summit” and a “Mini-Summit” which introduced them to the “sequential intercept model” of mental health diversion planning. The sequential intercept model identifies all “intercept points” along the criminal justice continuum where contact with those who suffer from mental illness occurs and appropriate intervention can take place. The five intercepts are: (1) Law Enforcement/Emergency Services First Contact; (2) Post-Arrest/Arrest; (3) Courts/Post-Arrest/Alternatives to Incarceration; (4) Community Reentry; (5) Community Support.

Using the sequential intercept model as an aid to discussion, the Advisory Board has met regularly over the past year. Most recently, the Advisory Board has begun to create and deploy Working Groups, which are designed as active problem solvers for subject areas deemed worthy of further study. The Working Groups are dynamic in nature and will evolve over time as current problems are solved and new ones are identified. The current Working Groups are: (1) Law Enforcement Working Group; (2) Community Based Restoration Working Group; (3) Criminal Justice Working Group; (4) Treatment Options and Supportive Services Working Group; (5) Pre-Booking Diversion Working Group; (6) Data and Systems Connectivity Working Group; (7) Long Beach Mental Health Diversion Working Group.

Data Collection and Sharing

Data collection and data sharing must be made a priority. It will also be necessary to establish metrics so that the efficacy of mental health diversion can be evaluated on an ongoing basis. These issues will be addressed in the Data and Systems Connectivity Working Group from an inter-departmental perspective.

Crisis Intervention Team (“CIT”) Training

Training is the most important priority for mental health diversion, because change cannot be effectuated without it. The first opportunity to divert a mentally ill person is when first responders encounter a person at the scene. At that point, law enforcement officers can take the person to a

community treatment option instead of the jail, but how the situation unfolds and whether the mentally ill person is arrested can be highly dependent upon how the first responders are trained.

The original Crisis Intervention Team (“CIT”) training was a 40 hour model, which is fully endorsed by the Advisory Board and by the District Attorney. CIT training will help to raise awareness of and sensitivity to mental health issues and provide law enforcement officers with the tools necessary to interact more effectively and compassionately with mentally ill persons in the field. Educating law enforcement officers about community based treatment options will encourage them to use those options in lieu of arrest and booking. Skills training to defuse potentially violent situations will make those encounters safer for both law enforcement and mentally ill persons alike and help to prevent encounters from turning violent or even fatal. In addition, CIT training will lead to decreased litigation and judgment costs.

Over the next six years, the LASD has created an ambitious plan to have 5,355 patrol deputies complete the full 40 hour CIT training. For smaller law enforcement agencies, an alternative 16 hour model will be available under the auspices of the District Attorney and Criminal Justice Institute, commencing in January, 2016.

Co-Deployed Law Enforcement Teams

The Department of Mental Health has paired with a total of seventeen different law enforcement agencies in the field, to provide crisis intervention services. The co-response model pairs a licensed mental health clinician with a law enforcement officer. Together, they jointly respond to patrol service requests where it is suspected that a person might have a mental illness, so that appropriate referrals to treatment facilities can be made. These teams have been universally praised by mentally ill persons who have interacted with them, and family members who have seen their loved ones treated with compassion and understanding.

These specially trained co-deployed teams are known as Mental Evaluation Teams (“MET”) by the LASD and as the System-wide Mental Assessment Response Team (“SMART”) by the LAPD. Regardless of the name, the demand for services is so great that there are not enough teams to provide sufficient coverage. Therefore, the Advisory Board recommends both expanding the MET and SMART teams, as well as providing CIT training for all officers whenever possible.

Mental Health Urgent Care Centers: The First 24 Hours After a Mental Health Crisis

When a law enforcement officer encounters a mentally ill person in the field, the choice is to either take the person to a crowded emergency room and possibly wait for an average of 6 to 8 hours, or arrest the person, book the person into the county jail, and return to their duties within the hour.

Mental health Urgent Care Centers (“UCCs”) provide another option. UCCs are acute care mental health facilities where mentally ill persons can be taken for specialized evaluation, but their stay must be less than 24 hours. Investing in UCCs takes the pressure off County hospitals by freeing up emergency rooms to deal with medical health crises as they arise, thus enhancing care for both medical and mental health patients. DMH currently has underway a plan to add three additional

UCCs to be located near Harbor UCLA, the San Gabriel Valley and the Antelope Valley. The Advisory Board endorses this plan.

Other Treatment Options: After the First 24 Hours

After a law enforcement officer has transported a mentally ill person to an Urgent Care Center, the person should then be linked to appropriate inpatient or outpatient mental health treatment options. Los Angeles needs the right combination of treatment services to serve the mentally ill population, and good linkage to those services. Current treatment options include law enforcement hospital beds, Institutions for Mental Diseases (“IMD” beds), Crisis Residential programs, Full Service Partnerships (“FSPs”), Field Capable Clinical Services, Wellness Centers and the Assisted Outpatient Treatment program.

In order for mentally ill persons to be diverted from the jail into community based treatment options, those treatment resources must be adequate to address a mental health crisis both during and after the first 24 hours. Therefore, the Advisory Board recommends increased mental health treatment resources in each of these categories.

Permanent Supportive Housing and Other Housing Options

Mentally ill individuals who are homeless are significantly more likely to become involved in the criminal justice system, and to remain incarcerated, than those who have a stable housing environment. It is also more difficult to engage homeless mentally ill individuals with treatment, resulting in high-cost utilization of medical, emergency and mental health care systems which could have been avoided by providing permanent supportive housing.

There are a variety of housing options and programs available, such as bridge housing, Shelter Plus Care, federal housing vouchers, Rapid Re-Housing and the Mental Health Services Act (“MHSA”) Housing Program. However, there are clearly insufficient resources in the area of permanent supportive housing.

The Department of Health Services has created an innovative rent subsidy program called the Flexible Housing Subsidy Pool, which provides permanent supportive housing. The Flexible Housing Subsidy Pool allows a provider to contract for housing, providing a range of options that include intensive case management, wrap-around services and move-in assistance. To fund the program, DHS has partnered with private foundations, which provides maximum flexibility because participants are not restricted based on criminal history, and the restrictive federal definition of homelessness does not apply.

The Advisory Board recommends a significant investment in a variety of permanent supportive housing beds to be dedicated to mentally ill offenders, both through the Flexible Housing Subsidy Pool and through the Department of Mental Health Specialized Housing Program. It is also recommended that a Mental Health Diversion County Housing Director position be created to administer these beds and generally oversee housing issues related to mentally ill offenders.

Co-Occurring Substance Abuse Disorders

Up to 80 percent of mentally ill offenders also suffer from co-occurring substance abuse disorders. As a practical matter, someone who is actively high on drugs or alcohol may be violent and combative, and will not immediately be amenable to mental health treatment or able to be received at an Urgent Care Center.

Therefore, an increased investment in services to help stabilize mentally ill offenders is recommended. In particular, Sobering Centers which would be able to be accessed by first responders should be pursued by the County. In addition to Sobering Centers, there is also a need for Residential Detoxification Services.

Additional investment in residential drug treatment services is also recommended, to provide substance abuse treatment for up to 90 days.

Finally, for the most acutely mentally ill offenders, there is currently an insufficient supply of IMD beds for individuals with serious mental illness and co-occurring disorders, so 40 additional beds are recommended.

Current Jail Programs and Resources

This report catalogues and describes the existing jail programs which are most relevant to mental health diversion. Of particular interest is the proposed expansion of the Public Defender and Alternate Public Defender Jail Mental Health Team. This innovative jail program is aimed at a broader, more holistic representation of mentally ill offenders who are housed at the county jail.

The Advisory Board supports this request for psychiatric social workers and clinical supervisors. Clients are much more likely to be forthcoming and cooperative with a psychiatric social worker assigned to their own legal team than with a clinician who is not. Enhancing this relationship could greatly assist in the evaluation of appropriate placement options outside of the jail.

Current Court Programs and Resources

Next, this report catalogues and describes the existing court programs which are most relevant to mental health diversion. One such program is the Department of Mental Health Court Linkage/Court Liaison Program, a collaboration between DMH and the Superior Court in which clinicians are co-located at 22 courts countywide. This recovery based program serves adults with mental illness or co-occurring substance abuse disorders who are involved with the criminal justice system. Last year's figures show that the Court Linkage Program helped to divert a total of 1,053 persons out of 1,997 referrals. This group of about a thousand mentally ill offenders annually is placed across the spectrum of available treatment options. The Advisory Board endorses the expansion of this program.

Expansion of Mental Health Diversion Related Staffing and Services

The Advisory Board also proposes the creation of a new, permanent planning committee. Based on the experiences of other jurisdictions, mental health diversion will be a long-term project for years to come. Therefore, a permanent leadership structure will be necessary.

The Advisory Board recommends a small, workable Permanent Planning Committee, to be comprised of one representative from each of the following County Departments: District Attorney, Public Defender, Sheriff's Department, Department of Mental Health, Department of Public Health, Department of Health Services, proposed new Mental Health Diversion County Housing Director, and others appointed by the District Attorney on an as-needed basis. These personnel would be management-level employees, with significant operational experience, who could bridge the gap between high-level policy recommendations and actual implementation decisions.

Recommendations

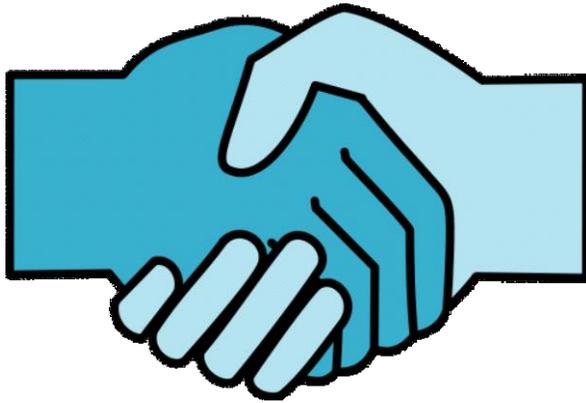
Based on this report, the Advisory Board recommends the following actions:

- 1. Fund CIT Training.**
- 2. Expand Primary Mental Health Treatment Resources. (Urgent Care Centers; Crisis Residential Treatment Programs; "Forensic" or "Justice Involved" versions of Full Service Partnerships; Field Capable Clinical Services and Wellness Centers; IMD beds for co-occurring disorders; DMH administrative staffing items; Court Linkage expansion).**
- 3. Establish the Permanent Mental Health Diversion Planning Committee.**
- 4. Expand Public Health/Health Services Treatment Resources. (Sobering Centers and Residential Substance Abuse Treatment facilities).**
- 5. Enhance Housing Services. (Create Mental Health Diversion County Housing Director; fund permanent supportive housing beds both within the Department of Health Services Flexible Housing Subsidy Pool and within the Department of Mental Health Specialized Housing Program).**
- 6. Expand Co-Deployed Teams.**
- 7. Prioritize Data Improvements to Enhance Data Collection, Data Sharing and Performance Metrics.**
- 8. Establish the Public Defender and Alternate Public Defender Jail Mental Health Team.**

- 9. Expand Secondary Mental Health Treatment Resources. (Men's Integrated Reentry Services and Education Center; Co-deployed DMH personnel at Probation Offices on a pilot project basis).**
- 10. Fund the LASD Mental Health Evaluation Bureau. (Fiscal Year 2016-2017).**

Managing Mentally Ill Offenders in the Criminal Justice System: Best Practices

Attachment Two



Mobile Crisis Support Team

The Mobile Crisis Support Team responds to emergency calls through local law enforcement dispatch.

This program is funded by the Division of Behavioral Health Services through the voter approved Proposition 63, Mental Health Services Act (MHSA) and the SB 82 Mental Health Wellness Grant

Bilingual/bicultural staff and interpreters are available at no cost.

Department of Health Services
Division of Behavioral Health Services

Navdeep S. Gill
County Executive

Sherri Z. Heller, Ed.D., Director
Department of Health Services

Uma K. Zykofsky, LCSW,
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Division of Behavioral Health Services
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Board of Supervisors

Phil Serna - 1st District
Patrick Kennedy - 2nd District
Susan Peters - 3rd District
Sue Frost - 4th District
Don Nottoli - 5th District



Division of Behavioral Health Services

In partnership with

The Sacramento City Police Department,

The Sacramento County Sheriff Department

The Citrus Heights Police Department

Folsom Police Department

and

TLCS Inc.

Mobile Crisis Support Team

Dispatch Hours of Operation
Tues – Fri. 9:00 a.m. - 7:00 p.m.

Follow up hours of operation:
Mon. – Fri. 8am – 5pm

Who is the Mobile Crisis Support Team?

The Mobile Crisis Support Team is a collaboration that brings County Behavioral Health and law enforcement into one team to mitigate mental health crisis in the community.

The team is accessed through local emergency and/or non-emergency Law Enforcement dispatch.

Four Mobile Crisis Support teams are assigned to five areas throughout Sacramento County:

- ❖ Sacramento Police Department- City Wide
- ❖ Sacramento Sheriff Department- North area
- ❖ Sacramento Sheriff Department- South area
- ❖ The Citrus Heights Police Department and the Folsom Police Department

Each team is comprised of:

- ❖ A Police Officer or Sheriff Deputy who is trained in Crisis Intervention Training (CIT) to respond to persons experiencing mental health crisis
- ❖ A licensed Senior Mental Health Counselor provided by the Department of Health and Human Services, Division of Behavioral Health
- ❖ County contracted Peer Navigator provided by TLCS Inc.

Mission Statement

The Mobile Crisis Support Team serves individuals of all ages and diversity in identified areas throughout Sacramento County by providing timely crisis assessment and intervention to individuals who are experiencing a mental health crisis.

- ❖ Providing safe, compassionate and effective responses to individuals with a mental illness
- ❖ Increasing public safety
- ❖ Decreasing unnecessary hospitalizations for community members experiencing a mental health crisis
- ❖ Decreasing unnecessary incarcerations for community members experiencing a mental health crisis
- ❖ Increasing consumer participation with mental health providers by problem solving barriers and increasing knowledge of local resources

How does the Mobile Crisis Support Team help people?

- ❖ The team responds to mental health crisis in partnership with law enforcement to reduce risks and threats to self or others.
- ❖ They build upon individual, family and community self-identified strengths and skills to divert individuals from unnecessary incarceration or hospitalization.
- ❖ They assist with making connections to and navigating services systems to support access to ongoing mental health support.
- ❖ They mobilize authorized mental health providers to support de-escalation, safety planning and ongoing care
- ❖ They educate key individuals, family members or natural supports on how to improve health and wellness.

For questions about the Mobile Crisis Support Team Program: (916) 874 -6057

California Relay Service: 711



Community Resources

National Suicide Prevention Line

1-800-273-TALK (8255)

1-800-SUICIDE

Consumer Operated Warm Lines

Consumer Operated (916) 366-4668

National Warm Line (855) 642-6222

211 Sacramento

(916) 498-1000 or 211

Community Support Team

(916) 874-6015

California Relay Service; 711

Mental Health Courts in California: A Judge's Perspective
Attachment Three



Lawrence Brown
Judge

SUPERIOR COURT OF CALIFORNIA
COUNTY OF SACRAMENTO

Sacramento Adult Mental Health Treatment Court
Tuesdays, 2:00 p.m., Dept. 8

Key contacts: Ryan Raftery, Public Defender's Office, (916) 874-6411; Chris Carlson, District Attorney's Office, (916) 874-1335; Christa Flewellen, Probation Dept., (916) 876-5152

The Mental Health Court (MHC) is a collaborative court involving criminal justice stakeholders and treatment professionals. It is designed to address non-violent offenders with diagnosed Axis I mental illnesses receiving treatment services by an authorized Sacramento County treatment provider.

If accepted into MHC, an offender enters a plea of no contest and is placed on formal MHC probation, with any jail sentence stayed pending successful completion of the MHC program. Probation terms will include participating in a treatment program and taking psychotropic medications as prescribed. Client will appear regularly before the MHC judge for updates on progress. On successfully completing 12-18 months in MHC, the underlying case will be dismissed at client's graduation.

Offense/Offender criteria:

- Resident of Sacramento County;
- Have a pending felony or misdemeanor case;
- Not charged with an offense involving violence or use of a weapon;
- Not charged with a sex offense or PC 422 Criminal Threats;
- Not charged with an offense where state prison is likely, or presently on parole.

Diagnosed mental illness:

- Have a diagnosis of Schizophrenia, Delusional Disorder, Psychotic Disorder NOS, Bipolar Disorder, Major Depression Recurrent, Borderline Personality, Paranoid Personality Disorder, Schizoaffective Disorder; Post-Traumatic Stress Disorder (PTSD);
- Have a global assessment of functioning score 60 or less; and
- All functioning impairments are identified and documented in writing.

Authorized Treatment Providers:

- Turning Point- Pathways (TP-Pathways)
- Turning Point- Integrated Services Agency (TP-ISA)
- Transitional Living & Community Support (TLCS)
- Sierra Elder-Wellness Program (El Hogar)
- Telecare-Sacramento Outreach Adult Recovery
- Transitional Community Opportunities for Recovery and Engagement (T-CORE)

Mental Health Courts

What are Mental Health Courts?

Mental health courts are a type of problem solving court that combine judicial supervision with community mental health treatment and other support services in order to reduce criminal activity and improve the quality of life of participants. The first mental health court was established in Florida in 1997 with California implementing its first mental health courts in 1999. Mental health courts are established to make more effective use of limited criminal justice and mental health resources, to connect individuals to treatment and other social services in the community, to improve outcomes for offenders with mental illness in the criminal justice system, to respond to public safety concerns, and to address jail overcrowding and the disproportionate number of people with mental illness in the criminal justice system.

Common Elements in Mental Health Courts

- Participation in a mental health court is voluntary. The defendant must consent to participation before being placed in the program.
- Each jurisdiction accepts only persons with demonstrable mental illnesses to which their involvement in the criminal justice system can be attributed.
- The key objective of a mental health court is to either prevent the jailing of offenders with mental illness by diverting them to appropriate community services or to significantly reduce time spent incarcerated.
- Public safety is a high priority, and offenders with mental illness are carefully screened for appropriate inclusion in the program.
- Early intervention is essential, with screening and referral occurring as soon as possible after arrest.
- A multidisciplinary team approach is used, with the involvement of justice system representatives, mental health providers, and other support systems.
- Intensive case management includes supervision of participants, with a focus on accountability and monitoring of each participant's performance.
- The judge oversees the treatment and supervision process and facilitates collaboration among mental health court team members.

(Taken from: <http://www.courts.ca.gov/5982.htm>)