



District Attorney Workshop

Mapping the Intersection of Mental Health, Homelessness, and Criminal Justice

October 22, 2018



9:00 — 9:30 AM

Check-in / Registration

9:30 AM — 12:00 PM

Welcome and Opening Remarks

San Diego County District Attorney Summer Stephan

Symposium in Review & S.I.M. Breakout Exercise Results

DDA Rachel Solov, Chief of Collaborative Courts Division

Morning Breakout Sessions

- A. *Mental Health Prevention and Intervention*
- B. *Mental Health Diversion*
- C. *Acute Crisis Response and Stabilization Management*
- D. *Data, Outcomes and Information Sharing*

12:00 — 1:00 PM

Mental Health Diversion Legal Updates (Lunch Presentation)

DDA Jessica Lees

1:00 — 2:30 PM

Afternoon Breakout Sessions

- A. *Mental Health Prevention and Intervention*
- B. *Mental Health Diversion*
- C. *Acute Crisis Response and Stabilization Management*
- D. *Data, Outcomes and Information Sharing*

Wrap-up Discussion & Next Steps

2:30 PM

Adjourned

April 30, 2018
DA Symposium in Review

Jackie Lacey
Los Angeles County District Attorney

Hallie Fader-Towe
Senior Policy Advisor, CSG Justice Center
Stepping Up Initiative
&
Sequential Intercept Mapping (S.I.M.)

S.I.M. Talks
*Short burst updates from our local
Criminal Justice and Mental Health Stakeholders*

County Supervisor Kristin Gaspar

Hon. Judge David Danielsen

Breakout Sessions: S.I.M. Exercise

S.I.M. Talks

Short burst updates from our local
Criminal Justice
and Mental Health Stakeholders

Lt. Chris May, SDSO PERT

Dr. Mark Marvin, PERT Director

Dr. Linda Richardson, NAMI, Director Next Steps

Luz Pinto, NAMI, Director Hospital Transitions

Dr. Alfred Joshua, Chief Medical Officer, SDSO

Neil Besse, Deputy Public Defender

Lara Easton, Deputy City Attorney

Harrison Kennedy, Deputy District Attorney

Honorable Judge Desiree Bruce-Lyle, San Diego Superior Court

Christine Brown Taylor, SDSO Reentry Services Manager

Dr. Michael Krelstein, Behavioral Health Services Medical Director

Commander Hank Turner, SDSO Homeless Task Force

Christiene Andrews, Supervising Probation Officer,
Mentally Ill Offender Unit

Lt. Chris May

SDSO PERT

- 25 years of law enforcement experience
 - Sheriff's Mental Health/PERT liaison for past 10 years
- Lack of options available makes jail the only place to take people
- Jan 1 – Present: Started to contact people outside jails and offer immediate mental health. However, none accepted
 - Need to figure out ways to engage
- Positive—strengthen collaborations with partners

Dr. Mark Marvin **PERT Director**

- Director of PERT since 2015
- Grown in recent years
 - 23 teams to 50 funded teams with county (increased to 70 since we last met)
- Estimated will respond to 10,000 crisis this year
 - Problem is seeing the same people all the time
- Open 6am-midnight 365 days a year, but minimal staffing on holidays.
- Success due to collaborations with family members
- Good communication between agencies
- Provide PERT Training
- Important to identify mental illness early on and make appropriate connections

Dr. Linda Richardson

NAMI, Director Next Steps

Luz Pinto

NAMI, Director Hospital Transitions

- Programs for individuals being released from psychiatric hospitals
 - Provides family support
 - Help connect with services
- Problem: Never get to NAMI unless referred...and usually means justice system contact

Dr. Linda Richardson

NAMI, Director Next Steps

Luz Pinto

NAMI, Director Hospital Transitions

- Things that would be helpful:
 - Tickets or low level crimes diverted to crisis center to get assessed
 - If sent to jail, peers in booking chat with person, educate what to expect in jail
 - Peers involved in jail, provide support plan for release
 - Peers point of release...a place to live when get out, find housing that will accept felons
 - Connections to community services when get out, transportation
 - Peers in community to help collaborate and makes sure connections exists
 - Crisis plan
 - Peers involved in court process...peers in court, could assist DA's and PD to make plans for recovery

Dr. Alfred Joshua
Chief Medical Officer, SDSO

- 84,000 people booked into jail per year
- Jail Intake
 - Screened by RN, identification & referral to appropriate level of care
- Acute
 - Crisis Stabilization Unit for danger to self/others or gravely disabled (LPS facility)
 - Inmate Safety Program- inmates at risk for suicide
- Subacute
 - Psychiatric Step Down Unit
 - Jail Based Restoration of Competency Program
- Stable
 - Mainline housing with psychiatric services
- Discharge Planning

Neil Besse

Deputy Public Defender

- 18 years as PD, Created and supervises Defense Transition Unit
- Different between normal criminal...and a person who has mental illness
- Paradigm shift for PDs
 - Want to be protective of client
 - What is best for the client
 - Start to realize letting them out isn't best path
 - It has to be more than just getting them out of custody

Neil Besse

Deputy Public Defender

- DTU: designed to make the most constructive use possible of the client's initial weeks in custody and bring timely and appropriate treatment plans to the court.
 - 3 mental health clinicians hired to assess for diagnosis and treatment needs
 - 1,000 referrals from our attorneys in first 13 months of program
- Moving Forward
 - Overhaul of Residential Treatment to tackle of co-occurring problems (substance abuse and mental illness)

Lara Easton

Deputy City Attorney

- SMART- addresses chronically homeless/drugs
- Offers individual case management, substance abuse & mental health services, housing for two years afterwards (not shelter beds). Harm reduction model...don't require sobriety
- Goals
 - Reduce recidivism and ER visits
 - Increase access to mental health care & increase days in treatment
 - Reduce court appearances
- Who is eligible
 - One or more current misdemeanor charges and twice in past for quality of life offense (e.g. Trespass, pee in public, illegal lodging, aggressive panhandling)

Lara Easton
Deputy City Attorney

- SMART at every stage
 - Point of arrest through to filed cases
 - Can do this without a case pending
- 3 graduates within 10 months of smart
- Housing is the challenge
 - City opening SMART house...84 bed facility in South Bay
 - One stop shop for participants- case management, MH treatment, job readiness, etc.

Harrison Kennedy

Deputy District Attorney

- DDA since 2001. Army Reservist who has served in Iraq & Afghanistan, and is recipient of the Bronze Star Medal
- SD has highest retired veterans population
- Veteran mentors have been critical to success of VTC
- Treatment providers
 - VA
 - Gives them structure they feel like they lost when leaving military
- Hurdles
 - Identifying the vets most in need—population doesn't like admitting they need help
 - Housing
 - Hard if co-occurring disorder, like drugs/PTSD
 - Finding mentors—must be a veteran

Honorable
Desiree Bruce-Lyle
San Diego Superior Court

- MS: typical person we see in MS is early 20s with long history of probation failures
- What options do we have when mental health issues exist
 - TELECARE- Case MGMT
 - If not eligible- EXODUS plus close supervision by probation
 - In Custody---good resources in JAILS
- Lack of options in community to address violent outbursts
- What do we do with mental health issues plus substance abuse who has shown violence while in custody....TELECARE or EXODUS cannot take such risks
- Mentally Ill person...will get back into community with no probation

Honorable
Desiree Bruce-Lyle
San Diego Superior Court

- 4 out of 10 in jail have mental illness
- Needed
 - Housing
 - Treatment and closely supervised with medication
 - Our jail is not the answer
- Moving Forward
 - Hope

Christine Brown Taylor **SDSO Reentry Services Manager**

- Oversees Reentry Services Division for San Diego County Jail
- Programming in county jails: Sheriff has tripled classes and programs offered in the jails
- Focus on the “criminal thinking” (Thinking For A Change)
- Programs
 - Look at targeting the right populations
 - Veterans Mod
 - All vets housed together
 - Work to stabilize while in jail (highly motivated)...but need help when they get out...partnership with probation/faith community
 - Connection to VA
 - Culinary Arts Program- come out with certificate

Christine Brown Taylor
SDSO Reentry Services Manager

- Need to connect to some support in the community while still in custody
- PROGRESS
 - People out of jail, alternative custody situation...get into intensive treatment programs and support system
 - Re-connect with families
 - Connect to services in the community so when released they are already plugged into that support system
- Need for better data
- Housing Issue
 - How can you come out of custody with no support and no money and avoid going back to using drugs and recycling

Dr. Michael Krelstein
**Behavioral Health Services Medical
Director**

- Board Certified in Adult Psychiatry and Forensic Psychiatry.
- Clinical Director of SD County Behavioral Health Services and Medical Director of San Diego Psychiatric Hospital
- How far we come
 - Back in the day- if you focused on treatment you were seen as soft on crime
- 5150---go to hospital instead of jail
 - Can backfire with disaster results
 - Sometimes more is needed
 - No substitute to legal leverage if needed

Dr. Michael Krelstein
**Behavioral Health Services Medical
Director**

- Arrests still need to be made, laws need pathways with teeth
 - Well intended clinicians get assaulted by scary people
 - Hard to know if “wolf” has not been sent
 - Need good communication
 - Shared respect and agenda
 - LE needs to screen them for prior history
 - Mental illness with co-occurring substance abuse or violence
- Behavioral Health
 - Much is needed in form of training
 - BH workers need police and courts to have their backs...currently violence in hospital is not criminally pursued...makes clinicians scared
 - BH treatment cannot be a substitution for jails in all cases
 - Start charging people for violence in hospitals

Commander Hank Turner

SDSO Homeless Task Force

- 9,000 homeless in San Diego
- 35% unsheltered suffering from mental illness
- Being homeless not a crime and we can't arrest our way out of this problem
- Many homeless people are victimizes
- Homeless Outreach Team
 - Teams of LE and Health and Human service
 - Contact people over and over again
 - Need to find person at "ROCK BOTTOM"
- Field Interview App to help identify & connect to resources
- Task Forces
 - With everyone in county

Christiene Andrews
**Supervising Probation Officer,
Mentally Ill Offender Unit**

- Supervising Probation Officer. Supervised the MIO since 2012. 18-years as a Probation Officer
- What works
 - Collaboration-
 - “defense transition unit” is doing well
 - Multiple disciplinary team meetings
 - We treat the “whole person”
 - Want to make sure addressing homelessness, co-occurring treatment
 - Incentives and sanctions that match our goals

Christiene Andrews
**Supervising Probation Officer,
Mentally Ill Offender Unit**

- What needs work
 - Help with social security and Medicare
 - It's very complicated....so how are our clients supposed to figure it out
 - Dual diagnosis residential treatment
 - Transitional
 - Short Term
 - Long Term
 - Release of information and information sharing
 - Lobbying
 - Irresponsible to put laws into place without support

Hon. Judge David Danielsen **(Retired)**

- Problem
 - Bottomless pessimism: treatment didn't work last time so it won't work this time mentality
 - Insufficient Budget
 - Compulsive Efficacy: when you sacrifice justice for efficiency you get what you asked for
- Don't need
 - DAs or judges with an "I don't do social work" mentality
 - Defense attorneys with "a closed case is a good case" mentality where straight time is easier than alternative programming
 - Probation officers that tell a probationer to "get into a program"
 - Collaborative Courts that don't take risks because they want good numbers
 - Politicians to continue making budget cuts to probation

Hon. Judge David Danielsen
(Retired)

- Do need
 - To focus on CBT and addressing Criminal Thinking
 - To audit and evaluate our programs to make sure our efforts are working
- ***Rehabilitation and Redemption are real.
Change does happen.***

Sequential Intercept Mapping

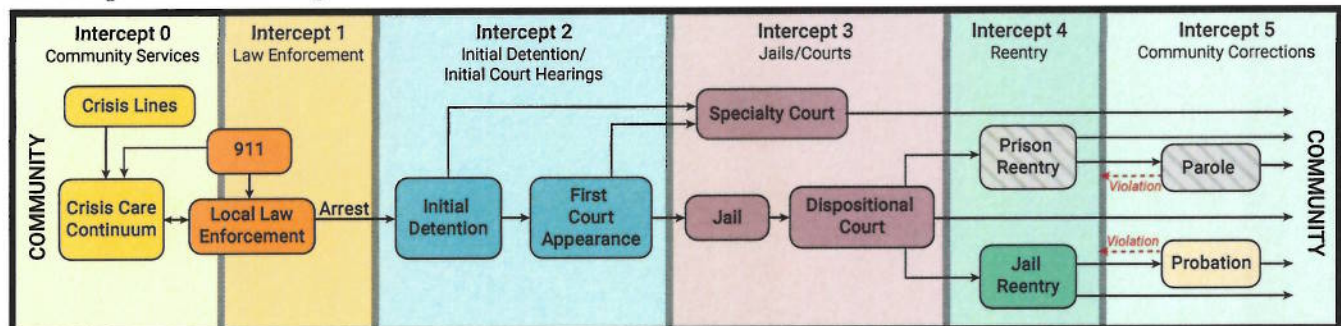
- SIM most effective when used as a community strategic planning tool to assess available resources, determine gaps in services, and plan for community change.
- SIM is best accomplished by a team of stakeholders that cross over multiple systems, including mental health, substance use, law enforcement, pre-trial services, courts, jails, community corrections, housing, health, social services, people with lived experience, family members, and many others.
- Goals:
 - ***Identify gaps, resources, and opportunities at each intercept for adults with mental and substance use disorders; and,***
 - ***Develop priorities for action designed to improve system and service level responses for adults with mental and substance use disorders***

THE SEQUENTIAL INTERCEPT MODEL

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



The Sequential Intercept Model



Key Issues at Each Intercept

Intercept 0

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

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

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

Intercept 1

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

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

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

Intercept 2

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

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

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

Intercept 3

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

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

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

Intercept 4

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

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

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

Intercept 5

Specialized community supervision caseloads of people with mental disorders.

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

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

Implementing Intercept 0

Crisis Response

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

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

Police Strategies

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

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

Sequential Intercept Model as a Strategic Planning Tool

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

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

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History and Impact of the Sequential Intercept Model

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

After years of refinement and testing, several versions of the model emerged. The "linear" depiction of the model found in this publication was first conceptualized by Dr. Steadman of PRA in 2004 through his leadership of a National Institute of Mental Health-funded Small Business Innovative Research (SBIR) grant awarded to PRA. The linear SIM model was first published by PRA in 2005 through its contract to operate the GAINS Center on behalf of the Substance Abuse and Mental Health Services Administration (SAMHSA). The "filter" and "revolving door" versions of the model were formally introduced in a 2006 article in the peer-reviewed journal *Psychiatric Services* authored by Drs. Munetz and Griffin. A full history of the development of the SIM can be found in the book *The Sequential Intercept Model and Criminal Justice: Promoting Community Alternatives for Individuals with Serious Mental Illness*.

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

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

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

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

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

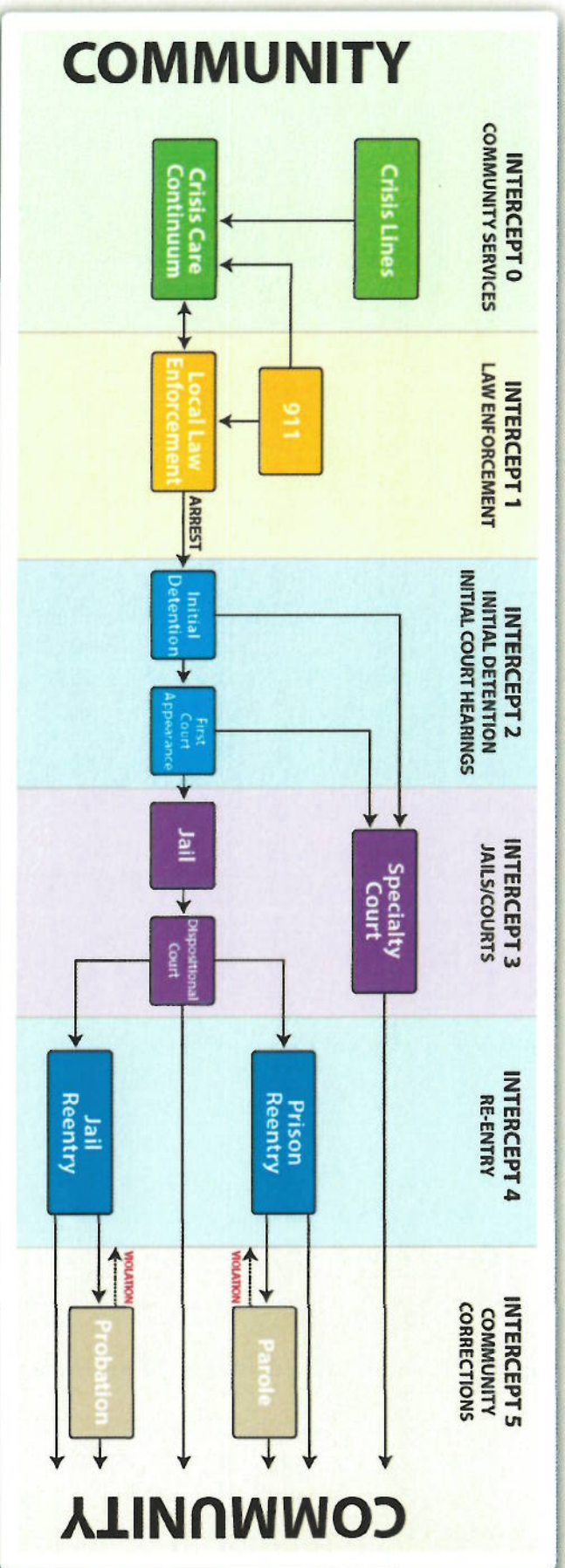
Breakout Exercise Results Sequential Intercept Mapping

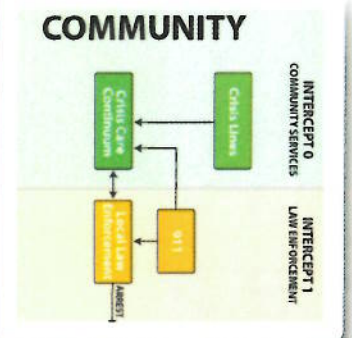
Resources/Strengths & Needs/Gaps

Breakout Exercise Results

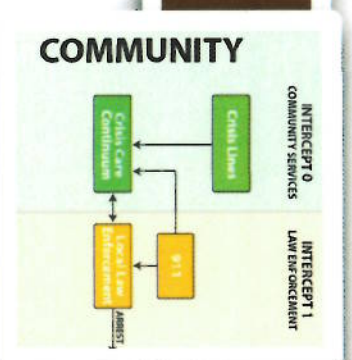
Sequential Intercept Mapping

Resources/Strengths & Needs/Gaps





Intercepts 0 & 1



Resources/Strengths

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

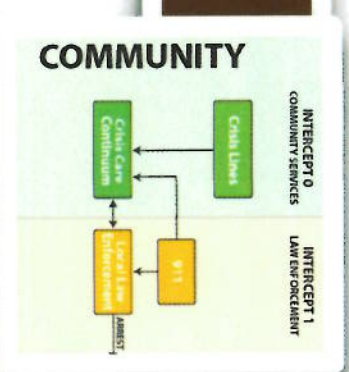
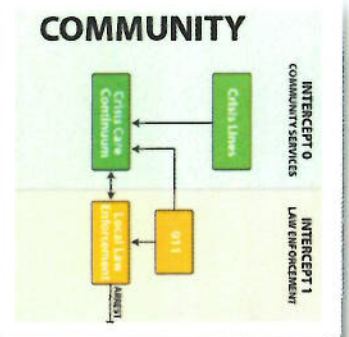
Needs/Gaps

- Data/Information Sharing (Universal release of info, central hub where info is available across disciplines (first responders, ER, Criminal Justice, treatment) (HIPPA- under what circumstances can it be waived)
- 24 hour PERT Teams
- Follow up contacts after PERT/LE/ER involvement (with individual and family)
- Threat Assessment Teams
- More training to dispatch and officers re: responding to crisis (Crisis Intervention Training) (Crisis response vs. LE response)
- Dispatch crisis teams w/o uniformed officers
- Expand peer based programs (link to peers earlier in process/ background checks for peers take too long)
- Enhanced training on what resources are available
- Mental Health Urgent Care Centers- somewhere for pre-crisis stabilization like "cool beds" for Juveniles
- Increased funding for EMS/Fire
- Expand Detox services
- Legislative change to allow EMS to transport someone other than to jail or ER
- Training to Family & general public re: what to do, what info to have available
- Lack of access for co-occurring disorders
- Access to treatment without barriers, and access to treatment w/o police response
- Warm handoff at early stage to a behavioral health specialist
- Community Paramedic Model
- Disparity in the way assessments take place (central coordination site for law enforcement)
- Lack of focus on prevention, early intervention programs, Mental Health "First Aid."
- More case management services
- Need more hospital beds instead of jail beds
- Housing
- Use of a universal assessment
- Expanded options once PERT responds (not just jail)

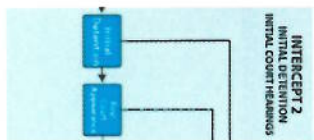
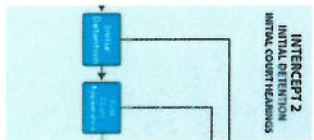
Intercepts 0 & 1

Needs/Gaps

- **Data/Information Sharing (Universal release of info, central hub where info is available across disciplines (first responders, ER, Criminal Justice, treatment) (HIPPA- under what circumstances can it be waived)**
- **24 hour PERT Teams**
- **More training to dispatch and officers re: responding to crisis (Crisis Intervention Training) (Crisis response vs. LE response)**
- **Mental Health Urgent Care Centers-** somewhere for pre-crisis stabilization like “cool beds” for juveniles
- **Increased funding for EMS/Fire**
- **Lack of access for co-occurring disorders**
- **Warm handoff** at early stage to a behavioral health specialist
- **Community Paramedic Model**
- **Housing**



Intercept 2



Resources/Strengths

SMART
Sobering Center
SIP
Inmate Screening
Pretrial Services
CERNER

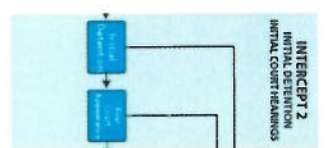
Needs/Gaps

Lack of data/information re: the individual. Need improved info sharing and IT solutions for privileged/private info
Lack of 24 hour psych coverage at jail- staffing resources
Capacity of PSU
Pre-trial/bail alternatives
Service referrals for cases not filed
Standardized Mental Health Screening upon admission
-evidence based intake screening
-share info at 1st court appearance
Communication & connection/reconnection to existing programs
Housing- reduce barriers/policies
Develop system to utilize existing beds better
Pre-charging diversion options for adults

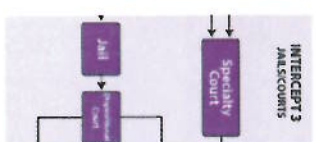
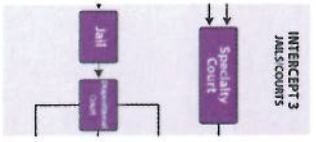


Intercept 2

Needs/Gaps

- **Lack of data/information re: the individual. Need improved info sharing and IT solutions for privileged/private info**
 - **Standardized Mental Health Screening upon admission**
 - **Pre-charging diversion options for adults**
- 

Intercept 3



Resources/Strengths

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

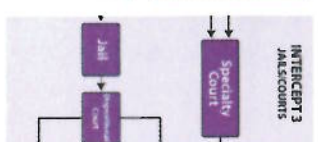
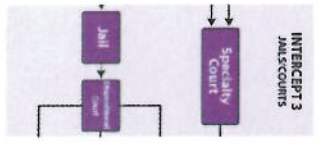
Needs/Gaps

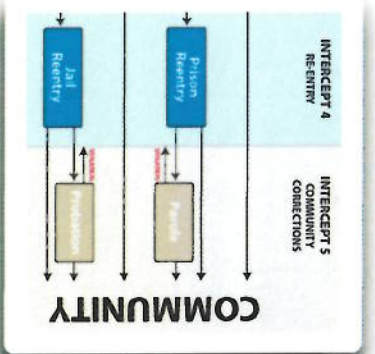
- Restoration of Competency in the community (long waits for Patton bed)
- Co-occurring/ Dual Diagnosis Court
- Increase engagement/enrollment in collaborative court programs
 - increase incentives for participation
 - more attorney/judge training
- Increase transitional services for misdemeanor and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

Intercept 3

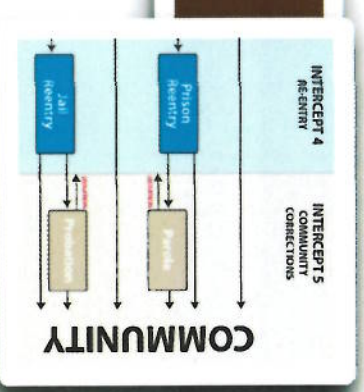
Needs/Gaps

- Restoration of Competency in the community (long waits for Patton bed)
- Co-occurring/ Dual Diagnosis Court
- Increase engagement/enrollment in collaborative court programs
- Universal screening process for collaborative court referrals
- More funding and increase capacity for collaborative courts (some courts need to be less “picky” about admitting defendants)
- Housing- need safe sober living space while defendants are in programs





Intercepts 4 & 5

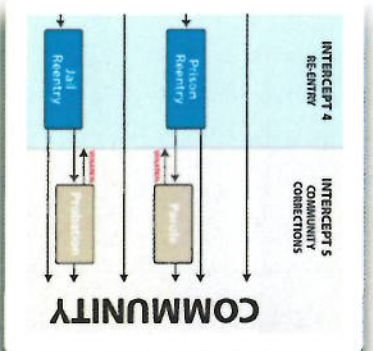


Resources/Strengths

Needs/Gaps

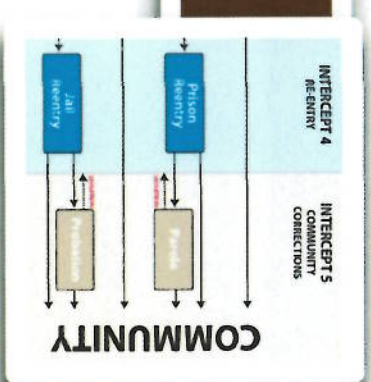
- East Mesa Re-entry Facility
- Collaborative Courts
- DTU
- Project In Reach
- Training Center
- Community Transition Center
- Probation's MIO Unit
- Telecare
- ACT
- Parole Outpatient Clinic
- Family Resource Centers

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

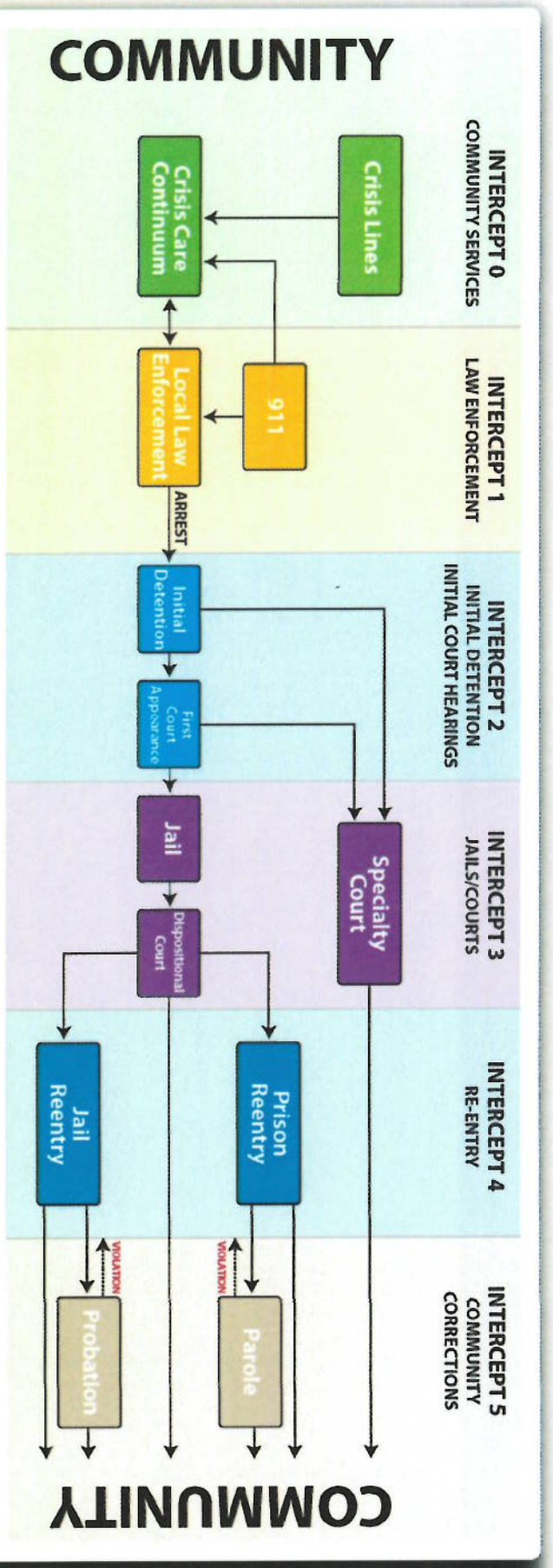


Intercepts 4 & 5

Needs/Gaps



- **Housing- especially for sex offenders, dual diagnosis, high risk. Need more housing navigators. Address barriers/regulations re: housing for felons/sex offenders**
- **Sober living/recovery residences**
- **Warm handoff** upon release: Support systems at time of release- peers, case managers, family, etc. to provide warm hand-off
- **Inmate release time NOT in the middle of the night**
- **Information sharing- link computer software so providers don't have to start at square 1 with re-entry.**
- **Track progress/outcomes upon release**



- ## Morning & Afternoon Breakout Sessions
- A. Mental Health Prevention & Intervention
 - B. Mental Health Diversion
 - C. Acute Crisis Response & Stabilization Management
 - D. Data, Outcomes, and Information Sharing

Morning & Afternoon Breakout Sessions

- A. Mental Health Prevention & Intervention
- B. Mental Health Diversion
- C. Acute Crisis Response & Stabilization Management
- D. Data, Outcomes, and Information Sharing

1. What does _____ look like?
2. Based on your experience, how would you address this gap/need?
3. Who else do we need at the table?

Survey Results

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

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

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

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

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

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

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

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

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

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

warm hand-offs, similar to when SIP clients are released from custody to a SIP officer for re-introduction to their new medical home, housing and treatment. 4
- lack of in-patient psych beds causes backlog of 5150 patients in EDs. This compromises care and leads to burnout among law enforcement, fire, EMS and hospital personnel who perceive the system as indifferent to their true roles.

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

- We need a mental health urgent care with a referral system to community services for addiction and even abuse.
- There is a gap for people who are not SMI but experience mild to moderate MH issues. Often, we work with the individual and do not include the family in the treatment/intervention process.
- Coordinated care between psychiatric, medical and Co-Occurring treatment
- Screening to identify inmates who have previously attempted suicide in custody, had certain charges which could be attributed to one's mental health or emotional wellbeing inmates can get identified and assisted earlier in the booking process.
- 1. Longer rehab programs. 2. More time in wrap services before community re-entry. 3. Specific peer-led jobs open to recent graduates at re-entry to society. 4. Options for population to remain in wellness peer-led community programs for extended time with the option to stay indefinitely if they are successful. 5. MAT programs offering housing and job placement assistance. 6. Continued efforts to educate the public about addiction, and increased de-stigmatization efforts against mental health, addiction and people who commit crimes. 7. Early childhood intervention, including educating parents, teachers, and school administration about mental illness in children and youth beginning in elementary school. 8. Parents associated with a school district must take parenting classes in order to be better equipped to address behavioral problems in their school aged children.
- The Gaps are experienced care givers who can identify with the root of the core symptoms. Then case by case basic develop treatment plans relative to each family. Because if it's one there are multiples in a family unit. Because some of it is learned behavior.
- More treatment - immediate access to treatment - sharing information across systems - quality treatment
- System navigation and community support. The people we serve spend unnecessary time repeating their trauma and establishing relationships with multiple agencies to receive critical services.
- long term inpatient treatment beds need expanding

Lunch Presentation

Mental Health Diversion Legal Updates

Jessica Lees
Deputy District Attorney

MENTAL HEALTH DIVERSION

IN SAN DIEGO COUNTY

San Diego County District Attorney – Summer Stephan

October 22, 2018

MENTAL HEALTH DIVERSION

AB1810 - Budget Trailer Bill, approved by
governor on June 27, 2018

SB215 – Approved by governor on September
30, 2018, Filed with Secretary of State on
October 1, 2018

DEFINITION OF "PRETRIAL MENTAL HEALTH DIVERSION"

Postponement of prosecution, either temporarily or permanently, to allow the defendant to undergo mental health treatment.

WHAT CRIMES ARE ELIGIBLE?

All Misdemeanors And Felonies Except:

- Murder, voluntary manslaughter.
- Registrable offenses per Section 290.
 - Except PC 314.
 - Statute specifies violations of PC 261, 220, 288(a), 264.1, 288.5.
- Use of weapons of mass destruction. (PC 11418(b) & (c).)

DEFENDANT ELIGIBILITY/SUITABILITY REQUIREMENTS

- **The defendant must suffer from a qualifying mental disorder from the most recent DSM .**
- The court must be satisfied the defendant's mental disorder was a significant factor in commission of charged offense.
- In the opinion of qualified mental health expert, the defendant's symptoms of the mental health disorder motivating the criminal behavior would respond to mental health treatment.
- The defendant consents and waives right to speedy trial.*
- The defendant agrees to comply with treatment.
- The court is satisfied that the defendant will not pose an unreasonable risk of danger to public safety if treated in the community.

* UNLESS IST

QUALIFYING DISORDERS

Any disorder from most recent edition of the Diagnostic and Statistical Manual of Mental Disorders.

Except:

- Antisocial Personality Disorder
- Borderline Personality Disorder
- Pedophilia

Evidence:

- Must be provided by defense.
- Must include a recent diagnosis by a "qualified mental health expert."

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* UNLESS IST

MENTAL DISORDER - SIGNIFICANT FACTOR IN THE COMMISSION OF THE CHARGED OFFENSE

The court can review all relevant and credible evidence, including:

- Police reports.
- Preliminary hearing transcripts.
- Witness statements.
- Statements by the defendant's mental health treatment provider.
- Medical records.
- Records or reports by qualified medical experts.
- Evidence that defendant displayed symptoms at or near time of offense.

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UNREASONABLE RISK OF DANGER

An unreasonable risk the defendant will commit a...

"super strike"

SUPER STRIKES

- A "sexually violent offense" (W&I 6600(b).)
- Oral copulation/sodomy/penetration with a child <14 years of age, and who is more than 10 years younger. (PC §§ 288a [287], 286, 289.)
- A lewd or lascivious act involving a child < 14 years (PC 288.)
- Any homicide offense, including attempts (PC [664]187 - 191.5.)
- Solicitation to commit murder. (PC 653f.)
- Assault with a machine gun on a peace officer or firefighter.(PC 245(d)(3).)
- Possession of a weapon of mass destruction. (PC 11418(a)(1).)
- Any serious and/or violent felony offense punishable in California by life imprisonment or death.

UNREASONABLE RISK OF DANGER

The court may consider:

- Opinions of the:
 - district attorney,
 - defense,
 - qualified mental health expert.
- The defendant's violence and criminal history.
- The current charged offense.
- Any other factors the court deems appropriate.

TREATMENT PROGRAM REQUIREMENTS

- Court must be satisfied the program will meet the specialized mental health needs of the defendant.
- May be publically or privately funded.
- May be inpatient or outpatient but must utilize existing resources.

WHEN CAN THE DEFENDANT REQUEST MENTAL HEALTH DIVERSION?

Any point from charging to adjudication....

- Guilt is adjudicated by trial or admitted by plea.
People v. Superior Court (Smith)

IST - Any time before transportation to facility for restoration of competency.

MENTAL HEALTH DIVERSION - GRANTED

- Discretionary with court.
- No longer than two years.
- Progress Reports: Treatment provider must provide regular progress reports.
- Restitution may be ordered during period of diversion.

DIVERSION VIOLATIONS

- Defendant is charged with misdemeanor reflecting propensity for violence.
- The defendant is charged with a felony.
- The defendant was engaged in criminal conduct rendering him/her unsuitable for diversion.
- A qualified mental health expert opines:
 - Defendant is performing unsatisfactorily in the assigned program.
 - The defendant is gravely disabled and should be conserved.

DIVERSION VIOLATIONS – COURT OPTIONS

- Reinstatement Criminal Proceedings.
- Treatment Modification.
- Refer to Conservatorship Investigator to Initiate Conservatorship Proceedings IF...
Defendant is gravely disabled in the opinion of qualified mental health expert.

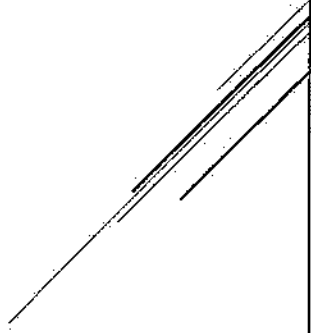
SUCCESSFUL COMPLETION OF DIVERSION

CRIMINAL CHARGES DISMISSED,

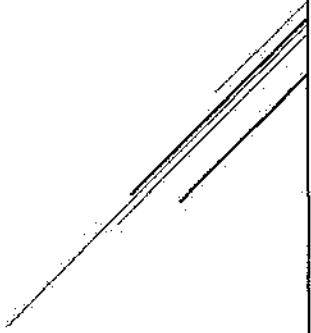
"If defendant performs satisfactorily during diversion."

1ST DEFENDANT NO LONGER DEEMED INCOMPETENT TO STAND TRIAL

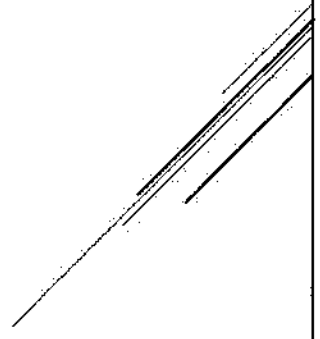
SATISFACTORY PERFORMANCE

- Substantial compliance with diversion.
 - Avoided significant new violations of law unrelated to mental health condition.
 - Long-term mental health plan in place.
- 

CRIMINAL RECORDS SEALED

- Defendant may indicate "no arrest."
Exception: Peace officer application
 - Criminal justice agency access still available per PC 851.92.
 - Court may consider during evaluation of MHD on future cases.
- 

QUESTIONS?



Wrap-up Discussion & Next Steps

Rachel Solov

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Chief of Collaborative Courts Division
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