The Report to the Judicial Council re Amend Welf. & Inst. Code §709 was added on 09/28/15.

JUDICIAL COUNCIL
OF CALIFORNIA

MENTAL HEALTH ISSUES
IMPLEMENTATION TASK FORCE

www.courts.ca.gov/mhiitf.htm
mentalhealthtaskforce@jud.ca.gov

Mental Health Issues Implementation Task Force Open Meeting Agenda

Open to the Public (Cal. Rules of Court, rule 10.75(c)(1))
THIS MEETING IS BEING CONDUCTED BY ELECTRONIC MEANS
THIS MEETING IS BEING RECORDED

Date:	September 29, 2015
Time:	12:15-1:15 p.m.
Public Call-in Number:	Toll Free: 1-877-820-7831; Listen Only Passcode: 3045675

Meeting materials will be posted on the advisory body web page on the California Courts website at least three business days before the meeting.

Agenda items are numbered for identification purposes only and will not necessarily be considered in the indicated order.

I. Open meeting (Cal. Rules of Court, Rule 10.75(c)(1))

Call to Order and Roll Call

Approval of Minutes
Approve minutes of the July 9, 2015 Mental Health Issues Implementation Task Force meeting.

II. Public Comment (Cal. Rules of Court, Rule 10.75(k)(2))

Written Comment
In accordance with California Rules of Court, rule 10.75(k)(1), written comments pertaining to any agenda item of a regularly noticed open meeting can be submitted up to one complete business day before the meeting. For this specific meeting, comments should be e-mailed to mentalhealthtaskforce@jud.ca.gov or mailed or delivered to 455 Golden Gate Avenue - San Francisco CA 94102, attention: Angelica Souza. Only written comments received by September 28, 2015 at 12:15 p.m. will be provided to advisory body members prior to the start of the meeting.

III. Discussion and Possible Action Items (Items 1–4)

Item 1
Proposed Changes Amending WIC 709: Juvenile Competency (Action Required)

Task Force members will review the Joint Juvenile Competency Working Group's recommended modifications related to WIC 709 and juvenile competency issues.

Presenter(s)/Facilitator(s): Dr. Amy Bacharach

Item 2

Final Report of the Task Force to the Judicial Council (Action Required)
Task force members will review the draft report of the task force and identify any modifications that should be made to the document prior to submission to the Judicial Council.

Presenter(s)/Facilitator(s): Hon. Richard J. Loftus, Jr.

Item 3

Mental Health Protocols (Action Required)
Task force members will review the draft Mental Health Protocols for *California Courts: A Guide for Implementing California Rule of Court 10.951 (c), (d) and 10.952* and identify any modifications that should be made prior to finalizing for dissemination for educational purposes.

Presenter(s)/Facilitator(s): Hon. Richard J. Loftus, Jr.

Item 4

Discussion on the Recommendation Concerning the Work of the Mental Health Issues Implementation Task Force (Action Required)
Task force members will identify and prioritize projects for 2016 and 2017.

Presenter(s)/Facilitator(s): Hon. Richard J. Loftus, Jr.

IV. INFORMATION ONLY ITEMS (NO ACTION REQUIRED)

Info 1

Legislative Updates
The Office of Governmental Affairs will provide an update on the status of current bills relating to the work of the task force.

Presenter(s)/Facilitator(s): Ms. Sharon Riley

Info 2

Los Angeles District Attorney's Mental Health Task Force

Judge Bianco will provide an update on the status of the district attorney's mental health task force and its report to the Los Angeles Board of Supervisors and next steps.

Presenter(s)/Facilitator(s): Hon. James Bianco

V. ADJOURNMENT

Adjourn

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MENTAL HEALTH ISSUES
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MENTAL HEALTH ISSUES IMPLEMENTATION TASK FORCE

MINUTES OF OPEN MEETING

July 9, 2015
12:15-1:15 p.m.
Teleconference Meeting

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Advisory Body Members Present:	Hon. Richard Loftus, Jr., Hon. Hilary Chittick, Hon. Suzanne Kingsbury, Hon. Clifford Klein, Hon. Stephen Manley, Hon. Heather Morse, Mr. Michael Planet, and Hon. Garrett Wong.
Advisory Body Members Absent:	Hon. Rogelio Flores, Hon. Susan Gill, Mr. Michael Roddy, Hon. Jaime Roman, Hon. Maria Stratton, and Hon. Michael Tynan.
Others Present:	Ms. Francine Byrne, Ms. Karen Moen, Mr. Dan Pone, Ms. Angelica Souza, and Ms. Nancy Taylor.

OPEN MEETING

Call to Order and Roll Call
The chair called the meeting to order at 12:18 p.m., and took roll call.

Approval of Minutes
The advisory body reviewed and approved the minutes of the May 6, 2015, Mental Health Issues Implementation Task Force meeting.

DISCUSSION AND ACTION ITEMS (ITEMS 1–3)

Item 1

Description of Item Discussed: Incompetent to Stand Trial (IST) Local Models and Protocols

Action:

- *Judge Loftus will continue tracking Santa Clara County efforts to develop a local competency restoration program for those found incompetent to stand trial (IST). This program may be developed either through the jail or through community-based programs. The district attorney, public defender, sheriff and mental health department representatives have expressed interest in developing a local program.*
- *Judge Kingsbury reported that she is meeting with groups providing mental health services in El Dorado County to identify ways to begin a local competency restoration program; in El Dorado County many of those found incompetent to stand trial are misdemeanants who are not eligible for state hospital competency restoration services. She has been talking with the sheriff and county of mental health representatives about the possibility of developing a special IST pod where initial competency restoration work could begin with individuals in custody. She will*

continue to provide updates on local efforts and forward the local report/plan to task force members.

- *Judge Loftus encouraged members to share updates and protocols with each other through the mental health list serve and to share materials related to developments regarding IST issues. Members may send information to staff with a request that the information be disseminated to list serve members.*
- *Judge Bianco reported that he visited San Joaquin's IST program to learn more about the county's outpatient restoration programs for felons. As the Los Angeles program develops, judicial officers are hopeful that the court will retain the authority to decide who is appropriate for jail based treatment program, who is appropriate for the state hospital restoration programs, and who is appropriate for the community outpatient treatment and restoration services.*

Item 2

Description of Item Discussed: Mental Health Education Recommendations

Action:

- *The chair asked task force members to identify any additional educational materials or resources that need to be developed for judicial officer educational toolkits. Suggestions should be forwarded to staff for inclusion in the final report of the task force to the Judicial Council.*
- *Judge Gill, also a member of CJER's Family Law Education Curriculum Committee, noted she has been in contact with CJER's director, Dr. Diane Cowdrey, to discuss ways to better identify mental health-related materials available as on-line resources. Judge Gill has recommended that a separate toolkit be created for all mental health related materials rather than having materials placed in various other toolkits where they might not be instantly identifiable; for example, a judge in a family law assignment might not look under the criminal law toolkit where the majority of mental health related materials reside.*

Item 3

Description of Item Discussed: Future Collaboration with Chief Probation Officers of California (CPOC) and other justice system partners

Action:

- *Sharon Reilly will coordinate with Chief Probation officers to discuss continued work with that group once the task force sunsets in December 2015.*

ADJOURNMENT

There being no further business, the meeting was adjourned at 1:21 p.m.

Approved by the advisory body on September 29, 2015.

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JUDICIAL COUNCIL OF CALIFORNIA

455 Golden Gate Avenue · San Francisco, California 94102-3688

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REPORT TO THE JUDICIAL COUNCIL

For business meeting on: December 11, 2015

Title
Judicial Council–Sponsored Legislation: Competency under Welfare and Institutions Code Section 709

Rules, Forms, Standards, or Statutes Affected
Amend Welf. & Inst. Code, § 709

Recommended by
Family and Juvenile Law Advisory Committee
Hon. Jerilyn L. Borack, Cochair
Hon. Mark A. Juhas, Cochair

Collaborative Justice Advisory Committee
Hon. Richard Vlavianos, Chair
Hon. Rogelio R. Flores, Vice-chair

Mental Health Issues Implementation Task Force
Hon. Richard J. Loftus, Jr., Chair

Agenda Item Type
Action Required

Effective Date
January 1, 2017

Date of Report
September 28, 2015

Contact
Dr. Amy Bacharach, 415-865-7913
amy.bacharach@jud.ca.gov

Executive Summary and Origin

The Family and Juvenile Law Advisory Committee, the Collaborative Justice Advisory Committee, and the Mental Health Issues Implementation Task Force (advisory bodies)

recommend amending Welfare and Institutions Code section 709 to clarify the legal process and procedures in proceedings that determine the legal competency of juveniles.[1]

Recommendation

The Family and Juvenile Law Advisory Committee, the Collaborative Justice Advisory Committee, and the Mental Health Issues Implementation Task Force recommend that the Judicial Council sponsor legislation to amend Welfare and Institutions Code section 709. The amendments will address the issues that arise when a doubt is expressed regarding a minor's competency, including the following:

- Who may express doubt regarding competency in minors;
- Who has the burden of establishing incompetency;
- What is the role of the forensic expert in assessment and reporting on competency in minors;
- What is the process for determining competency in minors;
- What is the process for determining whether competency has been remediated;
- What is the process for ensuring that proceedings are not unduly delayed; and
- What is the process for ensuring due process and confidentiality protections for minors during the proceedings.

The text of the amended statute is attached at pages X–X.

Previous Council Action

There has been no previous Council action of this recommendation. However, the Council received prior reports addressing the need for such a recommendation in the Juvenile Delinquency Court Assessment in 2008 and the Report from the Task Force for Criminal Justice Collaboration on Mental Health Issues in 2011.

Rationale for Recommendation

The Family and Juvenile Law Advisory Committee, the Collaborative Justice Advisory Committee, and the Mental Health Issues Implementation Task Force formed a join working group in 2014 composed of members of each entity, as well as judges from a cross-section of courts, a chief probation officer, a deputy district attorney, a deputy public defender, and a private defense attorney. The working group met ten times to discuss appropriate amendments to Welfare and Institutions Code section 709 before sending a draft to the full committees for further discussion and finalization.

The standard to determine competency for juveniles is different from that for determining competency for adults, as discussed in *Bryan E. v. Superior Court* 231 Cal.App.4th 385 (2014), 390–391. In *Bryan E.*, the appellate court held that the trial court incorrectly applied the standard

[1] This is an initial draft of this report. Please do not circulate. This report will be amended to incorporate feedback from committee members who have not yet had an opportunity to comment.

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of competency for adult proceedings, rather than the standard required in juvenile proceedings. The appellate court cited a litany of cases addressing the difference between adult and juvenile competency determinations.[2] Unlike an adult, a minor may be determined to be incompetent based upon developmental immaturity alone (*Timothy J. v. Superior Court* 150 Cal.App.4th 847 (2007)). Although the standards for competency for adults and juveniles is different, the purpose of competency determinations for adults and juveniles is similar. Therefore, the recommended changes to Welfare and Institutions Code section 709 adds language that mirrors that in Penal Code 1367, which applies to adults.

The recommended changes benefit minors who may be incompetent by providing them with a clear standard for determination, clarifying the procedure for the competency hearing, attributing to the minor the burden of establishing incompetence, clarifying what is expected from an expert who is appointed to evaluate a minor, requiring minors who are found incompetent to receive appropriate services, and requiring the Judicial Council to develop a rule of court outlining the training and experience needed for juvenile competency evaluators.

Comments, Alternatives Considered, and Policy Implications

The proposal was circulated for comment during the summer 2015 cycle, yielding a total of 24 comments. Of those, one agreed with the proposal, four agreed with the proposal if modified, and nineteen did not indicate a position.

Commentators made remarks regarding who can declare doubt about a minor's competency, who should have the burden to prove incompetency, what information evaluators should obtain, what qualifications evaluators should have, whether and when a petition should be dismissed, , remediation services and diversion programs, and developing protocols. The committee thoroughly discussed the comments and made changes accordingly. A chart with all comments received and committee responses is attached at pages x–x.

Members of the joint working group had an extensive discussion regarding who can provide the court with information about competency concerns and who could express a doubt of a minor's competency. Defense attorneys did not feel that prosecutors should be explicitly stated as participants who may express a doubt of a minor's competency while prosecutors felt that they should be explicitly stated. Defense attorneys were concerned about the potential for prosecutorial overreach while prosecutors were concerned that their exclusion from the list of people who could raise a doubt could violate the current law as stated in *Drope v. Missouri* 420 U.S. 162 (1975). The working group ultimately compromised on language for section (a) (2).

In addition, all members of the Family and Juvenile Law Advisory Committee, the Collaborative Justice Advisory Committee, and the Mental Health Issues Implementation Task Force reviewed the proposal and provided feedback. [Describe feedback.]

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[2] *In re Christopher F.* (2011) 194 Cal.App.4th 462; *In re Alejandro G.* (2012) 205 Cal.App.4th 472; *In re John Z.* (2014) 223 Cal.App.4th 1046.

Implementation Requirements, Costs, and Operational Impacts

Although this proposal may result in some additional hearings and expert appointments, it is anticipated that the proposed legislation will result in a net cost savings by limiting the amount of time a minor spends in juvenile hall. It is estimated that states spend approximately $150,000 per year for every youth in a juvenile facility.[3] By clarifying the procedures, allowing youth to be remediated in both the least restrictive setting and a diversion program, and enforcing timelines for determinations of competency, it is anticipated that a minor's stay in juvenile hall will be shortened.

Relevant Strategic Plan Goals and Operational Plan Objectives

The proposed legislative amendments support the policies underlying Goal I: Access, Fairness, and Diversity. Specifically, this legislation revision supports Goal I, policy 4, which provides that the Judicial Branch should "work to achieve procedural fairness in all types of cases." The proposed legislative amendment also supports the policies of Goal IV: Quality of Justice and Service to the Public. Specifically, these rules support policies 3 and 4, which provide that the judicial branch should "provide services that meet the needs of all court users and that promote cultural sensitivity and a better understanding of court orders, procedures, and processes" and "promote the use of innovative and effective problem-solving programs and practices that are consistent with and support the mission of the judicial branch."

Attachments

1. Welf. & Inst. Code, § 709, amended
2. Chart of comments

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[3] Juvenile Law Center, *Ten Strategies to Reduce Juvenile Length of Stay* (March 18, 2015), http://jlc.org/sites/default/files/publication_pdfs/LengthofStayStrategiesFinal.pdf (as of June 1, 2015)

Welfare and Institutions Code Section 709 would be amended, effective January 1, 2017, to read:

709. (a) Whenever the court has a doubt that a minor who is subject to any juvenile proceedings is mentally competent, the court must suspend all proceedings and proceed pursuant to this section.

(1) A minor is mentally incompetent for purposes of this section if he or she is unable to understand the nature of the delinquency proceedings or to assist counsel in conducting a defense in a rational manner, including a lack of a rational or factual understanding of the nature of the charges or proceedings. Incompetency may result from the presence of any condition or conditions, including, but not limited to, mental illness, mental disorder, developmental disability, or developmental immaturity. Except as specifically provided otherwise, this section applies to a minor who is alleged to come within the jurisdiction of the court pursuant to Section 601 or Section 602.

(2) ~~(a)~~ During the pendency of any juvenile proceeding, ~~the minor's counsel or~~ the court may receive information from any source regarding the ~~express a doubt as to the~~ minor's ~~competency. A minor is incompetent to proceed if he or she lacks sufficient present~~ ability to understand the proceedings. Minor's ~~consult with~~ counsel or the court may express a doubt as to the minor's competency. Information received or expression of doubt ~~and assist in preparing his or her defense with a reasonable degree of rational understanding, or lacks a rational as well as factual understanding, of the nature of the charges or~~ does not automatically require suspension of proceedings ~~against him or her~~. If the court has ~~finds substantial evidence raises~~ a doubt as to the minor's competency, the court shall suspend the proceedings ~~shall be suspended~~.

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Welfare and Institutions Code Section 709 would be amended, effective January 1, 2017, to read:

(b) Unless the parties stipulate to a finding that the minor lack competency, or the parties are willing to submit on the issue of the ~~Upon suspension of proceedings, the court shall order~~ that the ~~question of the~~ minor's lack of competency, ~~competence be determined at a hearing. The~~ the ~~court~~ Court shall appoint an expert to evaluate the minor and determine whether the minor suffers from a mental illness, mental disorder, developmental disability, developmental immaturity, or other condition affecting competency, and~~,~~ if so, whether the minor is competent to stand trial. ~~condition or conditions impair the minor's competency.~~

(1) The expert shall have expertise in child and adolescent development~~,~~ and ~~training in the~~ forensic evaluation of juveniles~~, and shall be familiar with~~ for purposes of adjudicating competency, ~~standards~~ and shall be familiar with competency standards and accepted criteria used in evaluating juvenile competency and shall have received training in conducting juvenile competency evaluations ~~competence~~.

(2) The expert shall personally interview the minor and review all the available records provided, including, but not limited to medical, education, special education, probation, child welfare, mental health, regional center, court records, and any other relevant information that is available. The expert shall consult with the minor's attorney and any other person who has provided information to the court regarding the minor's lack of competency. The expert shall gather a developmental history of the minor. If any information is not available to the expert, he or she shall note in the report the efforts to obtain such information. The expert shall administer age-appropriate testing specific

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to the issue of competency, unless the facts of the particular case render testing unnecessary or inappropriate. In a written report, the expert shall opine whether the minor has the sufficient present ability to consult with his or her attorney with a reasonable degree of rational understanding and whether he or she has a rational, as well as factual, understanding of the proceedings against him or her. The expert shall also state the basis for these conclusions. If the expert concludes that the minor lacks competency, the expert shall make recommendations regarding the type of remediation services that would be effective in assisting the minor in attaining competency, and, if possible, the expert shall address the likelihood of the minor attaining competency within a reasonable period of time.

(3) The Judicial Council shall ~~develop and~~ adopt a rule~~s~~ of court identifying the training and experience needed for an expert to be competent in forensic evaluations of juveniles and shall develop and adopt rules for the implementation of other ~~these~~ requirements related to this subdivision.

(4) Statements made to the appointed expert during the minor's competency evaluation, statements made by the minor to mental health professionals during the remediation proceedings, and any fruits of such statements shall not be used in any other delinquency or criminal adjudication against the minor in either juvenile or adult court.

(5) The prosecutor or minor may retain or seek the appointment of additional qualified experts, who may testify during the competency hearing. The expert's report and qualifications shall be disclosed to the opposing party

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Welfare and Institutions Code Section 709 would be amended, effective January 1, 2017, to read:

within a reasonable time prior to the hearing, and not later than five court days prior to the hearing. If disclosure is not made in accordance with this subparagraph, the expert shall not be allowed to testify, and the expert's report shall not be considered by the Court, unless the Court finds good cause to consider the expert's report and testimony. If, after disclosure of the report, the opposing party requests a continuance in order to prepare further for the hearing and shows good cause for the continuance, the court shall grant a continuance for a reasonable period of time.

(6) ~~(f)~~ If the expert believes the minor is developmentally disabled, the court shall appoint the director of a regional center for developmentally disabled individuals described in Article 1 (commencing with Section 4620) of Chapter 5 of Division 4.5, or his or her designee, to evaluate the minor. The director of the regional center, or his or her designee, shall determine whether the minor is eligible for services under the Lanterman Developmental Disabilities Services Act (Division 4.5 (commencing with Section 4500)), and shall provide the court with a written report informing the court of his or her determination. The court's appointment of the director of the regional center for determination of eligibility for services shall not delay the court's proceedings for determination of competency.

(7) An expert's opinion that a minor is developmentally disabled does not supersede an independent determination by the regional center ~~whether~~ regarding the ~~minor is eligible~~ minor's eligibility for services under the

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Welfare and Institutions Code Section 709 would be amended, effective January 1, 2017, to read:

1 Lanterman Developmental Disabilities Services Act (Division 4.5
2 (commencing with Section 4500)).

3 (8) ~~(h)~~ Nothing in this section shall be interpreted to authorize or require the
4 following:

5 A. ~~(1) The court to place~~ Placement of a minor who is incompetent in a
6 developmental center or community facility operated by the State
7 Department of Developmental Services without a determination by a
8 regional center director, or his or her designee, that the minor has a
9 developmental disability and is eligible for services under the Lanterman
10 Developmental Disabilities Services Act (Division 4.5 (commencing
11 with Section 4500)).

12 B. ~~(2) The director of the regional center, or his or her designee, to~~
13 ~~make determinations~~ Determinations regarding the competency of a
14 minor by the director of the regional center or his or her designee.

15 (c) The question of the minor's competency shall be determined at an evidentiary
16 hearing, unless there is a stipulation or submission by the parties on the findings of
17 the expert. The minor has the burden of establishing by a preponderance of the
18 evidence that he or she is incompetent to stand trial.

19 (d) ~~(c)~~ If the minor is found to be competent, the court shall reinstate proceedings and
20 proceed commensurate with the court's jurisdiction.

21 (e) ~~(part of (c))~~ If the court finds ~~incompetent~~ by a preponderance of evidence that the
22 minor is incompetent, all proceedings shall remain suspended for a period of time
23 that is no longer than reasonably necessary to determine whether there is a

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Welfare and Institutions Code Section 709 would be amended, effective January 1, 2017, to read:

substantial probability that the minor will attain competency in the foreseeable future, or the court no longer retains jurisdiction. During this time, the court may make orders that it deems appropriate for services~~, subject to subdivision (h), that may assist the minor in attaining competency~~. Further, the court may rule on motions that do not require the participation of the minor in the preparation of the motions. These motions include, but are not limited to, the following:

(1) Motions to dismiss.

(2) Motions ~~by the defense~~ regarding a change in the placement of the minor.

(3) Detention hearings.

(4) Demurrers.

(f) Upon a finding of incompetency, the court shall refer the minor to services designed to help the minor to attain competency. Service providers and evaluators shall adhere to the standards set forth in this statute and the California Rules of Court. Services shall be provided in the least restrictive environment consistent with public safety. Priority shall be given to minors in custody. Service providers shall determine the likelihood of the minor attaining competency within a reasonable period of time, and if the opinion is that the minor will not attain competency within a reasonable period of time, the minor shall be returned to court at the earliest possible date. The court shall review remediation services at least every 30 calendar days for minors in custody and every 45 calendar days for minors out of custody.

(g) Upon receipt of the recommendation by the remediation program, the court shall hold an evidentiary hearing on whether the minor is remediated or is able to be remediated, unless the parties stipulate to or submit on the recommendation of the

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1 remediation program. If the recommendation is that the minor has attained
2 competency, and if the minor disputes that recommendation, the burden is on the
3 minor to prove by a preponderance of evidence that the minor remains incompetent.
4 If the recommendation is that the minor is not able to be remediated and if the
5 prosecutor disputes that recommendation, the burden is on the prosecutor to prove
6 by a preponderance of evidence that the minor is remediable. If the prosecution
7 contests the evaluation of continued incompetence, the minor shall be presumed
8 incompetent and the prosecution shall have the burden to prove by a preponderance
9 of evidence that the minor is competent. The provisions of subdivision (c) shall
10 apply at this stage of the proceedings.

11 (1) ~~(d)~~ If the court finds that the minor ~~is found to be competent~~ has been
12 remediated, the court ~~may proceed commensurate with the court's jurisdiction~~
13 shall reinstate the delinquency proceedings.

14 (2) If the court finds that the minor is not yet remediated, but is likely to be
15 remediated, the court shall order the minor returned to the remediation
16 program.

17 (3) ~~(e) This section applies to a~~ If the court finds that the minor will not achieve
18 competency, the court must dismiss the petition. The ~~who is alleged to come~~
19 ~~within the jurisdiction of the~~ court ~~pursuant to Section~~ may invite all persons
20 and agencies with information about the minor to the dismissal hearing to
21 discuss any services that may be available to the minor after jurisdiction is
22 terminated. Such persons and agencies may include, but not be limited to, the
23 minor and his or her attorney; probation; parents, guardians, or relative

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Welfare and Institutions Code Section 709 would be amended, effective January 1, 2017, to read:

1 caregivers; mental health treatment professionals; public guardian;

2 educational rights holders; education providers; and social service agencies. If

3 appropriate, the court shall refer the minor for evaluation pursuant to Welfare

4 and Institutions Code Sections ~~601 or 602~~6550 et seq. or 5300 et seq.

5 (h) The presiding judge of the juvenile court; the County Probation Department; the

6 County Mental Health Department; the Public Defender and/or other entity that

7 provides representation for minors; the District Attorney; the regional center, if

8 appropriate; and any other participants the presiding judge shall designate shall

9 develop a written protocol describing the competency process and a program to

10 ensure that minors who are found incompetent receive appropriate remediation

11 services.

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LEG15-04
Welfare and Institutions Code Section 709

All comments are verbatim unless indicated by an asterisk (*).

Topic	Commentator	Position	Comment	Committee Response
Declaring Doubt (who can declare doubt)	San Bernardino Public Defender By Richard Sterling, Supervising Deputy Public Defender	AM	Concerned with anyone other than an attorney or judge declaring a doubt. *Parent* • Who would advise the parent and provide legal advice? The minor is represented by his attorney, but that attorney cannot advise the parent. • Would every parent be given an attorney? Some parents, guardians, siblings do not act in the minor's best interest. • What if the parent and attorney have a conflict? • Would the attorney advise the parent to request that an attorney be provided to them? *Family Members*. • What procedure would be in place for the family member to tell the court that the minor has mental issues and may not understand the proceedings? Many judges do not allow them to speak or allow them to ask any questions. Would the judge be required to make some sort of finding in each case that the minor is competent before going forward? • Would the court inquire from each family member whether they believe the minor is competent and why? What about family members that disagree with each other (divorced parents, siblings)? *Substantial Evidence* • Also, on the first court appearance, other than the family member telling the court and/or attorney that the minor has mental issues, what other evidence would amount to substantial evidence to declare a doubt? They may bring documentation, but many do not. In that instance, the attorney based on what he is told should declare the doubt about competency	*Parent and Family Member/ Substantial Evidence* The advisory bodies have considered all the comments regarding parties and participants. The advisory bodies decided to rewrite subdivision (a)(1) to address all these issues. The new language is: During the pendency of any juvenile proceedings, the court may receive information from any source regarding the minor's ability to understand the proceedings. Minor's counsel or the court may express a doubt as to the minor's competency. Information received or expression of doubt does not automatically require suspension of the proceedings. If the court has a doubt as to the minor's competence, the court shall suspend the proceedings.

Positions: A = Agree; AM = Agree if modified; N = Do not agree; NI = Not indicated.

Topic	Commentator	Position	Comment	Committee Response
	Christine Villanis, Deputy Chief Juvenile Services, San Mateo County Probation Department	AM	Yes [to adding Participants], they probably know more than an attorney can determine and they are generally very involved in the youth's life.	The advisory bodies have considered all the comments regarding parties and participants. The advisory bodies decided to rewrite subdivision (a)(1) to address all these issues. The new language is: During the pendency of any juvenile proceedings, the court may receive information from any source regarding the minor's ability to understand the proceedings. Minor's counsel or the court may express a doubt as to the minor's competency. Information received or expression of doubt does not automatically require suspension of the proceedings. If the court has a doubt as to the minor's competence, the court shall suspend the proceedings.
	Roger A. Luebs, Juvenile Judge Superior Court of California, County of Riverside		*Participants* Subsection (a)(1) creates confusion by allowing any "participant" in the proceedings to "express a doubt" thereby triggering a duty of inquiry by the court. This is especially true because subdivision (b) indicates that the competence of the minor can be resolved by "stipulation". As drafted, it appears that the prosecutor and the defense counsel can simply agree that the minor is or is not competent. If counsel can resolve the issue by "stipulation", what role do the other participants have in "expressing a doubt"?	The advisory bodies have considered all the comments regarding parties and participants. The advisory bodies decided to rewrite subdivision (a)(1) to address all these issues. The new language is: During the pendency of any juvenile proceedings, the court may receive information from any source regarding the minor's ability to

Topic	Commentator	Position	Comment	Committee Response
			I see no good purpose for conveying legal standing on "participants" to "express a doubt". The judge and minor's attorney should be trusted with the responsibility of "expressing doubt" when all the information available to them, including information offered by other "participants", suggests it is appropriate. Subdivision (b) seems to me to be drafted poorly. Since getting an expert evaluation occurs before conducting an evidentiary hearing, I think sentence three in that subdivision should precede the first two sentences. Also, sentence three indicates that the opinion should address whether the minor has "impair[ed]" capacity, but the issue is not "impairment", it is absence or presence of capacity. Almost every child who appears in juvenile court suffers from some degree of impairment, but that does not render them incompetent. I suggest that the third sentence be changed to read: "Upon suspension of the proceedings, the court shall appoint an expert to evaluate the minor and determine whether the minor suffers from a mental illness, mental disorder, developmental disability, developmental immaturity, or other condition affecting competence and, if so, whether the condition or conditions render the minor incompetent as defined in subdivision (a)." I also suggest this change in language because I do not think it is a good idea to repeat, in various forms, the definition of "incompetence" throughout the statute.	understand the proceedings. Minor's counsel or the court may express a doubt as to the minor's competency. Information received or expression of doubt does not automatically require suspension of the proceedings. If the court has a doubt as to the minor's competence, the court shall suspend the proceedings. That is different from the court suspending proceedings and potentially appointing an evaluator to determine a minor's competency. The stipulation or submission by the parties in subdivision (b) allows the court to appoint an evaluator without having to hear additional evidence about whether the minor may or may not be competent. The advisory bodies agree to rewrite the language in the first sentence of (b) to clarify the intent. The language is: Unless the parties stipulate or are willing to submit on the expression of doubt, the Court shall appoint an expert to evaluate the minor and determine whether the minor suffers from a mental illness, mental disorder, developmental disability, developmental immaturity, or other condition affecting competence, and if so, whether the minor is incompetent to stand trial as defined above.

Topic	Commentator	Position	Comment	Committee Response
	Ashleigh E. Aitken, President On behalf of Orange County Bar Association		No [to adding additional participants] No additional individuals should be added to the list of individuals who can raise a doubt.	The advisory bodies have considered all the comments regarding parties and participants. The advisory bodies decided to rewrite subdivision (a)(1) to address all these issues. The new language is: During the pendency of any juvenile proceedings, the court may receive information from any source regarding the minor's ability to understand the proceedings. Minor's counsel or the court may express a doubt as to the minor's competency. Information received or expression of doubt does not automatically require suspension of the proceedings. If the court has a doubt as to the minor's competence, the court shall suspend the proceedings.
	Kiran Savage-Sangwan, Director of Legislation and Advocacy on behalf of the National Alliance on Mental Illness (NAMI)	A	Yes [to adding additional participants] Family members or caregivers are often in the best position to provide information and raise doubt as to competency of a child. Family members and caregivers witness the child's behavior on a regular basis, and over time. Teachers and other providers of services such as health care should be able to raise doubt as to competency. Depending on the unique circumstances of each child, the adults best able to provide the information necessary to the proceedings	The advisory bodies have considered all the comments regarding parties and participants. The advisory bodies decided to rewrite subdivision (a)(1) to address all these issues. The new language is: During the pendency of any juvenile proceedings, the court may receive information from any source regarding the minor's ability to understand the proceedings. Minor's counsel or the court may express a doubt as to the minor's

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			may vary. The language included in § 709(a)(1) adequately addresses this issue.	competency. Information received or expression of doubt does not automatically require suspension of the proceedings. If the court has a doubt as to the minor's competence, the court shall suspend the proceedings.
	Hon. Michael I. Levanas, Presiding Judge, and Commissioner Robert Leventer, Superior Court of California, Los Angeles County, Juvenile Court		*Participants* No [to adding additional participants] Allowing any party or participant to intervene in the court process would be confusing and might cause the court to impermissibly interfere in the attorney-client relationship. • The decision about whether a minor is competent is a legal decision not just a mental health observation. ○ ["More is required to raise a doubt as to competence than mere bizarre action or bizarre statements. A lack of objectivity and possibly self-destructive emotional approach to self-representation does not equate to substantial evidence of incompetence to stand trial." People v. Halvorsen, 42 Cal. 4th 379, 403 (2007).] • The proposal does not define who is a party or participant, but would invite just about anyone to weigh in on the mental health condition of the minor. Certainly it is the obligation of minors' counsel and the court to consider information that parents, relatives, teachers, therapist, etc., have provided about the mental health of the minor. *Confidentiality* The court should not be obligated to invite, or even encouraged to make an inquiry, about a minors' competence or mental health from participants in the courtroom. Such an inquiry is fraught with confidentiality and other legal and strategical	*Participants* The advisory bodies have considered all the comments regarding parties and participants. The advisory bodies decided to rewrite subdivision (a)(1) to address all these issues. The new language is: During the pendency of any juvenile proceedings, the court may receive information from any source regarding the minor's ability to understand the proceedings. Minor's counsel or the court may express a doubt as to the minor's competency. Information received or expression of doubt does not automatically require suspension of the proceedings. If the court has a doubt as to the minor's competence, the court shall suspend the proceedings. *Confidentiality* The advisory bodies believe the rewrite addresses this issue.

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			implications which are necessarily left with minor's counsel. *Substantial Evidence* "Substantial evidence" is the long-standing legal standard in adult competency matters and there is ample case law on this standard to give the courts guidance. "Sufficient evidence" is ambiguous and would seem to take away judicial discretion on whether to suspend proceedings and initiate a costly and burdensome process. • [If the court finds ~~substantial~~ sufficient evidence that raises a reasonable doubt as to the minor's competency ....]	 *Substantial Evidence* The advisory bodies believe the rewrite addresses this issue.
	Sue Burrell, Staff Attorney on behalf of the Youth Law Center		*Participant* We are opposed to the proposed broadening of individuals who may raise the issue of competence. Specifically, we are opposed to allowing prosecutors raise the issue. Retain the existing language on who may express a doubt as to competency. • Recommending to retain the current language of Section 709, subdivision (a), subsection (1), providing that the minor's counsel or the court may express a doubt. In California, adults found incompetent may be held for up to three years in state hospitals. It is hardly a secret that prosecutors sometimes seek a finding of incompetence as a way to obtain custodial time in cases they might have difficulty proving, either because of the defendant's disabilities or because the evidence is weak. • We are concerned that allowing prosecutors to raise competence as an issue would introduce that kind of subterfuge into juvenile proceedings. The impact	*Participants* The advisory bodies have considered all the comments regarding parties and participants. The advisory bodies decided to rewrite subdivision (a)(1) to address all these issues. The new language is: During the pendency of any juvenile proceedings, the court may receive information from any source regarding the minor's ability to understand the proceedings. Minor's counsel or the court may express a doubt as to the minor's competency. Information received or expression of doubt does not automatically require suspension of the proceedings. If the court has a doubt as to the minor's competence, the court shall suspend the proceedings.

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			would be even worse for juveniles because, unlike the adult system, we have no state hospitals with adolescent programs. This means that incompetent youth needing a custodial setting would most likely be warehoused in juvenile detention or correctional facilities. Of all the parties involved in juvenile cases, prosecutors are in the worst position to know whether competence should be raised. • The California Supreme Court has expressly discounted the capacity of prosecutors in relation to juvenile competence. In *In re R.V.* (2015) 61 Cal.4th 181, 196, the Attorney General argued that "imposition of the burden of proof on a minor who claims incompetency comports with policy concerns because, like an adult criminal defendant, the minor and minor's counsel have superior access to information relevant to competency." Our Supreme Court agreed, stating that the defendant and defense counsel likely have better access to the relevant information (*Ibid*., citing *People v. Medina* (1990) 51 Cal.3d 870, 885) • The current provisions, allowing either defense counsel or the court to raise the issue are adequate to provide an avenue for parents or other caregivers to bring attention to conditions that could impact competence. • Part of the ethical duties of defense counsel include interviewing and communicating with parents or guardians, so parents or guardians have a ready avenue in which to offer concerns about competence. The court provides an important check and balance on this process. If for example, defense counsel has not raised the issue when it seems	

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			apparent to the court that it should have been raised, the court may raise the issue on its own motion to assure the integrity of the process. • The court can do this without the baggage that would inevitably taint an assertion of incompetence by the prosecutor. Our office has worked on juvenile incompetence issues for nearly a decade now, and we have not heard of a single case or situation in which the current language would have been inadequate to protect the rights of the young person before the court. *Substantial Evidence* Substantial to "sufficient" and adding "reasonable." Our review of the cases suggests that "substantial" and "sufficient" are interchangeable (*see*, *e.g*., *People v. Stankewitz* (1982) 32 Cal.3d 80, 92-93, "substantial evidence of incompetence is sufficient to require a full competence hearing even if the evidence is in conflict"), so we have no objection to that change. However, we do object to the addition of the word "reasonable." That appears to be interjecting a standard that is new and unsupported. We are concerned that adding "reasonable" will be viewed as adding some additional burden to what is currently required to justify the declaration of a doubt. Recommendation: Change "substantial" to "sufficient," but omit the proposed addition of "reasonable."	*Substantial Evidence* The advisory bodies believe the rewrite addresses this issue.
	Margaret Huscher, Supervising Deputy Public		I do not share the advisory bodies concern that a parent or caretaker may be the only person with sufficient information to raise a doubt.	The advisory bodies have considered all the comments regarding parties and participants. The advisory bodies decided to rewrite subdivision

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	Defender III, Law Office of the Public Defender, Shasta County		• Sometimes, it is immediately obvious that there is an unavoidable incompetency issue and we declare the doubt early in our representation. More frequently, however, , we will meet repeatedly with the minor, talk with family, review school records, consult with hall staff, etc. to explore alternatives to incompetency. *Family Member* Conversely, I have a grave concern that a family member may not understand the legal process and, albeit with good intentions, create legal chaos. • Family members generally do not know the collateral consequences to having an incompetent child or be able to weigh the risk to and benefits of declaring a doubt. • When we represent a child where there is a concern that the child may not be comprehending the proceedings, we have a heightened responsibility to that child: it is a balancing act between the child's express interests and what we think is best for the child. • Adding the uncertainty of the parents' opinion could potentially make the process more emotionally difficult and uncertain for the child, as well as create conflict between the family member and the minor's attorney. *Substantial Evidence* In all the years that I have practiced, I have never had a judge, after a doubt has been declared, hold a hearing on whether there is substantial evidence to suspend proceedings. Judges rely on defense attorneys to identify	(a)(1) to address all these issues. The new language is: During the pendency of any juvenile proceedings, the court may receive information from any source regarding the minor's ability to understand the proceedings. Minor's counsel or the court may express a doubt as to the minor's competency. Information received or expression of doubt does not automatically require suspension of the proceedings. If the court has a doubt as to the minor's competence, the court shall suspend the proceedings The advisory bodies believe the rewrite addresses this issue.

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			clients who are struggling to participate in the criminal process and to declare a doubt appropriately. However, it is unlikely that judges will have a professional relationship with the family members such that judges can rely upon the family's judgment in order to know whether to suspend proceedings. The proposed amendment requires the judge to make a finding of incompetency based upon sufficient evidence, but fails to provide guidance as to what sufficient evidence might be. • In the scenario where minor's attorney remains quiet and the parent, in an attempt to provide sufficient evidence, spews forth information about the minor, what finding is the judge supposed to make? Assuming the judge relies upon the attorney's judgment in *not* declaring a doubt, on what basis does the court make a finding that insufficient evidence was offered by the parents? *Evidentiary Hearing* Why is this sentence necessary? As defense attorneys, we routinely stipulate to the doctor's reports on the issue of competency rather than presenting live testimony. However, this sentence seems to suggest that the parties could stipulate to incompetency without a doctor's report as a foundation for that stipulation. As an experienced defense attorney, there is a temptation to declare a doubt when the client is argumentative and simply *will not listen to or follow* the attorney's advice. Likewise, there is a temptation to declare a doubt when the strategy is to delay the inevitable. If this language is to be included, I am	The advisory bodies believe the rewrite of subdivision (b) addresses this issue to clarify the intent of the subdivision: The advisory bodies agree to rewrite the language in the first sentence of (b) to clarify the intent. The language is: <u>Unless the parties stipulate or are willing to submit on the expression of doubt, the Court shall appoint an expert to evaluate the minor and determine whether the minor suffers from a mental illness, mental disorder, developmental disability, developmental immaturity, or other condition affecting competence, and if so,</u>

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			concerned that an unfettered stipulation could be abused by attorneys' agreement to avoid difficult clients/cases.	whether the minor is incompetent to stand trial as defined above.
	Greg Feldman, Deputy Public Defender, on Behalf of San Francisco Office of the Public Defender		We strongly object to allowing other parties express a doubt. • It is the defender and the resources and training that we dedicate to the determination of client competence who is in the best position to express a doubt. We are concerned that allowing other parties to express a doubt invites possible abuse of the competency process by other parties to delay proceedings especially when the majority of our clients are in custody. • Because there are almost no alternative placements for youth in various stages of the competency process, youth remain in custody without appropriate services for months. It is no surprise that they deteriorate with extended exposure to long term detention suffering from anxiety, depression, anger, and even suicidal ideation. The prosecutors are bound by their ethical obligation to not communicate with a child who is represented by counsel. They are in no position to express a doubt on behalf of a youth facing delinquent charges.	The advisory bodies have considered all the comments regarding parties and participants. The advisory bodies decided to rewrite subdivision (a)(1) to address all these issues. The new language is: During the pendency of any juvenile proceedings, the court may receive information from any source regarding the minor's ability to understand the proceedings. Minor's counsel or the court may express a doubt as to the minor's competency. Information received or expression of doubt does not automatically require suspension of the proceedings. If the court has a doubt as to the minor's competence, the court shall suspend the proceedings
	Lexi Howard, Legislative Director on behalf of the Juvenile Court Judges of California		Yes, [to adding additional participants] Since the raising of doubt is merely for the court's consideration and does not result in the suspension of proceedings automatically, we agree with adding "participants."	The advisory bodies have considered all the comments regarding parties and participants. The advisory bodies decided to rewrite subdivision (a)(1) to address all these issues. The new language is: During the pendency of any juvenile proceedings, the court may receive information from any source regarding the minor's ability to understand the proceedings. Minor's counsel or

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				the court may express a doubt as to the minor's competency. Information received or expression of doubt does not automatically require suspension of the proceedings. If the court has a doubt as to the minor's competence, the court shall suspend the proceedings
	Michelle Linley, Chief, Juvenile Division, on behalf of the San Diego county District Attorney's Association		No, [to adding additional participants] We would oppose the modification allowing any party or participant to raise the issue of competency. In the comments preceding the proposed legislation it is stated that it is believed that this legislation and the proposed timelines will reduce stays in Juvenile Hall. In practice some of the juveniles that are not competent are also very violent. The focus should be, not only on reducing Juvenile Hall stays, but on public safety. • When any party may raise the issue of competency we have a concern that non-attorneys will not understand the legal requirements for competency which will increase the number of allegations of incompetency. • This could result in unnecessary delays in the case, longer detention in Juvenile hall and misallocation of precious mental health resources. If instead, the concerns were brought to the attention of a Juvenile Justice Partner those allegations would be investigated by those with knowledge of the legal system and presented to the court in the appropriate circumstances.	The advisory bodies have considered all the comments regarding parties and participants. The advisory bodies decided to rewrite subdivision (a)(1) to address all these issues. The new language is: During the pendency of any juvenile proceedings, the court may receive information from any source regarding the minor's ability to understand the proceedings. Minor's counsel or the court may express a doubt as to the minor's competency. Information received or expression of doubt does not automatically require suspension of the proceedings. If the court has a doubt as to the minor's competence, the court shall suspend the proceedings The advisory bodies acknowledge that youth who commit violent crimes present additional challenges. This legislation clarifies process and procedure.
	Adrienne Shilton, Director, Intergovernmental Affairs, County Behavioral		Yes, [to adding additional participants] CBHDA recommends that this should primarily include adults who have been known by the individual youth for at least one year.	The advisory bodies have considered all the comments regarding parties and participants. The advisory bodies decided to rewrite subdivision (a)(1) to address all these issues. The new language is:

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	Health Directors Association of California			During the pendency of any juvenile proceedings, the court may receive information from any source regarding the minor's ability to understand the proceedings. Minor's counsel or the court may express a doubt as to the minor's competency. Information received or expression of doubt does not automatically require suspension of the proceedings. If the court has a doubt as to the minor's competence, the court shall suspend the proceedings
	Corene Kendrick, PJDC Board Member & Amicus Committee Member on behalf of the Pacific Juvenile Defender Center		*Participant* We strongly object to allowing other parties express a doubt as to a child's competency to assist his or her attorney. • We are strongly opposed to any broadening of the individuals who may raise the issue of competence. Currently, the Court or counsel for the child may raise a doubt as to his or her competency. • The child's defender, and the delinquency judge are the two individuals who are in the best position to express a doubt. • The proposed language to add any party opens the door to possible abuse of the competency process by other parties, including for reasons to delay proceedings, especially when the majority of children are in custody. Because there are almost no alternative placements for youth in various stages of the competency process, and California has no state hospitals with programs for children and adolescents, youth remain in custody without	The advisory bodies have considered all the comments regarding parties and participants. The advisory bodies decided to rewrite subdivision (a)(1) to address all these issues. The new language is: During the pendency of any juvenile proceedings, the court may receive information from any source regarding the minor's ability to understand the proceedings. Minor's counsel or the court may express a doubt as to the minor's competency. Information received or expression of doubt does not automatically require suspension of the proceedings. If the court has a doubt as to the minor's competence, the court shall suspend the proceedings

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			appropriate services for months, with concomitant deterioration in their mental well-being. • Prosecutors especially should not be permitted to raise a doubt. They are bound by their ethical obligation to not communicate with a child who is represented by counsel. They cannot speak with the child to get to know the child's capabilities and limitations, and therefore they are the least able to express a doubt on behalf of a youth facing delinquent charges. • The California Supreme Court recently discounted the ability of prosecutors to have complete knowledge in a competency proceeding, as the minor and the minor's counsel have superior access to relevant information. (*In re R.V*. (2015) 16 Cal.4th 181, 196, *citing People v. Medina* (1990) 51 Cal.3d 870, 885). *Reasonable Evidence (Substantial/Sufficient)* The proposed changes introduces an unsupported concept of "reasonable" evidence, which we oppose. • While case law supports the proposition that "substantial" and "sufficient" are interchangeable, the addition of the word "reasonable" in the proposed legislation has no basis in the law and introduces a new standard or additional burden of what evidence is required to raise a doubt. "Reasonable" is not used in Penal Code 1369.	The advisory bodies believe the rewrite of subdivision (a) addresses this issue.
	Roger Chan, Executive Director on behalf of the East		No, [to adding additional participant] We are strongly opposed to broadening the number of persons who can raise a doubt beyond the court or minor's counsel. • Other parties or participants in the case will not know the legal issues and factual investigation	The advisory bodies have considered all the comments regarding parties and participants. The advisory bodies decided to rewrite subdivision (a)(1) to address all these issues. The new language is:

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	Bay Children's Law Offices		necessary to evaluate a minor's competency. While other participants, such as parents or relatives, may have relevant information regarding the minor's competency, it is the responsibility of the minor's attorney to ascertain that information in the course of her investigation. • Allowing "any party" or "participant" to express a doubt may cause unnecessary court delays to the detriment of the minor's due process rights, potential undermining of the attorney-client relationship, and interference with or violation of confidential case strategy. • In any event, the categories of "any party" or "participant" are too broad. For example, Welf. & Inst. Code § 676 enumerates 28 offenses in which members of the public can be admitted to juvenile proceedings and become "participants." Recommendation: Retain the current language of Section 709(a), providing that the minor's counsel or the court may express a doubt.	 During the pendency of any juvenile proceedings, the court may receive information from any source regarding the minor's ability to understand the proceedings. Minor's counsel or the court may express a doubt as to the minor's competency. Information received or expression of doubt does not automatically require suspension of the proceedings. If the court has a doubt as to the minor's competence, the court shall suspend the proceedings
	Endria Richardson, Staff Attorney, Legal Services for Prisoners with Children ("LSPC")		By limiting the parties who may express doubt as to a minor's competency to the minor's counsel or the court, existing law may make it more likely that youth who are not, in fact, fit to stand trial, do not even have their competency considered by the court. By broadening the number of people who are able to raise competency issues—including specialists who may have adequate time to meet with and evaluate the minor, the minor's parents and loved ones who know them best, teachers who have observed the minor in an educational setting—as well as the criteria used to consider whether a minor is not competent to stand trial,	Information only. No comment needed.

Positions: A = Agree; AM = Agree if modified; N = Do not agree; NI = Not indicated.

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			the Advisory Committees are taking significant steps to ensure that a more comprehensive evaluation of justice involved juveniles. One of the most serious decisions the state makes about a young person is whether to send him or her through the criminal system. It is a decision that deserves a thorough, thoughtful review by an unbiased decision-maker who considers many factors. Developmental and neurological evidence about adolescents and young adults concludes that the process of cognitive brain development continues into early adulthood—for boys and young men especially, this developmental process continues into the mid-20s. The still-developing areas of the brain, particularly those that affect judgement and decision-making, are highly relevant to criminal behavior and culpability. The fact that teens are still developing neurologically and emotionally may mean that a thorough evaluation of their competence must be performed by an expert—one who is not burdened by excessive caseloads (as many public defenders are), and is a competent assessor of the healthy development of youth and adolescent brains (as courts are not). These amendments are an encouraging step towards ensuring that youth receive adequate services and are not simply ushered through the juvenile justice system as a matter of course. Studies have shown that that approximately 65%-70% of youth in juvenile detention have a diagnosable mental health disorder. (Skowyra, Kathleen, and Joseph	

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			Cocozza. "Research in Brief." *Communications* 21.4 (1996): n. pag. *National Center for Mental Health and Juvenile Justive*. June 2006. Web.)	
	Tari Dolstra, Division Director, Juvenile Services Riverside County Probation Department		• Should participants be added to the list of individuals who can raise doubt? If probation departments are included in "….social services agencies...", then there is no need to identify our agency specifically.	The advisory bodies have considered all the comments regarding parties and participants. The advisory bodies decided to rewrite subdivision (a)(1) to address all these issues. The new language is: During the pendency of any juvenile proceedings, the court may receive information from any source regarding the minor's ability to understand the proceedings. Minor's counsel or the court may express a doubt as to the minor's competency. Information received or expression of doubt does not automatically require suspension of the proceedings. If the court has a doubt as to the minor's competence, the court shall suspend the proceedings
	Angela Igrisan, Mental Health Administrator, on behalf of the Riverside County Department of Mental Health		The statute says "any party or participant can raise doubt" which is sufficient.	The advisory bodies have considered all the comments regarding parties and participants. The advisory bodies decided to rewrite subdivision (a)(1) to address all these issues. The new language is: During the pendency of any juvenile proceedings, the court may receive information from any source regarding the minor's ability to understand the proceedings. Minor's counsel or the court may express a doubt as to the minor's competency. Information received or expression of doubt does not automatically require

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				suspension of the proceedings. If the court has a doubt as to the minor's competence, the court shall suspend the proceedings
	Rosemary Lamb McCool, Deputy Director, Chief Probation Officers of California		Expanding who may Raise Doubt of Minor's Competency: We are supportive of the changes to allow additional parties to question the competency of a youth.	The advisory bodies have considered all the comments regarding parties and participants. The advisory bodies decided to rewrite subdivision (a)(1) to address all these issues. The new language is: During the pendency of any juvenile proceedings, the court may receive information from any source regarding the minor's ability to understand the proceedings. Minor's counsel or the court may express a doubt as to the minor's competency. Information received or expression of doubt does not automatically require suspension of the proceedings. If the court has a doubt as to the minor's competence, the court shall suspend the proceedings
Burden of Proof	Christine Villanis, Deputy Chief Juvenile Services, San Mateo County Probation Department	AM	Yes [the burden of proof should be placed on the minor], this makes sense in being consistent with the adult court. However, if you are saying they cannot contribute to their own defense, how do they then contribute to defending that they are incompetent to do so?	The advisory bodies agree. The defense attorney has a duty to communicate with their client and take direction from their client. However, the ability for an attorney to perform these tasks may be limited based on a minor's ability to understand the proceedings. The attorney for the minor still has a duty to zealously advocate for his or her client.
	Ashleigh E. Aitken, President		Yes, the burden to prove incompetency is best placed upon the minor.	The advisory bodies agree.

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	On behalf of Orange County Bar Association			
	Sue Burrell, Staff Attorney on behalf of the Youth Law Center	AM	Agrees on using the suggested language if language in (a)(1) remains the same. Do not expand the language to allow additional parties to raise the issues of competence. • The suggested change appears to incorporate the burden of proof recognized in *In re R.V.* (2015) 61 Cal.4th 181, placing the burden on the minor. -This provision points out the absurdity of allowing other parties such as the prosecutor to raise the issue of competence. If that were allowed, the minor's counsel would be in the position of being responsible to show incompetence in case in which they did not raise it. If the law is expanded to allow additional parties to raise the issue of competence, we believe the burden should be placed on the person raising the issue.	The advisory bodies agree that the minor has the burden of proof. The advisory bodies believe the rewrite of subdivision (a) addresses the remaining issues.
	Lexi Howard, Legislative Director on behalf of the Juvenile Court Judges of California		Yes, the Burden of proof to prove incompetency should be placed on the minor	The advisory bodies agree.
	Amanda K. Roze, Attorney at Law, Sebastopol, CA		The Invitation and proposed changes appear to contain conflicting information about the implied presumptions at such a hearing. According to information in the Invitation (p. 5), "the proposal places the burden of proof on the minor to prove, by a preponderance of the evidence, that the minor is incompetent." The proposed change themselves, though, seem to make a distinction based on whether the recommendation is that	

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			competency has been remediated. It appears that if the recommendation is that the minor has not attained competency, that the prosecution has the burden to prove that he or she is remediable. The language therefore suggests that the prosecution would have the burden to prove competence, if it sought to make competence itself an issue at that point. Where a minor has been found incompetent, competency services have been provided, and an expert opines that he has attained competency, there is some basis in reason to assign the burden to the minor to establish that he remains incompetent. However, it would defy reason to presume a minor competent at a remediation/attainment of competency hearing where he has previously been found incompetent and the provider of remediation services and/or the appointed expert states that competency has not yet been attained. • It is implicit in section 709 that once a minor is determined to be incompetent, he is presumed to remain incompetent until he is shown to have attained competency. (See § 709, subd. (c).) That is, after all, the purpose of the hearing on attainment of competency. Therefore, proposed subdivision (l) should be amended to clearly provide that the prosecution has the burden to establish competence where the recommendation is that the minor remains incompetent and/or whose competency has not been remediated. To establish parallelism in the provisions, subdivision (l) could provide:	

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			If the recommendation is that the minor's competency has been remediated, and if the minor disputes that recommendation, the burden is on the minor to prove, by a preponderance of evidence, that the minor remains incompetent. If the recommendation is that the minor is not able to be remediated, and if the prosecutor disputes that recommendation, the burden is on the prosecutor to prove by a preponderance of evidence that the minor is remediable. *If the prosecution contests the evaluation of continued incompetence, the minor shall be presumed incompetent, and the prosecution shall have the burden to prove that the minor is competent.* On a related issue, the proposed changes do not address the situation where anew section 602 petition is filed against a minor who has been found incompetent. In Alameda County's competency protocol, for instance, the minor is always presumed competent when new charges are filed. Under a section titled New Offenses, the protocol states: • The minor is presumed competent. ... If the court determines that there is not substantial evidence the minor is incompetent, the new case will not be suspended and the court will proceed with the new underlying juvenile proceedings. The issue of the minor's competence on the previously suspended petition/notice will remain as is, until the court makes a finding regarding competence on the matter. (Alameda County Competency Protocol, p. 20.) Thus, the Protocol posits the logically and legally untenable proposition that a minor can be both incompetent and competent simultaneously, i.e. currently incompetent as to prior suspended petitions but	The advisory bodies have considered all the comments regarding parties and participants. The advisory bodies decided to rewrite subdivision (a)(1) to address all these issues. The new language is: Upon receipt of the recommendation by the remediation program, the court shall hold an evidentiary hearing on whether the minor is remediated or is able to be remediated, unless the parties stipulate to or submit on the recommendation of the remediation program. If the recommendation is that the minor's competency has been remediated, and if the minor disputes that recommendation, the burden is on the minor to prove by a preponderance of evidence that the minor remains incompetent. If the recommendation is that the minor is not able to be remediated and if the prosecutor disputes that recommendation, the burden is on the prosecutor to prove by a preponderance of evidence that the minor is remediable. If the prosecution contests the evaluation of continued incompetence, the minor shall be presumed incompetent and the prosecution shall have the burden to prove by a preponderance of evidence that the minor is competent.

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			competent as to newly-filed petitions. To avoid such a result, it must be accepted that once a minor is found incompetent, he is presumed to remain incompetent until it is proven that he has attained competency, or until the appointed expert or an expert remediation provider opines that his competency has been remediated.	
	Michelle Linley, Chief, Juvenile Division, on behalf of the San Diego county District Attorney's Association		It is unclear what legal authority is the basis for shifting the burden to the Prosecution when there is an allegation that the minor cannot be remediable. We would oppose shifting of the burden in the event the prosecutor disputed the recommendation that the minor is not able to be remediated.	The advisory bodies disagree. In re R.V. clearly addresses that the minor has the burden to prove incompetence and cites Evidence Code 605 and 606 to fill the void. The advisory bodies agree that the minor has the burden of proof to prove incompetency, which logically follows that the prosecution has the burden to prove the opposite.
	Adrienne Shilton, Director, Intergovernmenta l Affairs, County Behavioral Health Directors Association of California		CBHDA recommends that the burden of proof be placed on the State. CBHDA further recommends that the Judicial Council of California convene experts to develop well thought-out set of consequences for children who commit serious crimes but who may not understand the legal system well enough to assist in their own defense.	The advisory bodies disagree. The In re R.V decision clearly states that the burden rests on the minor.
	Corene Kendrick, PJDC Board Member & Amicus Committee Member on behalf of the Pacific Juvenile Defender Center		Additionally, the suggested change regarding burden of proof proposed for subdivision (b), which appears to codify the *In re R.V.* decision that held that the burden of proof is on the child, illustrates that is illogical to let the prosecutor raise the issue of competency – minor's counsel would then be put in the position of being responsible for proving incompetency, when she did not raise the issue. • The current provisions of Section 709 that permit either defense counsel or the court to raise the issue of	The advisory bodies have considered all the comments regarding parties and participants. The advisory bodies decided to rewrite subdivision (a)(1) to address all these issues. The new language is: <u>During the pendency of any juvenile proceedings, the court may receive information from any source regarding the minor's ability to understand the proceedings. Minor's counsel or the court may express a doubt as to the minor's</u>

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			competency are adequate to provide an avenue for parents or other caregivers to bring attention to conditions that could impact competence. Pursuant to their ethical obligations, defense counsel must interview and communicate with a juvenile client's parents or guardians, so they already can avail themselves of the defender	competency. Information received or expression of doubt does not automatically require suspension of the proceedings. If the court has a doubt as to the minor's competence, the court shall suspend the proceedings The advisory bodies believe that the rewrite addresses the issues raised by the commentator.
	Roger Chan, Executive Director on behalf of the East Bay Children's Law Offices		As noted in In re R.V. (2015) 61 Cal.4th 181, "It necessarily follows from a presumption of competency that the burden of proving incompetency is borne by the party asserting it." Unless the presumption of competency is changed to a presumption of incompetency (e.g. following a prima facie showing of incompetency) similar to the presumption of incapacity under Penal Code § 26, the burden should not change. However, this underscores the impracticalities of adding participants to the list of individuals who can raise a doubt. The two proposed changes construed together would result in the absurd situation where the minor's counsel would be responsible to prove incompetence in cases where they did not raise it. In addition, the threshold requirement of "sufficient evidence, that raises a reasonable doubt" to suspend the proceedings creates a different standard than that for adults. Penal Code § 1368(a) references when "a doubt arises in the mind of the judge…" To avoid interjecting a new standard for juveniles, the word "reasonable" should be omitted.	The advisory bodies have considered all the comments regarding parties and participants. The advisory bodies decided to rewrite subdivision (a)(1) to address all these issues. The new language is: During the pendency of any juvenile proceedings, the court may receive information from any source regarding the minor's ability to understand the proceedings. Minor's counsel or the court may express a doubt as to the minor's competency. Information received or expression of doubt does not automatically require suspension of the proceedings. If the court has a doubt as to the minor's competence, the court shall suspend the proceedings The advisory bodies believe that the rewrite addresses the issues raised by the commentator.

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			Recommendation: Retain the proposed language in Section 709(a)(1) without adding individuals who may raise a doubt. Omit "reasonable" as modifying the court's "doubt."	
	Tari Dolstra, Division Director, Juvenile Services Riverside County Probation Department		Yes, it is agreed the burden of proof should be placed upon the minor.	The advisory bodies agree.
	Angela Igrisan, Mental Health Administrator, on behalf of the Riverside County Department of Mental Health		This appears to be a question best left for legal counsel to answer who can better define 'burden of proof' and the implications. Our initial thoughts are that it is inappropriate to place this burden on a protected class of people. Timothy J vs. Superior Court (2007) as referenced in the document ruled that a child could be ruled incompetent by developmental immaturity alone. • Hence, is there a double bind here? • Should incompetence of a minor be the presumptive stance? • Otherwise, minors would be granted the full rights and responsibilities of adults?	The advisory bodies read In re R.V. as presuming that the minor is competent. Once someone raises a doubt, the court considers that information when determine whether to suspend proceedings. It is clear that juvenile proceedings are different from adult proceedings, including juvenile competency proceedings.
	Rosemary Lamb McCool, Deputy Director, Chief Probation Officers of California		Responsibility to Prove Incompetency We agree that the individual asserting incompetency should bear the responsibility of proving such incompetency as is consistent with In re R.V. (May, 18, 2015, S212346).	The advisory bodies believe that minor bears the burden of proving incompetency.
Evaluators	Roger A. Luebs, Juvenile Judge Superior Court of California,		Regarding subsection (b)(2), requiring the expert to consult with the minor's attorney interjects an unnecessary opportunity for advocacy into what should be an objective scientific process. Should the expert also	The advisory bodies believe that evaluator should consult the minor's attorney as the minor's attorney may have additional

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	County of Riverside		be required to consult with the prosecutor to get the prosecutor's views on the competence of the minor? If the minor's counsel has objective information that would assist the expert in forming an opinion regarding the minor's competence, that information should be required to be furnished in written form which should reduce the risk of advocacy and also make the whole process more transparent	information about the minor regarding his or her ability to understand the legal process. The advisory bodies disagree that the information should be in written form. The attorney may not know what questions until the evaluator asks. The evaluator may not know what questions to ask until the evaluator has reviewed the materials. Requiring the answers in writing also seem burdensome and are not conducive to answering follow –up questions if the evaluator has any,
	Kiran Savage-Sangwan, Director of Legislation and Advocacy on behalf of the National Alliance on Mental Illness (NAMI)		Regarding subsection 709(b)(2) state "The expert shall personally interview the minor and review all the available records provided, including but not limited to medical, education, special education, child welfare, mental health, regional center, and court records. The expert shall consult with the minor's defense attorney and whoever raised doubt of competency, if that person is different from the minor's attorney and if that person is not the judge, to ascertain his or her reasons for doubting competency. The expert shall consult with family members and caregivers to the minor, when possible, to review information regarding the minor's developmental and psychological history. The expert shall consider a developmental history of the minor."	The advisory bodies agree with this concept. The advisory bodies rewrote the section to state: The expert shall personally interview the minor and review all the available records provided, including, but not limited to medical, education, special education, probation, child welfare, mental health, regional center, court records, and any other relevant information that is available.
	Margaret Huscher, Supervising Deputy Public Defender III, Law Office of the Public Defender, Shasta County		I am very pleased with the idea that the evaluator makes an opinion regarding the type of treatment and whether the minor can attain competency within a reasonable time. • It would be helpful to have the evaluator's opinion regarding "the least restrictive environment" possible is in order to receive remediation services.	The advisory bodies agree with this concept. The advisory bodies rewrote the section to state: Services shall be provided in the least restrictive environment consistent with public safety.

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			o With our regional center clients, we have had extensive arguments regarding whether the client needs to be in a group home and/or at Porterville Developmental Center in order to receive remediation. Indeed, these arguments have been based upon gut instinct and speculation. A psychologist's opinion would be very helpful.	
	Janice Thomas, Ph.D. Alameda County Behavioral Health Care Services		I especially support the language which directs the expert to "consult with the minor's defense attorney and whoever raised a doubt of competency." However, I would note that not all defense attorneys are willing to describe their perceptions of a youth's competency-related deficits and impairments.	The advisory bodies agree.
			• Although I have never encountered any difficulty in obtaining supporting records from defense attorneys, I have encountered difficulty when I have asked attorneys to complete the "Attorney CST Questionnaire" described in Evaluating Juveniles' Adjudicative Competence: A Guide for Clinical Practice (Grisso, 2005). One defense attorney explained that he did not want to become a witness to a competency proceeding by stating his observations in an interview or by completing the "Attorney CST Questionnaire."	Information only. No comment needed
			• When defense attorneys do not report to evaluators their perceptions of their clients' deficits, the expert can certainly report in the evaluation that he or she contacted the defense attorney and that the defense attorney did not choose to participate in the consultation. I suppose that would suffice in terms of the expert meeting the requirements of the statute. But still, I wonder if problems are raised when defense attorneys discuss their cases with	Information only; no comment needed.

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			court-appointed evaluators and whether there is a legitimate issue to be addressed.	
	Rosemary Lamb McCool, Deputy Director, Chief Probation Officers of California		Competency Evaluations: We would like the statute to be more explicit as to who is responsible to fund the evaluations and reports. Without such specificity we fear that the county, or probation more definitively, will bear the burden of those costs. The reports, in our view, are meant to aid the court in determining how to proceed with the minor's case and as such we believe the court and/or state should bear the cost of the evaluation and any accompanying reports.	The advisory bodies believe that funding decisions for the evaluation and reports should be at the discretion of the jurisdiction.
Expert Qualifications	Christine Villanis, Deputy Chief Juvenile Services, San Mateo County Probation Department	AM	No [do not take out of statute and put in rule of court]. I think it is helpful to have the information in one place. When statute refers to some other source, it becomes difficult to keep track. It will be much simpler for those who are not attorneys to follow. And since any party can now participate, less complicated may be appreciated. Same as above. [Keep expert qualifications in the rule of court] It is clear cut when we do not have to jump from one source to another to get information that is pertinent.	The advisory bodies agree.
	Roger A. Luebs, Juvenile Judge Superior Court of California, County of Riverside		With regard to subdivision (c), this would essentially put an evidentiary privilege created by judges into statute. Since a rule created by judges can be changed by judges, I do not think it is a good idea to make it less changeable by placing it in statute. It should be noted that the privilege as drafted applies to "[s]tatements made [by anyone] to the appointed expert", not just statements made by the minor to the expert. Is this really the law, or is it an expansion of the existing judge made privilege?	The advisory bodies disagree per People v. Arcega, 32 Cal.3d 504. Originally the advisory bodies made reference to Evidence Code Section 1017. However Evidence Code Section 1017 applies to communications made during the course of an evaluation relating to "a plea based on insanity or to present a defense based on his or her mental or emotional condition." A hearing to determine competence to stand trial is neither of these things. It is not necessary to mention a code section to convey the prohibition of using information gathered by an expert during a

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			In addition, the statute creates not only an evidentiary privilege with respect to the minor's statements to the evaluator, but also precludes the use of "any fruits of the minor's competency evaluation [not fruits of the minor's "statements", but fruits of the "evaluation".] Does this proposed legislation mean the prosecutor in other proceedings against the minor must prove that any evidence offered against the minor is not a "fruit of the minor's competency evaluation"? Finally, assuming the privilege against using the minor's statements in a criminal or delinquency context should be memorialized in statute, what is the basis for applying this judge made rule to dependency proceedings? It seems to me that the issue of the use of the minor's statements should be left to judges to decide in accordance with case law in effect at the time the issue is raised. There is a confusing reference in the second sentence of subdivision (i). What does subdivision (d) have to do with the court making orders for services?	competency evaluation in a latter juvenile or adult adjudication. The advisory bodies added the following language: Statements made to the appointed expert during the minor's competency evaluation, statements made by the minor to mental health professionals during the remediation proceedings, and any fruits of such statements shall not be used in any other delinquency or criminal adjudication against the minor in either juvenile or adult court. Because of the cross-over issues, the advisory bodies believe that these statements should not be used in dependency proceedings. Under Welfare and Institutions code 827, the parties with access to the delinquency files are the same as dependency files. The rules regarding protecting information need to be the same for both files. The advisory bodies agree. This was a drafting error. The reference should be to subdivision (j), not (d)
	Ashleigh E. Aitken, President		Expert qualifications and training are best left contained in a rule of court which can be more easily amended when needed than a statute.	The advisory bodies agree.

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	On behalf of Orange County Bar Association			
	Kiran Savage-Sangwan, Director of Legislation and Advocacy on behalf of the National Alliance on Mental Illness (NAMI)		Due to the specialized nature of these evaluations for juveniles with mental illness, the qualifications and training requirements should be in a statute as currently proposed. • Likewise, the directions for the process the experts shall follow in conducting the competency evaluation should be statute. • We recommend that this process include conferring with family members and caregivers when possible. Family members and caregivers are often in the best position to provider information about the child's behavior and changes over time. It is important that the expert evaluator have this information when providing an opinion to the court	The advisory bodies disagree that the qualifications and trainings should be directly in the statute. There are several reasons for this: 1) it is more difficult to change things in statute; 2) it has been discussed that the qualifications and training requirements will need to be detailed and require input from many different individuals; 3) the intent of this statute is process and procedure' deep substance should be left to the rule of court process.
	Hon. Michael I. Levanas, Presiding Judge, and Commissioner Robert Leventer, Superior Court of California, Los Angeles County, Juvenile Court		This amendment *[§709(c) Statements made to the appointed expert ... shall not be used in any other delinquency, dependency, or criminal adjudication against the minor in either juvenile or adult court.]* is excellent and should also be extended to statements made to remediation instructions. The proposed amendment of subsection (d) would seriously undermine the Los Angeles County Protocol and by doing so, impose a significant costs to the county general fund. This procedure has worked successfully because our panel of experts is trusted by both sides. When a request is made for a competency evaluation, a psychologist is selected from a panel of approved experts. A rate of reimbursement is negotiated with this	Mention of remediation instructions has been removed. The advisory bodies added the following language: <u>Service providers and evaluators shall adhere to the standards set forth in this statute and the California Rules of Court.</u> Information only; no comment needed.

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			panel. The minor's counsel maintain the confidentiality of the competency evaluation obtained for investigative purposes by providing that they may choose not to disclose the evaluation until, and unless, a doubt is expressed. The district attorney, or the minor's counsel may request another competency evaluation upon a showing of "good cause". • A thorough competency evaluation is costly and time-consuming. We have been advised that repeated competency testing is unreliable and contraindicated. • Repeated competency testing also imposes a significant burden on the minors (who miss school), parents (who miss work) and the court (which has to schedule additional hearings). If the initial testing was incomplete or new relevant information became available then the court could find good cause to order a second evaluation. This procedure has successfully limited the number of evaluations and curtailed the use of "hired guns" by opposing parties.	
	Mike Roddy, Executive Officer, Superior Court of California, County of San Diego		It is important to include something like this so that the minor can speak freely during the evaluation and not risk self-incrimination, but our court believes the proposed language is too vague and overly broad and could lead to litigation as to its meaning.	The advisory bodies agree.
	Sue Burrell, Staff Attorney on behalf of the Youth Law Center		The Youth Law Center agrees with the proposed language and with putting it [Evaluator information] into statute. Although we understand the desire not to freeze in law requirements that could change, it is difficult to imagine that anything in the proposed language would change over time. There is need for just the sort of guidance this language provides.	The advisory bodies agree.

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			Notice and process when additional experts are to be used. We support adding requirements for handling the process when additional experts will be used. We are worried that limiting the notice requirements to when counsel "anticipates" presenting the expert's testimony may provide too much wiggle room. The better rule would be to simply require 5 days notice before an expert may testify or have his/her report presented. **Recommendation:** We suggest removing the language that could provide excuses for not disclosing expert reports and expected testimony, as follows: (d) The prosecutor or minor may retain or seek the appointment of additional qualified experts, who may testify during the competency hearing. *In the event a party seeking to obtain an additional report anticipates presenting t T*he expert's *testimony and/or report, the* report and the expert's qualifications shall be disclosed to the opposing party within a reasonable time prior to the hearing, and not later than five court days prior to the hearing, *or the expert may not testify and the report may not be received in evidence.* If, after disclosure of the report, the opposing party requests a continuance in order to prepare further for the hearing and shows good cause for the continuance, the court shall grant a continuance for a reasonable period of time.	The advisory bodies agree with this concept. The advisory bodies rewrote the section to state: The prosecutor or minor may retain or seek the appointment of additional qualified experts, who may testify during the competency hearing. The expert's report and qualifications shall be disclosed to the opposing party within a reasonable time prior to the hearing, and not later than five court days prior to the hearing. If disclosure is not made in accordance with this subparagraph, the expert shall not be allowed to testify, and the expert's report shall not be considered by the Court, unless the Court finds good cause to consider the expert's report and testimony. If, after disclosure of the report, the opposing party requests a continuance in order to prepare further for the hearing and shows good cause for the continuance, the court shall grant a continuance for a reasonable period of time.
	Mike Roddy, Executive Officer, Superior Court of California, County of San Diego		Our court likes most of the changes to subdivision (b), especially the clarification regarding the burden of proof. That said, the level of detail in (b)(2) is normally reserved for rules of court, and rules of court are much easier to revise as revisions become necessary; therefore, it may be better to shift some of the details to	The advisory bodies disagree that the qualifications and trainings should be directly in the statute. There are several reasons for this: 1) it is more difficult to change things in statute; 2) it has been discussed that the qualifications and training requirements will need to be detailed and require input from many different individuals; 3)

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			the rules of court for ease of amending later should the need arise. Our court likes most of the changes to subdivision (b), especially the clarification regarding the burden of proof. That said, the level of detail in (b)(2) is normally reserved for rules of court, and rules of court are much easier to revise as revisions become necessary; therefore, it may be better to shift some of the details to the rules of court for ease of amending later should the need arise. I agree with subdivision (d) although it is possible that the process will become too drawn out and it may lead to over detention of incompetent youth. I agree with subdivision (e), (f), and (g) but as an alternative, these sections could all be combined into one subdivision with subparts, which may be easier to understand.	the intent of this statute is process and procedure' deep substance should be left to the rule of court process. No comment needed. No comment needed.
	Janice Thomas, Ph.D. Alameda County Behavioral Health Care Services		*Directing experts* I do not see the harm in the statute containing direction to experts. The proposal lays out general requirements which anyone who is qualified would presumably follow independently of being directed. • The requirements therefore benefit the Court, without interfering with the judgment of a trained, independent expert, by informing the Court as to what should be included. These requirements would hopefully add efficiency to the Court's ability to assess the quality of an evaluation and would improve quality across jurisdictions.	The advisory bodies agree. Information only, no comment needed.

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			• I would prefer, in fact, that a requirement be added. I have seen evaluations in which an opinion of mental retardation or intellectual disability has been offered without the benefit of standardized testing. I would recommend that standardized testing be required to support any opinion regarding intellectual disability or mental retardation. Such a requirement would conform to best practices as laid out in the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (American Psychiatric Association, 1994), where the diagnostic criteria of mental retardation require "an IQ of approximately 70 or below on an individually administered IQ test ... " (p. 46). *Qualifications of experts* Whether expert qualifications and training currently found in rule 5.645 be explicitly put into the statute or left to a rule of court. • I would recommend that expert qualifications and training be explicitly included in the statute. For one, non-lawyers would probably find it helpful to have the qualifications spelled out in the statute. It might also be helpful to legal professionals who are considering retaining an expert. • Most importantly, it would seem that these requirements are the bare minimum and that no harm would come from spelling out the minimum credentials. If any local jurisdiction wants additional requirements, then those requirements could be included in a rule of court.	The advisory bodies have discussed whether to add the requirement of standardized testing. However, in reading *In re R.V.*, the expert in that case tried to administer standardized testing, but the youth would not cooperate. Also, the advisory bodies believe the experts have the knowledge regarding whether or not standardized testing is needed. The advisory bodies agree.

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			In closing, overall the revisions reflect a great improvement over the existing statute. My main concerns have to do with the revisions pertaining	Information only. No comment needed.
	Amanda K. Roze, Attorney at Law, Sebastopol, CA		The standards for appointed experts leave too much room for unqualified individuals to conduct evaluations. Proposed section 709, subdivision (b)(1) provides: "The expert shall have expertise in child and adolescent development and forensic evaluation of juveniles, and shall be familiar with competency standards and accepted criteria used in evaluating competence." While subdivision (b)(3) provides that the Judicial Council shall develop a rule of court outlining the training and experience needed, that rule would likely be unnecessarily limited due to the language in subdivision (b)(1). • Juvenile competency evaluations are highly complex and involve considerations beyond those present in adult evaluations. • They require special expertise and more extensive review of materials and interviews of witnesses than required for adults. Isolated impressions of a minor are not necessarily reliable indicators of his abilities. (Grisso, Evaluating Juveniles' Adjudicative Capacities, at pp. 21-22.) • A comprehensive expert assessment based on multiple sources and spanning a longer period of time is necessary to accurately measure a youth's capabilities. (*Ibid.*) As proposed, subdivision (b)(1) is insufficient to protect the rights of minors. It calls for an expert to have expertise in forensic evaluation of juveniles and familiarity with competency standards and accepted criteria used in evaluating competency.	Information only, no comment needed.

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			Forensic Evaluation • The term forensic evaluation is not limited to *competency* determinations, and the requirement of familiarity with competency evaluations does not necessarily include *juvenile* competency. As a result, the provision does not exclude a witness who has never conducted a juvenile competency evaluation, and who has done no more than reviewed the JACI (Juvenile Adjudicative Competency Interview) format to conduct a juvenile competency evaluation. Therefore, the provision should be amended to provide: The expert shall have expertise in child and adolescent development and forensic evaluation of juveniles *for the purposes of adjudicative competency*, and shall be familiar with competency standards and accepted criteria used in evaluating *juvenile* competence *and have received training in conducting juvenile competency evaluations*. Additionally, subdivision (b)(2) should be amended to include that experts shall conduct multiple interviews with the minor, and also interview other relevant individuals who have not been listed such as family members and school staff, and in the case of cross-over children, CASA workers, and the minor's delinquency attorney and social worker. A basis of a juvenile competency determination is the capacity to learn. (Grisso, Evaluating Juveniles' Adjudicative Capacities, supra, at pp. 21-22.) • This factor cannot be assessed without retesting for retention at a later date because all that is being	Information needed. No comment needed The advisory bodies believe that by rewriting (b)(2) and adding the language for the evaluator to review all relevant information, this concern is addressed.

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			tested at the first session is the ability to parrot back information. (*Ibid*.) Evidence of learning is meaningless without evidence that the information is retained and can be applied. Additionally, Thomas Grisso, the recognized expert in the field has also opined that multiple sources of information are required. Therefore, more than a single interview with the minor and his or her attorney should be required. *Permitting prosecution experts to evaluate the minor* The provisions should include the ability of the minor's counsel to observe the interview through a two-way mirror, or to have the interview audio recorded. • Where questions are raised about the minor's competency, he or she is not a reliable witness for relaying information to defense counsel about the interview process. Therefore, without an objective means of evaluating the prosecution expert's interview and the minor's responses, defense counsel is placed at a disadvantage. Since it is a violation of due process to force an incompetent person to trial, counsel must be given every reasonable means of evaluating prosecution expert evidence	Information only. No comment needed The advisory bodies believe that each evaluator should determine the best way to evaluate the child and whether it would be helpful to have minor's counsel observe the evaluation.
	Adrienne Shilton, Director, Intergovernmental Affairs, County Behavioral Health		• CBHDA recommends that it should be in the rule of court; not in the statute. • CBHDA recommends that the qualifications should be in a rule of court.	The advisory bodies believe that at least brief qualifications should be in the statute.

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	Directors Association of California			
	Corene Kendrick, PJDC Board Member & Amicus Committee Member on behalf of the Pacific Juvenile Defender Center		There may be a reason for the child's statements to the appointed expert to be used in a dependency proceeding involving the child. • The experts appointed by the court may be mandated reporters, and statements made to the expert by the child regarding abuse or neglect she has experienced are the sort of thing they would have to raise with child protective services. The proposed language refers to "dependency… adjudication *against* the minor…" (emphasis added), but dependency cases are not brought *against* a child; they are *for* the child's benefit. We appreciate the recognition that statements should not be used against a child in a criminal prosecution or juvenile adjudication, and think that language should remain, but believe that the reference to dependency court should be deleted. Children should be held in the least restrictive environment if he or she is found incompetent. Section (i) should include language stating that at all times, the minor should be held in the least restrictive environment.	The advisory bodies agree and have rewritten the statement: Statements made to the appointed expert during the minor's competency evaluation, statements made by the minor to mental health professionals during the remediation proceedings, and any fruits of such statements shall not be used in any other delinquency or criminal adjudication against the minor in either juvenile or adult court. The advisory bodies do not believe that section (i) is the appropriate place to add a statement regarding least restrictive placement. Least restrictive placement is in subdivision (k)
	Roger Chan, Executive Director on behalf of the East Bay Children's Law Offices		We agree with the proposed language (*discussion directing experts in Subdivision (2) of paragraph (b) be taken out of the statute and placed in a local rule of court*) and with including the discussion in statute. The proposed language provides needed guidance and uniformity in the evaluation of a minor's competency.	The advisory bodies agree.

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			However, proposed Section 709(c)'s prohibition on using statements and any other fruits of the competency evaluation in dependency proceedings may unduly prevent the protection of the minor when abuse or neglect is discovered. Often, initiating dependency proceedings is appropriate and necessary for these youth where competence is in question.	The advisory bodies agree.
	Tari Dolstra, Division Director, Juvenile Services Riverside County Probation Department		It is believed both the direction to experts and the qualifications and training required should be comprehensively addressed in either the statute *or* the Rules of Court.	The advisory bodies understand that the commentator would like all information either in the statute or rule of court. The advisory bodies believe that some direction in the statute on expert qualifications is warranted to provide consistency among evaluators statewide.
	Angela Igrisan, Mental Health Administrator, on behalf of the Riverside County Department of Mental Health		We prefer that the qualifications and directing experts be kept in statute. This would move more closer to statewide equity for the children. • For example, if a child on Riverside county probation committed a crime in Sacramento County while in placement, would the argument about both directing experts and the qualifications of the experts result in a delay to court proceedings for the child? • Also, the question of more concern is had the determination of competency raised by an expert with one set of qualms be different than one with another set? • Would there be a difference in justice served? It also provides everyone with a clear and directive base to start the discussion. If left to court discretion, they would potentially be changing each time a new judicial team was appointed.	The advisory bodies agree.

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			Again, we support keeping the qualifications clear and specific in statute as indicated above.	
	Rosemary Lamb McCool, Deputy Director, Chief Probation Officers of California		Expert's Access to Records: In subsection (b)(2) the proposed language outlines all the records that the expert shall be permitted to review and does not reference probation. Was the intent not to include probation or did the joint committees and task force believe that probation falls under the category of court records? If probation's records are not covered under court records, we believe that probation records should be listed in statute.	The advisory bodies agree that probation records should be included. In most counties, the probation department is responsible for providing all the records. However, in those counties where the probation department does not collect the records for the evaluator, probation records should be given.
Remediation Services	San Bernardino Public Defender By Richard Sterling, Supervising Deputy Public Defender	AM	There should be clarification on what a reasonable period of time is for remediation, such as no longer than 6 months for out of custody and a defined shorter period of time for a minor in custody. • At the end of a certain time period, the law should state the minor will not gain competency in the foreseeable future and dismiss the case. • What is the remediation time frame? • How often is the remediation treatment provided? One time per week or more?	The advisory bodies treat each minor on a case-by-case basis. As such, it is difficult to put a time limit on remediation services. "Reasonable period of time" is the current statutory structure as is "foreseeable future." The advisory bodies chose not to define these terms to give the court discretion to treat each minor differently according to the circumstances of their case. The advisory bodies did not address a remediation time frame as each minor should be evaluated on a case-by-case basis. The remediation treatment goes beyond the scope of this proposal. This proposal discusses only the process and procedures to establish competency
	Christine Villanis, Deputy Chief Juvenile Services, San Mateo County Probation Department		Unfunded statute: • Who is responsible for the cost of remediation, especially where developmentally delayed is concerned. • It is cost prohibitive to create a remediation program for this population when a county may or may not get one or two candidates per year.	The advisory bodies are aware that each county and court addresses funding for remediation services in different ways. The development of the protocol as required by statute should address who is responsible for cost of remediation and address a situation where a county has very few of these cases.

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	Christine Villanis, Deputy Chief Juvenile Services, San Mateo County Probation Department	AM	It does not address who is responsible for providing remediation services • Who pays for them? In counties where there are not very many competency cases, it is cost prohibitive to put together a program, especially for developmental immaturity, where there is no specific agency that might be set up to address this (unlike developmentally delayed and mentally ill).	The advisory bodies specifically did not address cost in this proposal as cost is determined differently in each county.
	Ashleigh E. Aitken, President On behalf of Orange County Bar Association		Continuing current local county practice for payment is best. Expert fees can vary greatly across the counties. Specific payment information included in the statute will discourage each county from negotiating the best fees for such services which are available for that locale.	The advisory bodies agree.
	Kiran Savage-Sangwan, Director of Legislation and Advocacy on behalf of the National Alliance on Mental Illness (NAMI)		We support the development of a written protocol and program for remediation services and diversion programs at the county level, as specified in Sec. 709 (j). We recommend that the Judicial Council consider requiring the presiding judge of the juvenile court to also designate family and consumer advocates to participate in the development of the protocols and programs. By adding these perspectives to those of the Court, the County Probation Department and the County Mental Health Department, juveniles may be better served by the programs and treatment they receive.	The advisory bodies rewrote subsection h: The presiding judge of the juvenile court; the County Probation Department; the County Mental Health Department; the Public Defender and/or other entity that provides representation for minors; the District Attorney; the regional center, if appropriate; and any other participants the presiding judge shall designate shall develop a written protocol describing the competency process and a program to ensure that minors who are found incompetent receive appropriate remediation services.
	Hon. Michael I. Levanas, Presiding Judge, and Commissioner		Los Angeles limits remediation services to minors who are detained, or have an open or sustained 707(b) or Penal Code §290.008(c) petition, or have three or more open or sustained petitions within a three year period. [All Regional Center clients are eligible to receive	Information only. No comment needed.

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	Robert Leventer, Superior Court of California, Los Angeles County, Juvenile Court		remediation services through Regional Center as specified in their Individualized Program Plan.] • We try to divert minors who do not meet these criteria to programs and services, separate from our remediation program, which will address their underlying delinquent behaviors. • This, we believe, is most consistent with the purposes of the juvenile court. It typically takes well over a year from the time a petition is filed and a doubt is expressed through the completion of a remediation program and ultimate disposition of a case. During that time there will have been many court hearings, therapist appointments and weeks or months of remediation training. The cost of the remediation program, as well as the burden on the parents and minor in attending court hearings and appointments, is enormous. There is no reason to think that after this lengthy delay minors charged with misdemeanors or lower level felonies will be "accountable" for their delinquent behavior in any meaningful sense or that public safety will be enhanced by a formal grant of probation. Mandating that all minors participate in a remediation program is harmful and wasteful in many, if not most, cases where a minor is found incompetent.	
	Margaret Huscher, Supervising Deputy Public Defender III, Law Office of the Public Defender, Shasta County		My experience has been, when departmental resources are scarce, there seems to be more focus on inter-departmental fighting than on an individual minor's best interests; therefore, it would be helpful if the statute set forth which department is responsible for providing the county's remediation program. • Developmental immaturity is not a recognized mental illness or disorder, and if that is the	The advisory bodies understand that resources are scare. The local protocol should set forth which department is responsible for providing the county's remediation program. Information only. No comment needed

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			foundation for the incompetency, I can predict our mental health department will not cooperate in providing services. There must be a funding source for a remediation program. • The adoption of standards and rules of court setting forth the contents of a remediation program could clarify probation's role with incompetent minors. Likewise, standards for remediation programs could solve our current difficulty with the regional center treatment provider who is contracted to provide restoration services yet does not have practical experience with the court's processes.	
	Janice Thomas, Ph.D. Alameda County Behavioral Health Care Services		I read the proposed revisions to say that the specifics of the "Remediation Program" will be left to local jurisdictions. • There are many good reasons for this as the empirically-based, peer-reviewed scientific basis of remediation is still in early stages. However, while giving discretion on the one hand, the proposed revisions are prescriptive on the other. • Specifically, the Remediation Program is charged with giving an opinion as to the likelihood of the youth attaining competency. In my opinion, this charge is outside the scope of expertise for such an undefined entity. Given that the nature of the remediation programs would vary by jurisdiction, there is no guarantee that the remediation program would include a qualified expert to render an opinion as to the minor's attainment of competency or the minor's likelihood of attainment of competency. • As laid out here, the Remediation Program might have a remediation counselor render an opinion,	The advisory bodies agree that the remediation program should be left to local jurisdictions. The commentator raises an issue regarding whether the remediation program would have a psychologist or psychiatrist on staff to render an opinion as to whether the youth has attained competency. The advisory bodies discussed this issue and dealt with it by allowing counsel for the minor or people request another evaluation.

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			which is a practice I have seen in at least one other jurisdiction. *Definition of Remediation Counselor* • Furthermore, the proposal uses the phrase "remediation counselor" but does not define remediation counselor. • The remediation phase involves not only legal instruction, but also involves case management and treatment. • It would be useful to clarify the role of the remediation counselor with respect to these entirely different roles of instructor, case manager, and treatment provider. In Alameda County, I have found capable case managers as critical to competency remediation and although essential to any Remediation Program are not trained to render opinions about attainment of competency. • A case manager has expertise in community-based services, knows the qualifications needed for the patient to access those services, can identify funding complexities, e.g., re-applying for Medi-Cal after the minor was an inmate for an extended period of time, and knows which programs require a youth to be a 602 and which do not. o A case manager might also assist with obtaining additional services, e.g., legal advocacy in those instances in which a youth needs additional school-based mental health services. In short, a case manager can implement a plan that has been laid out by the evaluator or by a multi-disciplinary team; but they have not been trained and do	The advisory bodies chose not to define remediation counselor as each program would define the roles and responsibilities of the remediation counselors. Information only. No comment needed. Information only. No comment needed.

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			not have experience in evaluating competency. • A rehabilitation counselor might be defined as someone who instructs the youth in the legal proceedings. o One jurisdiction has considered utilizing special education teachers as rehabilitation counselors. In fact, the rehabilitation counselor, as defined as the instructor, might have a legitimate opinion about the youth's attainment of factual knowledge, but whether or not the youth has rational understanding and whether the youth can consult with his or her attorney would likely be outside the scope of the rehabilitation counselor. In short, I do not think the proposed revisions should prescribe that the "Remediation Program shall determine the likelihood of the minor attaining competency ..." I think opinions of this nature should be excluded from the Program's charge. • Instead, I believe the Courts are better served by an opinion from a qualified expert who can take into consideration the minor's progress in the Remediation Program and form an opinion based on the progress, or lack thereof, and based on the totality of information The totality of information might include the fact that mental health services have not been adequate and that had services been adequate, the youth might attain competency. Assessment of the relationship	The advisory bodies believe that it is up to the defense or prosecution to ask for further evaluation if they do not believe the opinion from the Remediation program.

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			between disorders, services, and attainment is outside the scope of the rehabilitation counselor's expertise.	
	Amanda K. Roze, Attorney at Law, Sebastopol, CA		There are additional concerns regarding the "remediation" phase. The Invitation (p. 5, fn. 17) posits the choice as being between the terms restoration and remediation. Certainly, between those choices, remediation is preferable. However, an even better, or at least alternate, term would be "attainment" of competency. Since juveniles maybe, and very often will be, deemed incompetent on the basis of developmental immaturity, the question is whether they have attained competency, not whether they have been restored. (Compare § 709, subd. (c) [Whether minor will "attain" competency] with Pen. Code, § 1372 [whether adult has "recovered" competency.) • The term remediation connotes a need to "correct something that is wrong or damaged or to improve a bad situation." (http://dictionary.cambridge.org/us/ dictionary/english/remediate.) • There is nothing wrong with children who are not competent to stand trial. They are often simply immature. Using the term attainment will avoid denigrating minors and will be consistent with the use of the term "attain" in subdivision (i) of section 709. It would serve the additional benefit of avoiding confusion between the terms restoration and remediation, and therefore further emphasize the differences between adult and juvenile competency procedures. If the term remediation is retained, perhaps it is more accurate and less damaging to state that competency has	The advisory bodies considered many alternatives to restoration. The advisory bodies selected the term remediation to use throughout the proposal. As noted in the recent article in the *Juvenile and Family Court Journal* (Spring 2014), some scholars prefer the term *remediation* rather than *restoration* when referring to juveniles because, in some states, juveniles may be found to be incompetent due to developmental immaturity as well as because of mental illness and intellectual deficits or developmental disabilities. Remediation involves utilization of developmentally and culturally appropriate interventions along with juvenile/child-specific case management to address barriers to adjudicative competency. See Shelly L. Jackson, PhD, Janet I. Warren, DSW, and Jessica Jones Coburn, "A Community-Based Model for Remediating Juveniles Adjudicated Incompetent to Stand Trial: Feedback from Youth, Attorneys, and Judges" (Spring 2014), Vol. 65, Issue 2, *Juvenile and Family Court Journal* 23–38.

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			been remediated, rather than that the minor him- or herself has been remediated. [See e.g. Invitation, p. 5, "If the court finds the minor is remediated ... "].) • Proposed section 709's use of these constructions is inconsistent. Subdivision (l) refers to whether the "minor's competency has been remediated" but also refers to a recommendation when "the minor is not able to be remediated." (See Proposed changes, p. 5.) • The remediation/attainment phase should also have a time limit for remediation services prior to dismissal, in order to provide for statewide consistency. Currently, some counties such as Los Angeles County appear to have a 120-day limit (*In re Jesus G.*(2013) 218 Cal.App.4th 157, 162), while others like Alameda County appear to have no limit (http://www.acbhcs.org/providers/documentation/SOC/AC_Juvenile_Competency_Protocol.pdf). There are also concerns with the standards at the remediation/attainment hearing.	
	Corene Kendrick, PJDC Board Member & Amicus Committee Member on behalf of the Pacific Juvenile Defender Center		The court shall review remediation services**,** the continuing necessity of detention if the minor is detained, and the welfare of the minor at least every ~~30~~ 14 calendar days for minors in custody, and every ~~45~~ 60 calendar days for minors out of custody. If the minor is detained in custody, such a review must consider the effect of the minor's continued detention on his or her physical and emotional well-being, and include an update on the status of the minor's remediation. If remediation services are not being provided, or are	Q to working group: I think the 14 day rule we can say would create too many hearings and be burdensome on all parties. However, what do you think of the additional language about the review must consider? The advisory bodies disagree and feel that a 14-day rule would be burdensome to all parties.

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			ineffective, the minor should be released from custody and placed in the least restrictive environment.	The advisory bodies agree that minors should be placed in the least restrictive environment and have rewritten: Upon a finding of incompetency, the court shall refer the minor to services designed to help the minor to attain competency. Service providers and evaluators shall adhere to the standards set forth in this statute and the California Rules of Court. Services shall be provided in the least restrictive environment consistent with public safety. Priority shall be given to minors in custody. Service providers shall determine the likelihood of the minor attaining competency within a reasonable period of time, and if the opinion is that the minor will not attain competency within a reasonable period of time, the minor shall be returned to court at the earliest possible date. The court shall review remediation services at least every 30 calendar days for minors in custody and every 45 calendar days for minors out of custody.
	Rosemary Lamb McCool, Deputy Director, Chief Probation Officers of California		Written Protocols and Remediation Program CPOC agrees that WIC 709 is gravely in need of improvement, but those improvements go beyond clarifying the legal process and procedures as outlined in the proposal. In clarifying legal process and procedures, the joint entities putting forward the proposal are also tasking counties with developing written protocols and a remediation program without clearly defining how such activities are to be funded. We believe that protocols and a remediation program would greatly benefit youth who may be incompetent to	The advisory bodies understand that funding is an issue. However, many counties have already addressed this issue in protocols. Also, the purpose of this proposal is to help clarify the court process and procedures.

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			stand trial; however, by choosing not to address the underlying and all important issue as to how to fund these services, the risk then becomes that disparate programs will be developed due to lack of resources – in the form of capitol and service capacity – at the county level. In your executive summary it is noted on page 5 that subsection (j) is intended to ensure that all youth who are found incompetent receive appropriate services; however, without funding to accompany the changes to WIC 709 it is unfair to assume that all counties will be positioned to establish and operate a remediation program. The proposed statute is silent as to whether the state, courts or counties are to assume this responsibility and how the program is to be funded. We contend that this is a state responsibility. Further, appropriate services are not defined nor is there guidance as to the core elements of a successful remediation program.	
Remediation Timeframe / Foreseeable Future	San Bernardino Public Defender By Richard Sterling, Supervising Deputy Public Defender	AM	The expert appointed should address in their competency evaluation whether the minor will attain competency in the foreseeable future. If that answer is no and remediation will have no impact per the expert as addressed in their report, the case should be dismissed based on lack of jurisdiction as soon as possible. However, the dismissal may not occur, or it may take months of litigation. This issue is the subject of litigation between DA's office and Public Defender, as the DA will not accept the expert's opinion on that issue and courts are reluctant to dismiss cases in general when crimes are committed. Many minors due to developmental disabilities or otherwise are incompetent and will never become competent. Once the expert states that in their report, the case should be dismissed soon thereafter. Unfortunately, they are not.	The current proposal requires the expert to address the likelihood that the minor can attain competency within a reasonable period time rather than "foreseeable future." The advisory bodies understand that there may be some reluctance to terminate cases based on incompetency when there has been a serious crime. Subdivision (d) of the proposal states that the prosecutor or minor may see the appointment of additional qualified experts.

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	Roger A. Luebs, Juvenile Judge Superior Court of California, County of Riverside		The last sentence of subsection (b)(2) contains a misstatement of the law pertaining to time frames. I suggest that it be changed to read: "The expert shall also state the basis for these conclusions, make recommendations regarding the type of remediation services that would be effective in assisting the minor in attaining competency, and, if possible, express an opinion regarding what would be a reasonable time within which to determine the likelihood that the minor might attain competency within the foreseeable future".	
	Phyllis Shibata, Commissioner of the Superior Court of California, County of Los Angeles, Juvenile Court	NI	As a bench officer who has presided over many competency hearings, I would find it helpful if we had a clear definition of the term “foreseeable future” in the context of whether a substantial probability exists that an incompetent minor will attain competency in the foreseeable future. If one of the concerns of the legislation is to limit the amount of time a minor spends in juvenile hall, knowing what the outside time limit is essential.	This proposal eliminates “foreseeable future” in favor of “reasonable period of time” (b)(2).
	Hon. Michael I. Levanas, Presiding Judge, and Commissioner Robert Leventer, Superior Court of California, Los Angeles County, Juvenile Court		Only trained psychologists or psychiatrists can render an opinion on the likelihood of a minor attaining competency. • Remediation instructors generally do not have these credentials. In Los Angeles the initial competency evaluation includes an assessment of the likelihood of the minor attaining competency. The court will only send those minors likely to attain competency to a remediation program. Spending the time and resources on remediation when attainment is not likely is not necessary.	The advisory bodies agree. The remediation program recommendations in subdivision (*l*) are anticipated to be from a trained psychologist or psychiatrist. If not, then the parties can seek an independent evaluation.
	Sue Burrell, Staff Attorney on behalf		We agree with the rationale for limiting the use of statements made to an expert in evaluating competency. The only limitation we wonder about is the one on not	The advisory bodies agree and has rewritten the section:

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	of the Youth Law Center		using statements in dependency proceedings. For example, couldn't there be times when a young person's statements would be relevant and helpful in establishing the need for dependency jurisdiction or obtaining needed services in a dependency case? Is there a way to allow such use at the request of the minor? One way to handle this would be to add a clarifying sentence. Recommendation: Add the following sentence to the end of Section 709, subdivision (c): Nothing in this section shall prohibit the use of such statements at the request of the minor.	(4) Statements made to the appointed expert during the minor's competency evaluation, statements made by the minor to mental health professionals during the remediation proceedings, and any fruits of such statements shall not be used in any other delinquency or criminal adjudication against the minor in either juvenile or adult court.
	Sue Burrell, Staff Attorney on behalf of the Youth Law Center		*Remediation and Timelines* We have two suggestions for this section. First, the court should review remediation services for detained youth at least every 15 days, just as it does the cases of youth detained pending placement (Welf. & Inst. Code § 737). The proposed 30 days is far too long a period between reviews for youth in custody. Second, the language appears to suggest that there is only one kind of remediation program, when in fact remediation services make take many different forms. Some youth may be appropriately sent to the kind of curriculum-based training in which they learn court concepts. Others may benefit from medication or mental health services. Others may benefit from regional center services. Any of these services could contribute to the attainment of competence. We suggest revising the language slightly to reflect this.	The advisory bodies have considered all the comments regarding parties and participants. The advisory bodies decided to rewrite subdivision (a)(1) to address all these issues. The new language is: Upon a finding of incompetency, the court shall refer the minor to services designed to help the minor to attain competency as described in (m). Service providers and evaluators shall adhere to the standards set forth in this statute and the California Rules of Court. Services shall be provided in the least restrictive environment consistent with public safety. Priority shall be given to minors in custody. Service providers shall determine the likelihood of the minor attaining competency within a reasonable amount of time, and if the opinion is that the minor will not attain competency, the minor shall be returned to court at the earliest possible time. The court shall review remediation services at least

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			Recommendation: Revise the proposed language as follows: (k) Upon a finding of incompetency, the court shall refer the minor to *services designed to help the minor to attain competency* ~~the county's remediation program~~, as described in (m). *Service providers* ~~Remediation counselors~~ and evaluators shall adhere to the standards set forth in this statute and the California Rules of Court. ~~The program shall provide s~~ Services *shall be provided* in the least restrictive environment consistent with public safety. Priority shall be given to minors in custody. *Service providers* ~~The Remediation Program~~ shall determine the likelihood of the minor attaining competency within a reasonable amount of time, and if the opinion is that the minor will not, the minor shall be returned to court at the earliest possible time. The court shall review remediation services at least every *15* ~~30~~ calendar days for minors in custody and every 45 calendar days for minors out of custody.	every 30 calendar days for minors in custody and every 45 calendar days for minors out of custody.
	Amanda K. Roze, Attorney at Law, Sebastopol, CA		Finally, while *In re R.V.* concluded that a minor is presumed competent, it is important to note that this finding applies only to the initial competency determination. *In re R.V.* did not concern post-incompetency determination or remediation/ attainment proceedings. • A presumption of incompetence must be preserved for this aspect of the proceedings, both as a matter of due process, logic, and public trust in the process. • Once a child has been declared incompetent, he cannot be presumed competent in the absence of the expert's evaluation that he has attained competency through the remediation services.	Information purposes only. No comment needed.

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			• This conclusion is consistent with California's approach toward child competency in other areas. Minors are incompetent to authorize most medical treatment, buy cigarettes or alcohol, vote, marry without written parental consent and a court order, or possess an unrestricted driver's license. (Cal. Const., art. 2, § 2; Bus. &Prof. Code, § 25658; Fam. Code., §§ 302, 6500 et seq., 6900 et seq.; Health & Saf. Code, §119405; Pen. Code, § 308; Veh. Code, § 125812.) • They are permitted to disaffirm contracts and cannot enter an admission in juvenile court without the consent of an attorney. (Fam. Code, § 6710; Welf. & Inst. Code, § 657; Rule 5.778(d).) California law even protects minors from tattoos and body piercings. (Pen. Code, §§ 613, 652, subd.(a).) It stands to reason that a child should be protected from a presumption of competence once he or she has been found to be incompetent. This is especially true for children under the age of 14 who are presumed incapable of committing a crime and are categorically ineligible for prosecution as adults. (Pen. Code, § 26; Welf & Inst. Code, §707, subd. (b).) It would defy reason to suggest that a child who is presumed incapable of committing a crime is nevertheless competent to stand trial.	
Dismissal of Petition	Christine Villanis, Deputy Chief Juvenile Services, San Mateo County Probation Department	AM	Indicating that the court is to invite people to discuss and allows them to make a referral for evaluation implies that they are still involved and still have jurisdiction and some level of control over the matter.	The advisory bodies believe the language is clear that the court must dismiss the petition. The additional language is permissive state that the court may invite persons to a dismissal hearing. If parties object to this invitation, then it will be up to the court to decide whether to proceed.

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	Sue Burrell, Staff Attorney on behalf of the Youth Law Center		The proposed language appears appropriate, except that in subdivision (l) (3),- "may" should be substituted for "shall." -We believe that there might be occasions when the minor could meet the definition or "gravely disabled" but there are reasons not to refer him or her to the involuntary treatment system under the Lanterman-Petris Short Act (LPS). Changing the word "shall" refer to "may" refer would preserve the intention of the proposal without locking the court into an LPS referral when the minor could be cared for adequately without that. Recommendation: Change "shall" refer to "may" refer.	The advisory bodies believe that the language as written is permissive. This language appears at the hearing to dismiss the petition. The language is, "If appropriate, the court shall refer the minor for evaluation pursuant to Welfare and Institutions Code Section 6550 et seq. or Section 5300 et seq." The court must make a determination of appropriateness prior to making the referral.
	Margaret Huscher, Supervising Deputy Public Defender III, Law Office of the Public Defender, Shasta County		A law without teeth (such as a judge without jurisdiction) is useless. • Judges are routinely concerned about dismissing a minor's petition when the minor is not progressing adequately towards restoration and yet continues to need treatment and supervision. Already, judges have the power to bring stakeholders together to discuss appropriate services for the minor after the court loses jurisdiction. • Why codify a judge's leadership position to cajole and suggest?	The advisory bodies disagree and believe that statutory authority is needed to allow the court to bring people together.
	Michelle Linley, Chief, Juvenile Division, on behalf of the San Diego county District Attorney's Association		In the proposed language of WIC 709 (l)(3), we would oppose the dismissal of the petition prior to referral of the minor for evaluation pursuant to WIC 6550 et seq. or WIC 5300 et seq. The referral, evaluation and determination of eligibility should occur prior to dismissal of the petition. This is especially true in cases where there is a significant danger to the public due to the actions of the minor.	The advisory bodies believe the court has the discretion to make a referral pursuant to section 6550 et seq. or section 5200 et seq. However, the advisory bodies believe the serious and violent offenders is outside the scope of this legislation. The advisory bodies realize that these minors present additional challenges. However, this proposal discusses only the process and procedures to establish competency, as the

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			• The changes to WIC 709 apply to a myriad of charges. Our concern centers around the application to some of our cases where the minor is charged with murder, rape and other serious and violent felony charges. We as a county use the diversion type process on many of our less serious offenses, however, straight dismissal on serious and violent offenses is of grave concern to us in light of the danger to the minor and the public.	issue of the minor's dangerousness is beyond the scope of the proposal.
	Rosemary Lamb McCool, Deputy Director, Chief Probation Officers of California		Dismissal of Petition due to Inability to Remediate Subsection (l)(3) outlines what happens if it appears that a youth will not achieve remediation and directs the court to dismiss the petition. The proposed language permits the court to invite all persons and agencies with information about the minor to the dismissal hearing and lists persons and entities that may be included. While the list is not intended to be exhaustive since the word "may" is used, we believe probation should be listed in statute.	The advisory bodies agree that probation should be listed in the statute.
Protocol	Roger A. Luebs, Juvenile Judge Superior Court of California, County of Riverside		My greatest concern is that your proposal does not sly address the need to insure that remediation services are made available to incompetent minors. • Proposed subdivision (k) states that the court "shall" refer the incompetent minor to the "county's Remediation program, as described in (m)". However, there is no subdivision "(m)" in the proposed legislation and, indeed, there is no real description of the required remediation program in the proposed legislation. • Subdivision (J) requires that the court and county agencies create a "protocol" to provide remediation services, but the proposed legislation does not address how remediation services will be provided while	The advisory bodies agree that the reference to subdivision (m) is an error and should be a reference to subdivision (j). The advisory bodies did not describe or give detail regarding remediation services because each individual county may design their remediation programs to suit the local counties needs and resources. The advisory bodies took into consideration input from many local counties regarding their remediation process. Currently, in section 709 (c), the law allows the court to make order that it

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			these protocols are developed or what power the juvenile judge has to require agencies to provide the needed services. o I believe the proposed legislation should include some additional language in subdivision G) reading something like: "In the absence of a protocol, or in the event the court finds the adopted protocol insufficient to address the remediation needs of the minor, the court may order the County Probation Department to provide, directly or through engaging the services of others, such remediation services as the court finds reasonable and appropriate." A comprehensive rewrite of the juvenile competency law must address the "elephant in the room", the provision of remediation services.	seems appropriate for services that may assist the minor in attaining competency. The advisory bodies acknowledge it may take counties some time to develop protocols. However, their current process of helping a minor attain competency should be used until a protocol is established.
	Sue Burrell, Staff Attorney on behalf of the Youth Law Center		• We strongly disagree with making diversion an optional feature in county protocols. Our state is in dire need of a dismissal/diversion option for use in cases involving potentially incompetent youth. • We agree with the requirement of having each county prepare its own protocol, but request that the scope be broadened and that additional parties be added to the list of who should develop it. The proposed language appears to limit the protocol to consideration of remediation services. In our experience, it has been useful in the counties that have protocols, to cover the entire competence process. This has enabled counties to insert specific timelines, to address things like appointment of experts, and to provide other expectations about the local process.	The advisory bodies agree.

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			Also, we believe it is important to include the public defender, the prosecutor, and the regional center in development of the protocol. We took out the optional diversion language, as that has been replaced by a statewide provision in paragraph 5. Recommendation: Revise the proposed language as follows: (j) The presiding judge of the juvenile court, the County Probation Department, the County Mental Health Department, *the public defender or other entity that provides representation for minors, the prosecutor, the regional center,* and any other participants the presiding judge shall designate, shall develop a written protocol *describing the competency process* and *a* program to ensure that minors who are found incompetent receive appropriate services for the remediation of competency. ~~The written protocol may include remediation diversion programs.~~	
	Mike Roddy, Executive Officer, Superior Court of California, County of San Diego		I agree with subdivision (h) if the minor is found to be competent, the court shall reinstate proceedings and proceed commensurate with the court's jurisdiction.	The advisory bodies agree.
	Greg Feldman, Deputy Public Defender, on Behalf of San Francisco Office of the Public Defender		San Francisco competence committee has already established a strong protocol that supports dismissal of charges where there is a substantial likelihood that the minor will not gain competence in the foreseeable future. Without such a requirement of dismissal, youth can face grave consequences due to prolonged detention and the lack of adequate service delivery to meet the individualized needs of the youth. The trial judge is in a unique position to view the behavior and the mental health evidence and records presented and should have	Information only. No comment needed.

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			the authority to dismiss in the interest of justice and the best interests of the minor. We would support a provision in the legislation to mandate dismissal within a reasonable period of time. We have learned that the collaborative process in developing San Francisco's competence protocol included the active participation of the juvenile court, the probation department, mental health department, district attorney, and defense counsel. By having a shared 0nd transparent process, San Francisco was able to develop a protocol that served the integrity of the process while also addressing public safety and the best interests of the minor. We would recommend that the parties listed above be incorporated into the legislation to develop a written protocol.	
	Lexi Howard, Legislative Director on behalf of the Juvenile Court Judges of California		Yes, The language in subdivision (3) of paragraph (i) clearly portrays that a minor may not be kept under the court’s jurisdiction once a determinate finding is incompetence has been made.	The advisory bodies agree.
	Adrienne Shilton, Director, Intergovernmental Affairs, County Behavioral Health Directors Association of California		CBHDA believes that it is not clear from this language that the minor may not be kept under the court's jurisdiction once a determinate finding of incompetence has been made. CBHDA recommends that the paragraph read: "A minor who is found mentally incompetent and is not a threat to public safety will not be under juvenile court jurisdiction".	The advisory bodies disagree with adding this language. The advisory bodies realize that the youth who dangerous are a special population. However, once a determination is made that competency cannot be attained, the court has no choice but to dismiss proceedings.
	Roger Chan, Executive Director on behalf of the East Bay		The proposed language in proposed Section 709(l)(3) appears appropriate. However, this provision would be strengthened by specifying a maximum timeline after	The advisory bodies discussed the timelines in depth and agreed that 30 calendar days for youth in custody and 45 calendar days for youth out of custody is an appropriate timeframe. The

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	Children's Law Offices		which the petition shall be dismissed (perhaps distinguishing felonies from misdemeanors). • Similarly, the period for review of remediation services in paragraph (k) should be changed to every 15 calendar days for minors in-custody, and every 45 calendar days for minors out-of-custody. • The 15 day timeline is consistent with Welf. & Inst. Code § 737, requiring court review pending execution of a disposition order. Likewise for minors in-custody, the court should review the effect of detention upon the minor in addition to the remediation services. However, detention based on incompetence for the purpose of remediation should be discouraged. One of the earliest opinions on juvenile competence found that, "…a finding of incompetence in a juvenile proceeding should not result in a confinement order or its equivalent." In re Patrick H. (1997) 54 Cal.App.4th 1346, 1359. The proposed legislation should re-emphasize this principle and avoid unintentionally promoting in-custody remediation options.	advisory bodies understand that youth should not be detained longer than necessary and work needs to be done to move these youth to the least restrictive placement. However, the remediation services need time to work for the youth and the advisory bodies believe that 30 days is a minimum length that services should be offered to determine whether the youth has attained competency. Information only, no comment needed. The advisory bodies agree that youth should be in the least restrictive placement possible.
	Tari Dolstra, Division Director, Juvenile Services Riverside County Probation Department		Yes; however, is it intended that the court will order identified persons or agencies to be present at this hearing in order to discuss services following dismissal? In Riverside County, the current protocol outlines a "Juvenile Competency Attainment Team" (JCAT) who develops a remediation plan and reports to the court (via a Probation Memorandum) the progress of the minor throughout the proceedings. Members of this team include: Probation, Department of Mental Health,	Information only. No comment needed.

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			Riverside County Office of Education, Department of Public Social Services, and the Inland Regional Center. Following thorough execution of remediation services, and a final forensic psychological evaluation supporting that the minor has not, and will not reach competency, a plan for continued services is submitted to the court prior to dismissal. While it is supported that information should be gathered from all involved parties (parents, the minor, counsel, etc.) it is believed JCAT (or a similarly organized group) should be the formal organized party to develop a 'post-dismissal' service plan, as they are the parties most appropriately experienced in services available in the community.	
	Angela Igrisan, Mental Health Administrator, on behalf of the Riverside County Department of Mental Health		Does the language in subdivision (3) of paragraph (l) clearly portray that a minor may not be kept under the court's jurisdiction once a determinate finding of incompetence has been made? Yes, the language is completely clear.	The advisory bodies agree.
Diversion Program	Christine Villanis, Deputy Chief Juvenile Services, San Mateo County Probation Department	AM	The court's needs may be served on one level, but one of the tools encouraging completion of diversion is the assurance of not taking it to court. • If taking it to court upon failure of diversion is not an option, what is the consequence of not being compliant with diversion? Also, this likely puts the burden on probation without the support of the court.	The protocol may address a diversion program and any consequences of not completing diversion.
	Ashleigh E. Aitken, President		Yes, the option of diversion program in local protocols can fulfill the need of the court. In many instances, had a minor not been found incompetent, a diversion program would have been already available to the minor.	The advisory bodies agree.

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	On behalf of Orange County Bar Association			
	Hon. Michael I. Levanas, Presiding Judge, and Commissioner Robert Leventer, Superior Court of California, Los Angeles County, Juvenile Court		The juvenile court needs statutory authority for a diversion program which allows for judges to order services for minors which address the underlying reasons for their delinquent behavior while proceedings are suspended. This authority needs to be expressly stated. • *A minor who is charged with an assault might benefit from anger management counseling. A minor charged with possession of drugs may benefit from drug counseling.* A minor with mental health problems may benefit from therapy. Presently the court does not have the authority, and Probation does not have the mandate, to provide services to minors without juvenile court jurisdiction. If the court had the ability to allow minors to participate in a diversion program which offered these services, *without punishment,* in exchange for a dismissal, we could enhance public safety and assist the minor in becoming crime fee in most competency cases.	The advisory bodies did try to include a diversion program into previous drafts. However, commentators to those drafts were confused by the diversion language and no consensus could be reached regarding the applicability in each local court. The advisory bodies therefore moved the option of a diversion program into the protocol to address the concerns of the larger and smaller courts.
	Sue Burrell, Staff Attorney on behalf of the Youth Law Center		Of all the proposed changes, we were the most troubled by the failure to include a dismissal or diversion mechanism. Relegating it to a permissible option in county level protocols is totally inadequate, given the tremendous need to provide a path out of lengthy competence proceedings in some cases. All of the previous drafts of the proposed changes have included such a provision. We will oppose this measure in the Legislature if it fails to include a statewide mechanism for dismissal.	The advisory bodies did try to include a diversion program into previous drafts. However, commentators to those drafts were confused by the diversion language and no consensus could be reached regarding the applicability in each local court. The advisory bodies therefore moved the option of a diversion program into the protocol to address the concerns of the larger and smaller courts.

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			For more than a decade, our office has heard from probation officers, lawyers, experts and courts that some youth simply do not belong in the juvenile justice system, and/or will be ill-served by being forced to endure lengthy competence proceedings potentially followed by prosecution. We also know that some defenders walk their clients through inauthentic admission, not because they believe their client is competent, but to avoid the negative impact of lengthy proceedings. We also know what happens to youth with cognitive limitations in custody. They are often isolated out of a misguided attempt to protect them, and their mental status almost inevitably deteriorates. Their needs require an inordinate amount of staff time, and few juvenile halls have staff who are adequately trained to work with youth who are very young, have intellectual challenges or suffer from serious mental illness. • The Chief Probation Officers of California commissioned an entire monograph on this issue, *Costs of Incarcerating Youth with Mental Illness: Final Report* (Ed Cohen and Jane Pfeifer, 2008). Congressman Henry Waxman published a paper on *Incarceration of Youth Who Are Waiting for Community Mental Health Services in California* (2005). There is very much a need to assure that young people with intellectual challenges and mental illness are treated in the right system, and having a dismissal mechanism in the competency process may provide an opportunity to redirect some of these youth. • There are also practical considerations for the court and prosecutors. A substantial number of cases involving cognitively impaired youth will result in dismissals months down the road because of Penal	

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			Code 26 issues, or statements found to be involuntary or in violation of *Miranda*. Others will be dismissed because, in the passage of time, witnesses have disappeared or no longer remember what happened. And from the standpoint of the court, forcing all youth to go through formal competence proceedings and "remediation" puts the court in the difficult position of trying cases involving youth who didn't understand what was happening then, and surely do not understand any better months down the road. Many youth who were found incompetent, but are later deemed "remediated," are still barely functioning. As a matter of fundamental fairness, we need to provide an alternative path for handling at least some of these cases. • Finally, everything and more that we would do at the end of formal competence proceedings could be done at the beginning. In fact, the services provided after a finding of incompetence must be limited to services designed to help the minor attain competence, but the services prior to such a finding are not so limited. We recognize that some cases may involve alleged behavior so serious that the proceedings will need to go forward with a formal hearing and remediation, but at least some cases could fairly be disposed of if the court were satisfied that the behavioral issues are being addressed, or in the interest of justice if the minor is unlikely to attain competence in the foreseeable future. Maybe the stumbling point on this has been that what is called for isn't "diversion" in the sense of the person agreeing to do certain things (since some of the youth	

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			may actually be incompetent), but instead is a facilitated dismissal. These comments offer a possible solution. This is an attempt to address previous sticking points such as whether admissions are needed, and also to require a full evaluation to assure that dismissal occurs in cases that truly merit it. Recommending to add 709 (a)(2) providing for dismissal without formal proceedings**.** *When a doubt has been declared and the expert appointed pursuant to subsection (a), the court may, upon motion of the minor or on the court's own motion, set a hearing to consider whether the case may be dismissed without formal competency proceedings. Upon receipt of the expert report, or such additional expert reports and evidence as may be presented, the court may dismiss the case in the interest of justice where there is a substantial likelihood that the minor is incompetent and will not attain competence in the foreseeable future, or where services and supports can be arranged to adequately address the behavior that brought the minor to the attention of the court.* *The court may employ the joinder provisions of Section 727, subdivision (a),subsection (4), to facilitate the involvement of other agencies with legal duties to the minor, and may invite the participation of family members, caregivers, mental health treatment professionals, the public guardian, educational rights holders; education providers, and social service agencies.*	
	Adrienne Shilton, Director, Intergovernmental		CBHDA recommends that a diversion program should be available, especially for minor offenses. There are some that are evidence-based and may be the better	The advisory bodies agree.

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	Affairs, County Behavioral Health Directors Association of California		choice, for example. It would appear that treatment programs would also be included in local protocols, if only for intervention purposes.	
	Lexi Howard, Legislative Director on behalf of the Juvenile Court Judges of California		Yes, a diversion program in the local protocols fulfills the need of the court.	The advisory bodies agree.
	Adrienne Shilton, Director, Intergovernmental Affairs, County Behavioral Health Directors Association of California		CBHDA's chief concern regarding these recommendations has to do primarily with: • What happens after the child is determined incompetent. This proposal largely addresses the actual qualification process and not the truly difficult matter of what happens after the decision is made that the child is incompetent to stand trial. • The programs to restore competency or remediation services will vary wildly from inpatient to an array of outpatient services. o Youth who are violent will more likely require an inpatient service. o These services should be evidence-based and provided in the least restrictive setting. o The 30 day review process for those who have a severe mental illness seems arbitrary and not likely to be fruitful; many evidence-based programs are of much longer duration. The issue of how to serve children who are found incompetent is very complex, and far more involved than the qualification process as contained in the Judicial Council's proposal.	The advisory bodies are aware that there are many issues to juvenile competency. This legislation is limited to process and procedure. This legislation is not proposed to solve all the issues that surround our incompetent youth.

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	Corene Kendrick, PJDC Board Member & Amicus Committee Member on behalf of the Pacific Juvenile Defender Center		The proposed statutory language does not include a mechanism for early dismissal or diversion, which must be included. The proposed language fails to include procedures for early dismissal or diversion, and it should not be left to be discretionary and up to the courts county-by-county to have different standards. • The statutory language should call for the dismissal of charges where there is a substantial likelihood that the minor will not gain competence in the foreseeable future. Without such a requirement of dismissal in the interest of justice, youth can face grave consequences due to prolonged detention. • We also believe that if remediation services are not being provided, or are ineffective, the child should be released from detention. • We propose that the general rule should be that if a minor charged with a misdemeanor has not gained competency within six months, the case should be dismissed; and if a minor charged with a felony has not gained competency with 12 months, that the case be discharged. We understand that some cases may involve charges so serious that the proceedings need to proceed to a hearing and disposition, but in those cases, the Court could use its inherent joinder power under Welfare & Institutions Code section 727(b)(1) to ensure that other agencies and professionals are involved in the treatment of the youth.	The advisory bodies believe that each local court protocol should address timelines for diversion. Adding a specific requirement of when the case should be dismissed would limit judicial discretion. These minors need to be treated on a case-by-case bases.
	Roger Chan, Executive Director on behalf of the East Bay		No, Diversion programs should not be an optional component of county protocols. Nearly every county is struggling with what to do when youth are found to be incompetent and proceedings are suspended. Diversion programs are often a desired outcome as they may	Mention of a diversion program was eliminated.

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	Children's Law Offices709		potentially address a minor's family, social, and educational, supervision or mental/developmental health needs, as well as public safety concerns. While it is appropriate for each county to develop its own protocol, the scope should be broadened beyond remediation services and the statute should specifically identify additional participants in the protocol's development, including the district attorney and public defender.	
	Tari Dolstra, Division Director, Juvenile Services Riverside County Probation Department		Yes, the option of a diversion program in the local protocols fulfill the need of the court. However, it is believed, as indicated, a program of diversion pursuant to 654.2 WIC is not appropriate to be used 'in lieu' of a disposition. Development of a remediation plan and monitoring of this plan and the minor's progress until such time is it determined to effect competency or terminate proceedings/dismissal of the case is best served by the probation department. However, parameters are needed to establish the extent of this supervision, as well as abilities to remove the minor from the community and detain in juvenile hall during the course of remediation, should concern for the safety of the minor or the community become evident. While keeping the 'least restrictive environment' in mind, and the committee's notation that a 'minor's dangerousness is beyond the scope of this proposal' it would be beneficial to outline the parameters for custodial action should it be warranted.	The advisory bodies agree.
	Angela Igrisan, Mental Health Administrator, on behalf of the Riverside County		Does the option of a diversion program in the local protocols fulfill the need of the court • This is a question to the court, not mental health. Our opinion is that it would be helpful to have diversion programs as an option because each child's circumstances are different. The discussion	Information only. No comment needed.

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LEG15-04
Welfare and Institutions Code Section 709
All comments are verbatim unless indicated by an asterisk (*).

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	Department of Mental Health		centered around the fact that some diversion programs are voluntary. This appears less relevant to me because the court and probation could amend the voluntary aspect of the program.	
Should the statute include specific information regarding payment for initial court ordered competency evaluations or continue following current local county based practices?	Christine Villanis, Deputy Chief Juvenile Services, San Mateo County Probation Department	AM	In some counties, I would think that they would appreciate something to help make this determination. I could see fiscal restraints becoming an issue and the courts using their power to order others to pay.	Information only. No comment needed.
	Hon. Michael I. Levanas, Presiding Judge, and Commissioner Robert Leventer, Superior Court of California, Los Angeles County, Juvenile Court		Services that need to be funded in a typical competency case. Different counties use different funding mechanisms for various parts of these programs. It would be difficult to quantify, but some of the common costs include a) Competency evaluators [*LA uses county funds. Other counties include these funds in the budget of the Public Defender's office, others use DMH funding.]* *b)* Added staff from Probation. *In Los Angeles Probation has assigned special staff to monitor and service competency cases. Of course, these employees require training and supervision.* c) Remediation Instructors. *Probation officers and DMH staff serve as*	Information only. No comment needed.

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			remediation instructors in Los Angeles. It is too soon to tell how many instructors will be required. These positions are funded from different sources in different counties. Each county will handle competency cases differently according to the number of cases they project, funding sources, the relative cooperation between the players in that court's culture, whether Probations is under the court administration, availability of Proposition 63 funds, the availability of experts, and the type of remediation program they select. It may be too soon to create a statewide law or rules in this area. It would probably be best to revisit this area after counties, and the country, have had a chance to experiment.	Information only. No comment needed.
	Margaret Huscher, Supervising Deputy Public Defender III, Law Office of the Public Defender, Shasta County		• I do not foresee any county department volunteering to fund or administer an expensive and time consuming remediation program, and I predict a judge's committee, as established in (j), would be incapable of agreeing on which department will provide the necessary program. • This skepticism comes as a result of watching our probation department's reluctance to supervise, counsel or provide case management planning for incompetent minors. Their position has been that, until the date the minor is deemed competent, the minor is not on probation. This reluctance to provide for counseling and case management is true even when the minor is held in juvenile hall pending restoration. • Likewise, I cannot imagine our mental health department willingly providing remediation	Information only. No comment needed.

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			services, especially if they cannot bill Medi-cal or private insurance for the treatment.	
	Lexi Howard, Legislative Director on behalf of the Juvenile Court Judges of California		Continue to follow county based practices	The advisory bodies agree.
	Adrienne Shilton, Director, Intergovernmental Affairs, County Behavioral Health Directors Association of California		CBHDA recommends that payment should not be discussed in statute.	The advisory bodies agree.
	Roger Chan, Executive Director on behalf of the East Bay Children's Law Offices		Continue following current local county based practices. • Given the wide range of resource and economical considerations between counties and geographic regions, local counties should have discretion to establish payment procedures for court-ordered competency evaluations. For example, in Alameda County, the court has a partnership with the county's Behavioral Health Care Services for evaluations to be performed by county providers.	The advisory bodies agree.
	Tari Dolstra, Division Director, Juvenile Services Riverside County Probation Department		It is believed the agency or entity raising the doubt should be responsible for payment of evaluations. If, following the initial evaluation, any party wishes to seek additional evaluations for the sake of a 'second opinion', that party should be responsible for payment.	The advisory bodies do not take a position on who should pay for the evaluations. The advisory bodies are leaving this up to local county practice.

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	Angela Igrisan, Mental Health Administrator, on behalf of the Riverside County Department of Mental Health		Should the statute include specific information regarding payment for initial court ordered competency evaluations or continue following current local county based practices? • Yes, this would be much appreciated. None of the county agencies are clear on whose mandate necessitates competency activities.	The advisory bodies decided to not include language on funding and payment. This could be included in a future protocol.
Potential ramification/ Unintended consequence	Christine Villanis, Deputy Chief Juvenile Services, San Mateo County Probation Department		What are the ramifications if the statute isn't addressed? • What happens if a county is not in compliance with this statute? • Are there any ramifications?	The advisory bodies believe that all remedies that are currently available under section 709 will be available under the new section. The advisory bodies also believe that the protocols can discuss ramifications, if warranted. The option of appealing a court order is also still available to the parties.
Dangerousness	Christine Villanis, Deputy Chief Juvenile Services, San Mateo County Probation Department	AM	One of the big issues for many jurisdictions is about how to deal with juveniles who are a danger to their communities but are also deemed incompetent, especially in regards to developmental immaturity. If there is no real danger, it is fine to dismiss charges as the risk to the community is minimal. In the adult system, offenders are held until they are competent. It would make more sense to me if, based on the seriousness of the crime, that there was some provision to keep a youth detained in some way until they can be found competent or we can show that they are no longer a danger to their community. We have had a couple of situations where, due to developmental immaturity, charges were dismissed and the youth continued to seriously victimize the community without consequence. As a law enforcement officer and protector of the community, this does not make sense to me.	The advisory bodies have heard that the issue of dangerousness is a concern ad that these minors present additional challenges. However, this proposal discusses only the process and procedures to establish competency, as the issue of the minor's dangerousness is beyond the scope of the proposal.

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	Hon. John Ellis, Presiding Juvenile Judge on Behalf of Solano County Superior Court	AM	Although substantial changes to W&I 709 are desperately needed, I do not think the proposed amendment goes far enough regarding guidelines for competency training. On occasion, minors who are found incompetent are also a public safety risk if they are released from custody. However, probation departments are not equipped to treat these minors. IN PC 1368 incompetent defendants are sent to a state hospital or a regional center for treatment. W&I 709 needs a similar provision.	The advisory bodies believe that subdivision (*l*)(3) allows courts to make a referral to an assessment to determine if the youth is gravely incapacitated. The advisory bodies have heard that the issue of dangerousness is a concern ad that these minors present additional challenges. However, this proposal discusses only the process and procedures to establish competency, as the issue of the minor's dangerousness is beyond the scope of the proposal.
	Rosemary Lamb McCool, Deputy Director, Chief Probation Officers of California		Omission of Violent/Dangerous Youth found to be Incompetent: We are disappointed that the joint committee declined to address the issue of incompetent youth with dangerous and violent behavior. What are the court's options when a petition involving a violent and/or dangerous behavior is dismissed due to the court's finding that the youth cannot be remediated?	The advisory bodies understand that the dangerous and violent youth present additional challenges.
Technical Changes	Ashleigh E. Aitken, President On behalf of Orange County Bar Association		Agrees that the proposal addressed the stated purpose. • Subdivision (k), end of first sentence (page5, line 6), "as described in (m)". There appears to be no (m) in the proposed legislation. The phrase should be corrected to read, "as described in (j)."	The advisory bodies agree.
	Mike Roddy, Executive Officer, Superior Court of California, County of San Diego		*There is no subdivision (m). Remediation program should not be capitalized in the subdivision.*	The advisory bodies agree.
	Mike Roddy, Executive Officer, Superior Court of California,		Subdivision (i): The cross-reference to subdivision (d) is a mistake. We believe it would now be (g). I agree with subdivision (j)	The advisory bodies agree.

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	County of San Diego		For consistency purposes, use "subdivision" (not subsection). Our court does not understand how the process laid out in (l)(3) can work. Instead of inviting all those stakeholders to a hearing, it may be better to set up a multidisciplinary team meeting prior to the hearing and allow the team to make appropriate referrals to services. The team could then make recommendations to the court for the final hearing.	
	Corene Kendrick, PJDC Board Member & Amicus Committee Member on behalf of the Pacific Juvenile Defender Center		A subdivision has a reference to a subdivision (m), which does not exist.	The advisory bodies agree.
Miscellaneous	Sue Burrell, Staff Attorney on behalf of the Youth Law Center		Subdivision (a), wrongly limits incompetence to 4 causes. In fact, incompetence may stem from any cause resulting in the person's inability to meet both prongs of the Dusky test. A sentence in the same section, a little bit further down states the causation correctly by adding "including but not limited to." This is important because, while most cases probably fit into the big categories of mental illness, mental disorder, developmental disability, or developmental immaturity, there may be cases involving additional causes (for example, linguistic or cultural issues).	The advisory bodies agree with the re-write proposed.

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			Remove the first statement of causation and retain the second, and get rid of the surplus language in the second statement. The section would read as follows: (a) Whenever the court believes that a minor who is subject to any juvenile proceedings is mentally incompetent, the court must suspend all proceedings and proceed pursuant to this section. A minor is mentally incompetent for purposes of this section if~~, *as a result of mental illness, mental disorder, developmental disability, or developmental immaturity, the minor*~~ *he or she* is unable to understand the nature of the delinquency proceedings or to assist counsel in conducting a defense in a rational manner including a lack of a rational or factual understanding of the nature of the charges or proceedings. Incompetency may result from the presence of any condition or conditions ~~*that result in an inability to assist counsel or understand the nature of the proceedings*~~, including but not limited to mental illness, mental disorder, developmental disability, or developmental immaturity. Except as specifically provided otherwise, this section applies to a minor who is alleged to come within the jurisdiction of the court pursuant to Section 601 or Section 602.	
			Section 709, subdivision (i). Orders upon finding the minor incompetent. We agree with the rewording of the standard of proof for incompetence. Our additional request is that this section specifically state the minors must be held in the least restrictive appropriate environment. We have heard anecdotal evidence that children in some counties are being held for months to receive remediation services in juvenile hall for relatively minor offenses. In our view, those counties	The advisory bodies agree that minors should be held in the least restrictive environment. The advisory bodies address this issue in subdivision (k) and do not believe that it needs to be articulated in subdivision (i)

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			are vulnerable to liability for violating the Americans with Disabilities Act and the 14th Amendment. The respected remediation programs provide services primarily in the community or in non-secure settings, and we should be assuring that happens except in the most extreme cases. **Recommendation:** Insert the following sentence: (i) ~~If the minor is found to be incompetent by a preponderance of the evidence~~, If the court finds by a preponderance of evidence that the minor is incompetent, all proceedings shall remain suspended for a period of time that is no longer than reasonably necessary to determine whether there is a substantial probability that the minor will attain competency in the foreseeable future, or the court no longer retains jurisdiction. *The minor shall be held in the least restrictive appropriate environment.*	
	Mike Roddy, Executive Officer, Superior Court of California, County of San Diego		We have some youth who have significant mental health issues and/or pose a risk of safety to themselves and others, but no one is legally responsible (other than mom/dad) in overseeing their care. Oftentimes the parents are trying to help the youth but the options are limited. These are the youth with serious charges--murder, rape, sexual assault, assaults where the parents are locking their doors, or can't have them home due to safety concerns. • The youth have high mental health needs, but may not necessarily qualify for regional center services, conservatorship or WIC 300. Based upon these facts, our court welcomes the changes to WIC 709. *Competence v. Competency*	Information only. No comment needed

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			We would prefer the use of the term "competence" over "competency" in the statute because that is the term used in the criminal statutes. *Restoration v. Remediation* We prefer the term "restoration" over "remediation" because it is a more understandable term by the general populous.	The advisory bodies disagree. The advisory bodies selected the term remediation to use throughout the proposal. As noted in the recent article in the *Juvenile and Family Court Journal* (Spring 2014), some scholars prefer the term *remediation* rather than *restoration* when referring to juveniles because, in some states, juveniles may be found to be incompetent due to developmental immaturity as well as because of mental illness and intellectual deficits or developmental disabilities. Remediation involves utilization of developmentally and culturally appropriate interventions along with juvenile/child-specific case management to address barriers to adjudicative competency. See Shelly L. Jackson, PhD, Janet I. Warren, DSW, and Jessica Jones Coburn, "A Community-Based Model for Remediating Juveniles Adjudicated Incompetent to Stand Trial: Feedback from Youth, Attorneys, and Judges" (Spring 2014), Vol. 65, Issue 2, *Juvenile and Family Court Journal* 23–38.
			Case Management Responsibility This proposed legislation doesn't identify case management responsibility for youth who are in the competency stage of proceedings (proceedings suspended but youth in need of services)	There was much discussion concerning the cost of remediation services. During this discussion, it was discovered that not all counties pay for

Topic	Commentator	Position	Comment	Committee Response
			Funding Who is responsible for funding these items, which is an important piece that is lacking in the current WIC 709, • It is hoped that these areas can be addressed in future legislation after this proposal becomes law. Our court recommends the language be changed to state: "During the pendency of any juvenile proceeding for a minor who is alleged to come within the jurisdiction of the court pursuant to Section 601 or Section 602, the minor's counsel, any party, participant, or the court may express a doubt as to the minor's ~~competency~~ competence. ~~Doubt expressed by a party or participant does not automatically require suspension of the proceedings, but is information that must be considered by the court.~~ A minor is incompetent to proceed if he or she lacks sufficient present ability to consult with counsel and assist in preparing his or her defense with a reasonable degree of rational understanding, or lacks a rational as well as factual understanding of the nature of the charges or proceedings against him or her. ~~Doubt express by a party or participant does not automatically require suspension of the proceeding, but is information that must be considered by the court. If the court finds sufficient substantial evidence, that raises a reasonable doubt as to the minor's competency, the court shall suspend the proceedings.~~ Incompetence may be caused by any condition or combination of conditions that	remediation services in the same way. Some counties already have protocols in place that address remediation services and funding; others do not. The advisory bodies decided not to address the specific issue of funding. They thought it was better left to be discussed in the local protocols. The advisory bodies changed the language in subdivision (a) and believe this rewrite addresses the concern of the commentator.

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			results in an inability to assist counsel or understand the nature of the proceedings, including but not limited to mental illness, mental disorder, developmental disability, or developmental immaturity. Expression of a doubt as to the minor's competence does not require automatic suspension of the proceedings but must be considered by the court. If the court finds sufficient evidence that raises a reasonable doubt as to the minor's competence, the court shall suspend the proceedings.	
	Lexi Howard, Legislative Director on behalf of the Juvenile Court Judges of California		Would the proposal provide cost savings? If so please quantify. • Unknown but likely not. What would the implementation requirements be for courts? For example, training staff (please identify position and expected hours of training), revising processes and procedures (please describe), changing docket codes in case management systems, or modifying case management systems. • A couple of hours training. Beyond that, unknown. How well would this proposal work in courts of different sizes? • Unknown.Local practice, particularly with respect to diversion, may have a greater impact than county size. The most difficult questions are those immediately above, dealing with costs, implementation and training. There are so many factors including size of the county, what kind of competency development program is involved, whether minors are in juvenile hall during remediation, what the state of knowledge is concerning competency and competency development, etc. that it is	The advisory bodies do not know the specific cost savings, but believe there will be cost savings by moving the children out of the hall and keeping them in the least restrictive placements. The advisory bodies agree. The advisory bodies agree. Information only. No comment needed.

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			difficult to accurately predict and assess costs and training.	
	Amanda K. Roze, Attorney at Law, Sebastopol, CA		An overall concern is that the proposal appears to blur the line between adult and juvenile competency by adding language that mirrors Penal Code section 1367. As the Invitation notes (p. 3), the standards for adult and juvenile competency determinations are different. Juvenile competency issues must be understood in the context of recent scientific advances. Within the last 15 years, developments in psychology and brain science have demonstrated fundamental differences between juvenile and adult brain functioning which require that juveniles be treated differently from adults in numerous aspects of the juvenile justice process. (See, e.g., *J.D.B. v. North Carolina* (2011) 564 U.S. __ [131 S.Ct. 2394, 2403] [“children ... lack the capacity to exercise mature judgment and possess only an incomplete ability to understand the world around them”].) The courts have already reached into the case law surrounding section 1367 in analyzing competency issues for minors. • Mirroring the language from section 1367 in section 709 will only increase this trend and cause stagnation in the law instead of forcing the courts to recognize the differences in adults and children. In order to foster more enlightened approaches for children, section 709 and rule 5.645 should make as much of a break from section 1367 as possible.	The advisory bodies changed the language in subdivision (a) and believe this rewrite addresses the concern of the commentator
	Adrienne Shilton, Director, Intergovernmental Affairs, County Behavioral Health Directors		Does the proposal appropriately address the stated purpose? • CBHDA believes that the proposal does address the stated purpose.	The advisory bodies agree.

Topic	Commentator	Position	Comment	Committee Response
	Association of California			
	Corene Kendrick, PJDC Board Member & Amicus Committee Member on behalf of the Pacific Juvenile Defender Center		Competency may stem from any cause resulting in the person's inability to meet both prongs of the *Dusky* standard, and the proposed language limits the Dusky standard. We are concerned that the proposed language has excessive verbiage that is confusing and may inadvertently narrow the *Dusky* standard to limit incompetence to four potential causes (mental illness, mental disorder, developmental disability, or developmental immaturity) when in fact there may be other causes of incompetency under *Dusky*. Furthermore, the *Matthew N*. and *Alejandro G.* decisions by the Court of Appeal included the concept that the individual must not only understand the nature of the proceedings, but appreciate them. (*In re Matthew N.* (2013) 216 Cal.App.4th 1412; *In re Alejandro G.* (2012) 205 Cal.App.4th 47). (The phrase "and appreciate" should also be added in subsection (b), between the words "understand" and "the nature of the proceedings.") We therefore propose that the section should read as follows (deletions in red, additions in bold underline, including minor grammatical changes): (a) Whenever the court believes that a minor who is subject to any juvenile proceedings is mentally incompetent, the court must suspend all proceedings and proceed pursuant to this section. A minor is mentally incompetent for purposes of this section if, ~~*as a result of mental illness, mental disorder, developmental disability, or developmental immaturity, the minor*~~ he or	The advisory bodies changed the language in subdivision (a) and believe this rewrite addresses the concern of the commentator

Topic	Commentator	Position	Comment	Committee Response
			she is unable to understand and appreciate the nature of the delinquency proceedings, or to assist counsel in conducting a defense in a rational manner, including a lack of a rational or factual understanding or appreciation of the nature of the charges or proceedings. Incompetency may result from the presence of any condition or conditions ~~*that result in an inability to assist counsel or understand the nature of the proceedings*~~, including but not limited to mental illness, mental disorder, developmental disability, or developmental immaturity. Except as specifically provided otherwise, this section applies to a minor who is alleged to come within the jurisdiction of the court pursuant to Section 601 or Section 602.	
	Roger Chan, Executive Director on behalf of the East Bay Children's Law Offices		The proposed changes to Section 709(a) erroneously limit incompetence to four causes. In fact, incompetence may stem from *any* one cause resulting in the person's inability to meet both prongs of the *Dusky* test. Recommendation: (a) Whenever the court believes that a minor who is subject to any juvenile proceedings is mentally incompetent, the court must suspend all proceedings and proceed pursuant to this section. A minor is mentally incompetent for purposes of this section if*, as a result of mental illness, mental disorder, developmental disability, or developmental immaturity, the minor he or she* is unable to understand the nature of the delinquency proceedings or to assist counsel in conducting a defense in a rational manner including a lack of a rational or factual understanding of the nature of the charges or proceedings. Incompetency may result from the presence of any condition or conditions *that result in an inability to assist counsel or understand the nature of*	The advisory bodies changed the language in subdivision (a) and believe this rewrite addresses the concern of the commentator

Topic	Commentator	Position	Comment	Committee Response
			the proceedings, including but not limited to mental illness, mental disorder, developmental disability, or developmental immaturity. Except as specifically provided otherwise, this section applies to a minor who is alleged to come within the jurisdiction of the court pursuant to Section 601 or Section 602.	
	Tari Dolstra, Division Director, Juvenile Services Riverside County Probation Department		While the cost of remediation and the burden to pay for such services was not addressed in this proposal, it would be beneficial to designate the appropriate party/agency and the ability to procure funding.	The advisory bodies believe the cost of remediation programs should be left to local county protocols.
	Angela Igrisan, Mental Health Administrator, on behalf of the Riverside County Department of Mental Health		Yes, the proposal appears thorough and appropriate	Information only. No comment needed.
	Rosemary Lamb McCool, Deputy Director, Chief Probation Officers of California		In our view, WIC 709 cannot be examined in isolation. It is undoubtedly interconnected to the larger challenge to meet the needs of youth who come into the delinquency system due to a lack of resources at the community level. The changes to WIC 709 will provide more process direction to judicial officials, but the proposal does not address how to move youth through the system and get them the services they need to either be remediated and adjudicated or, in the cases of those found to be incompetent, long-term treatment services. • Additionally, we recommend the statute be more explicit that youth whose competency is in question are better served in the community rather than in the	Information only. No comment needed. The advisory bodies discussed, at length, the purpose of the proposal. The advisory bodies wanted to a proposal that was politically viable. The intent of the proposal was never to solve all

Topic	Commentator	Position	Comment	Committee Response
			juvenile hall unless they pose a risk to public safety. Understandably, addressing the needs of the youth in need of remediation is a challenge and the joint committees undertaking this process needed to start somewhere. We appreciate the changes to the code sections where additional clarity and direction are provided; however, we believe that more needs to be done to address the very important needs of youth found incompetent to stand trial. This issue needs more conversation and cannot be done in isolation or without addressing the all-important question about how to fund what these youth need and deserve.	the issues with incompetent youth, but to provide some directions to the courts and juvenile stakeholders.

-

Mental Health Issues Implementation Task Force: Final Report

A TEMPLATE FOR CHANGING THE PARADIGM FOR PERSONS WITH MENTAL ILLNESS IN THE CALIFORNIA COURT SYSTEM

JANUARY 2015

DRAFT

JUDICIAL COUNCIL OF CALIFORNIA

OPERATIONS AND PROGRAMS DIVISION

CENTER FOR FAMILIES, CHILDREN & THE COURTS

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A Template for Changing the Paradigm for Persons with Mental Illness in the California Court System

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For more information on the Mental Health Issues Implementation Task Force or to view the 2011 report of the Task Force for Criminal Justice Collaboration on Mental Health Issues online, please visit *http://www.courts.ca.gov/mhiitf.htm.*

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Acknowledgments

Funding for the Mental Health Issues Implementation Task Force was provided by the following:

- Mental Health Services Act (MHSA) /California Proposition 63 (2004)
- Judicial Council of California

We would like to acknowledge the support of the Judicial Council staff whose work contributed to the accomplishments of the Implementation Task Force, specifically Cory T. Jasperson, Director of the Office of Governmental Affairs as well as Daniel Pone, Senior Attorney; Sharon Reilly, Attorney; Christine Miklas, Senior Editor; and David Glass, Senior Conference Center Coordinator. We would also like to extend our special thanks to our partners at the Mental Health Services Oversight and Accountability Commission, County Behavioral Health Directors Association of California (CBHDA), California Institute for Behavioral Health Solutions (CIBHS), Chief Probation Officers of California, California State Sheriffs' Association, and the trial courts of California for their valuable contributions to this project.

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Introduction

The Task Force for Criminal Justice Collaboration on Mental Health Issues (TFCJCMHI) was established in 2008 as a Chief Justice–led initiative that was part of a national project of the Council of State Governments[1]. The project was designed to assist state judicial leaders in their efforts to improve responses to people with mental illnesses in the criminal justice system. The TFCJCMHI was charged with exploring ways to improve practices and procedures in cases involving adult and juvenile offenders with mental illness, to ensure the fair and expeditious administration of justice, and to promote improved access to treatment for defendants with mental illness in the criminal justice system.

The TFCJCMHI developed 137 recommendations designed to improve outcomes for offenders and other individuals with mental illness in the justice system by promoting collaboration at the state and local level.

Specifically, the recommendations were designed to:

- Promote innovative and effective practices to foster the fair and efficient processing and resolution of cases involving mentally ill persons in the court system;
- Expand education programs for the judicial branch, State Bar of California, law enforcement, and mental health service providers to address the needs of offenders with mental illness;
- Foster excellence through implementation of evidence-based practices for serving persons with mental illness; and
- Encourage collaboration among criminal justice partners and other stakeholders to facilitate interagency and interbranch efforts that reduce recidivism and promote improved access to treatment for persons with mental illness.

The recommendations focused on the following areas:

- Community-based services and early intervention strategies that reduce the number of individuals with mental illness who enter the justice system;
- Court responses that enhance case processing practices for cases involving mental health issues and reduce recidivism for this population;
- Policies and procedures of correctional facilities that ensure appropriate mental health treatment for inmates with mental illness;

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[1] This project was supported by the Conference of Chief Justice in Resolution II: In support of the Criminal Justice/Mental Health Leadership Imitative http://ccj.ncsc.org/~/media/Microsites/Files/CCJ/Resolutions/01182006-In-Support-of-the-Judicial-Criminal-Justice-Mental-Health-Leadership-Initiative.ashx

- Community supervision strategies that support mental health treatment goals and aim to maintain adult and juvenile probationers and parolees in the community;
- Practices that prepare incarcerated individuals with mental illness for successful reintegration into the community;
- Practices that improve outcomes for juveniles who are involved in the delinquency court system; and
- Education, training, and research initiatives that support the improvement of justice responses to people with mental illness.

The recommendations were outlined in the final report received by the Judicial Council in April 2011.

In January 2012, Chief Justice Tani G. Cantil-Sakauye appointed the Mental Health Issues Implementation Task Force (Implementation Task Force), chaired by Judge Richard J. Loftus, Jr., of the Superior Court of Santa Clara County, to review the recommendations of the TFCJCMHI and to develop a plan for implementing the recommendations of that report. Implementation Task Force membership included judicial officers and court executive officers from throughout the state, as noted in the roster included with this report. While developing the implementation plan, it became clear that mental health issues cut across all case types and treatment, social service, and policy issues impacting defendants and other court users were often complex and multi-faceted. While the Implementation Task Force has focused on identifying ways to improve outcomes and reduce recidivism rates in criminal cases involving mental health issues, being mindful of cost and public safety considerations in the post-recession/post-realignment environment, members recognized the need to develop protocols and practices that support improved outcomes for court users with mental illness across other case types particularly those in juvenile, probate, dependency, and family courts.

Background

As noted in the final report of the TFCJCMHI, people with mental illness are overrepresented in the justice system.[2] One study found that although only 5.7 percent of the general population has a serious mental illness,[3] 14.5 percent of male and 31 percent of female jail inmates have a serious mental illness.[4] A 2009 study reported that in California there are almost four times more people with mental illness in jails and prisons than in state and private psychiatric hospitals.[5] It was also noted that inmates with serious mental illness often need the most resources and can be the most challenging to serve while incarcerated.[6] California's state psychiatric hospitals currently provide treatment primarily to a forensic population. California's forensic state hospital population of approximately 4,600 includes mostly individuals who have been found Not Guilty by Reason of Insanity (NGI) and Incompetent to Stand Trial (IST) or who are categorized as Mentally Disordered Offenders (MDO) or Sexually Violent Predators (SVP).[7] Persons with mental illness are also overrepresented in the courtroom. One study found that 31 percent of arraigned defendants met criteria for a psychiatric diagnosis at some point in their lives and 18.5 percent had a current diagnosis of serious mental illness.[8]

Evidence has demonstrated that only a systemic approach that brings together stakeholders in the justice system with mental health treatment providers and social service agencies can effectively address the needs of persons with mental illness. The TFCJCMHI was established with the recognition that courts are uniquely positioned to take a leadership role in forging collaborative solutions by bringing together these stakeholders. The Mental Health Issues Implementation Task Force was appointed by Chief Justice Tani G. Cantil-Sakauye to continue the important work the original task force had begun. The focus of the Implementation Task Force was to examine how to begin making the systemic changes needed to improve services for people with mental illness who are involved in the justice system. Unlike the original TFCJCMHI, which included representation from a wide array of justice system and mental health treatment partners, the Implementation Task Force is comprised only of trial court judges and court executive officers and was appointed for a limited term, with a sunset date of December 31, 2014.

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[2] Bureau of Justice Statistics Special Report, *Mental Health Problems of Prison and Jail Inmates* (September 2006), www.nami.org/Content/ContentGroups/Press_Room1/2006/Press_September_2006/DOJ_report_mental_illness_in_prison.pdf.

[3] Ronald Kessler, Wai Tat Chiu, Olga Demler, and Ellen Walters, "Prevalence, severity, and comorbidity of twelve-month DSM-IV disorders in the National Comorbidity Survey Replication (NCS-R)," *Archives of General Psychiatry, 62*(6) (2005), pp. 617–627.

[4] Henry J. Steadman, Fred C. Osher, Pamela C. Robbins, Brian Case, and Steven Samuels, "Prevalence of Serious Mental Illness among Jail Inmates," *Psychiatric Services, 60* (2009), pp. 761–765.

[5] Treatment Advocacy Center and the National Sheriffs' Association, *More Mentally Ill Persons Are in Jails and Prisons than Hospitals: A Survey of the States* (May 2010).

[6] *Ibid.*

[7] Pursuant to e-mail correspondence with Long Term Care Services Division, California Department of Mental Health, January 13, 2009.

[8] Nahama Broner, Stacy Lamon, Damon Mayrl, and Martin Karopkin, "Arrested Adults Awaiting Arraignment: Mental Health, Substance Abuse, and Criminal Justice Characteristics and Needs," *Fordham Urban Law Review, 30* (2002–2003), pp. 663–721.

Mental Health Issues Implementation Task Force Charge

The Implementation Task Force is charged with developing recommendations for policymakers, including the Judicial Council and its advisory committees, to improve system wide responses to mentally ill persons and to develop an action plan to implement the recommendations of the Task Force for Criminal Justice Collaboration on Mental Health Issues.

Specifically, the Implementation Task Force is charged with:

1. Identifying recommendations under Judicial Council purview to implement;
2. Identifying potential branch implementation activities; and
3. Developing a plan with key milestones for implementing the recommendations.

This charge recognizes the importance of the work begun by the TFCJCMHI and helps ensure that progress will continue to be made toward helping the criminal justice system and courts address the challenges posed when handling cases involving people with mental illness.

Guiding Principles

Members of the TFCJCHMI identified key principles that focused the work of the initial task force in the formulation of its recommendations. These same principles have guided the work of the Implementation Task Force. These guiding principles include the following:

- Courts should take a leadership role in convening stakeholders to improve the options and outcomes for those who have a mental illness and are at risk of entering or have entered the criminal justice system.
- Resources must be dedicated to identify individuals with mental illness who are involved or who are likely to become involved with the criminal justice system. Interventions and diversion possibilities must be developed and utilized at the earliest possible opportunity.
- Diversion opportunities should exist for defendants with mental illness as they move through the criminal justice system.
- Treatment and disposition alternatives should be encouraged for individuals who are detained, arrested, or incarcerated primarily because of actions resulting from a mental illness or lack of appropriate treatment.
- Effective responses to this population require the collaboration of multiple systems and stakeholders, because offenders with mental illness interface with numerous systems and agencies as they move through the criminal justice system.
- Flexible and integrated funding is necessary to facilitate collaboration between the various agencies that interact with offenders with mental illness.
- Offenders with mental illness must receive continuity of care as they move through the criminal justice system in order to achieve psychiatric stability.
- Information sharing across jurisdictions and agencies is necessary to promote continuity of care and appropriate levels of supervision for offenders with mental illness.
- Individuals with mental illness who have previously gone through the criminal justice system, and family members of criminally involved persons with mental illness, should be involved in all stages of planning and implementation of services for offenders with mental illness.
- Programs and practices with evidence-based practice models should be adopted in an effort to utilize diminishing resources and improve outcomes effectively.

Report and Recommendation Implementation

Organization of This Report and Recommendations

The original 2011 task force report was written using the Sequential Intercept Model (SIM)[9] as a framework for formulating and organizing its recommendations. The SIM illustrates various points along the justice continuum where interventions may be utilized to prevent individuals from entering or becoming more deeply involved in the system. Ideally, most people can be diverted before entering the justice system, with decreasing numbers at each subsequent point along the continuum.[10]

This report follows the same SIM framework used in the 2011 report, and begins with a brief overview of each section, beginning in section one with community-based strategies for early intervention and diversion followed by recommendations in section two focused on court-based strategies and responses for those not successfully diverted and who enter the justice system. The third and fourth sections outline responses related to individuals in custody or on probation or parole. The fifth section focuses on reducing recidivism and ensuring successful community reentry for those with mental illness. The sixth section focuses exclusively on juveniles with mental health issues in the delinquency system. The final section of the report highlights the education, training, and research necessary to implement the recommendations effectively and to measure the effectiveness of practices targeting justice-involved persons with mental illness.

The narrative portion of this report primarily discusses the recommendations that were found to be within the Judicial Council's purview and were the focus of the work of the Implementation Task Force. Next steps and the need for continuing the work is addressed at the conclusion of the report. Appendix A provides a chart of all 137 of the recommendations contained in the TFCJCMHI's final report, the full text of each recommendation, and the Implementation Task Force's response to each recommendation.

The work of both task forces, pursuant to their respective charges, focused on people with mental illnesses who may be, or are at risk of becoming, involved in the criminal justice or other juvenile or adult court systems, including dependency, family, or probate court proceedings. For purposes of this report, "mental illness" is used as a collective term for all diagnosable mental disorders; "serious mental illness" is defined to include schizophrenia and other psychotic disorders, bipolar disorder, and other mood disorders, and some anxiety disorders, such as obsessive-compulsive disorder, that cause serious impairment. Typically, both task forces focused their work on individuals with diagnoses that fall within the scope of serious mental illness. The terms "mental illness" or "offenders/people with mental illness" throughout the report should be understood to include co-occurring disorders, as approximately 50 percent of those in the general population with a mental illness also have a co-occurring substance use

[9] Created by Summit County, Ohio, and the National GAINS Center.
[10] Mark R. Munetz and Patricia A. Griffin, "Use of the sequential intercept model as an approach to decriminalization of people with serious mental illness," *Psychiatric Services, 57* (April 2006), pp. 544–549.

disorder,[11] and incarcerated individuals with a severe mental illness have been found to have a 72 percent rate of co-occurring substance use disorder. [12]

Implementation of Recommendations

The Implementation Task Force members approached their work by identifying what could be done within the branch and what must be done by partners acting alone or in concert with one another. Although some of the recommendations developed by the initial task force and addressed by the Implementation Task Force may initially appear to be outside the purview of the judicial branch, Implementation Task Force members believe that not addressing relevant areas could have a deleterious impact on the branch and be antithetical to the charge and goals of both task forces.

After identifying recommendations within the judicial branch's purview, the Implementation Task Force prioritized its work, taking into consideration whether implementation would need to occur on a statewide or local level, whether there is a need for collaboration and involvement from justice and mental health partners, and what is needed to make implementation of recommendations viable. Each recommendation was prioritized using this framework and Implementation Task Force members made significant progress toward implementing many of the recommendations, as well as formulating strategies for implementation of recommendations that the Implementation Task Force was not in a position to implement during its limited appointment term.

Members of the original task force and members of the current Implementation Task Force recognized that some of their recommendations may require additional funding, legislative changes, or changes in the culture and practices of systems involved in responding to people with mental illness in the justice system. However, the goal throughout has been to develop and address recommendations that not only can be implemented with little cost but also recommendations that are aspirational in nature and can serve as a blueprint for developing and implementing the best possible responses over time. During the development of the original recommendations and in addressing implementation issues, members of both task forces were sensitive to the current economic climate and the fiscal difficulties still confronting state and local government and community-based programs. However, in both 2011 and in 2014, task force members felt that, even in difficult economic times, it is imperative that courts and counties jointly develop and pursue programs, services, and interventions that will best maximize resources to improve outcomes for offenders with mental illness. Moreover, task force members believe that effective approaches to mentally ill offenders will ultimately reduce the amount of fiscal resources expended on a long-term basis.

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[11] California Department of Alcohol and Drug Programs, Co-Occurring Disorders Information *(Co-Occurring Disorders Fact Sheet)* http://cojac.ca.gov/cojac/pdf/COD_FactSheet.pdf (as of December 2008).
[12] Karen M. Abram and Linda A. Teplin, "Co-Occurring Disorders Among Mentally Ill Jail Detainees: Implications for Public Policy," *American Psychologist, 46*(10) (1991), pp. 1036–1045; the CMHS National GAINS Center, *The Prevalence of Co-Occurring Mental Illness and Substance Use Disorders in Jails* (2002), http://gainscenter.samhsa.gov/pdfs/disorders/gainsjailprev.pdf.

Fostering a collaborative approach to creating solutions for defendants with mental illness has become even more critical in the time since the report of the TFCJCMHI was submitted to the Judicial Council. Criminal justice realignment (realignment), enacted as part of the Budget Act of 2011 and various budget trailer bills, transferred the responsibility for managing and supervising non-serious, non-violent, non-sexual felony offenders from the state to county governments. Under realignment, trial courts are now responsible for conducting revocation hearings in cases where individuals released from prison violate their conditions of supervision. Realignment also gave trial courts the responsibility for setting the terms of mandatory supervision. While this has presented some challenges, it also presents an opportunity to establish local protocols and set local conditions of supervision for individuals with mental illness.

It is important to remember that many of the original recommendations and implementation strategies are cost-neutral recommendations and may not require additional funding. Even without new or additional funding, many recommendations can be implemented at little or no cost through cooperative ventures and through innovative collaborative efforts with state and local justice and mental health partners. In fact, many of the recommendations are associated with cost savings, as they often focus on ways to maintain offenders with mental illness in the community through connections to treatment services as an alternative to costly state hospital stays or incarceration in local or state facilities. However, some recommendations do require additional court and staff time and the implementation of some of these recommendations may be hampered or limited by the serious reduction in judicial branch funding that has occurred since the original TFCJCMHI report was submitted.

In implementing the recommendations, courts and county partners require flexibility in developing appropriate local responses to improving outcomes for people with mental illness in the criminal justice system. Implementation Task Force members have been aware of and sensitive to the differences among California's counties and courts, recognizing that county size, county resources, and local county culture will influence what type of collaborative efforts would be most effective.

The Implementation Task Force identified 74 recommendations as being under Judicial Council purview, benefitting from judicial branch leadership or involvement, requiring educational programming of judicial officers, or being best practice recommendations for the courts. The balance of the recommendations requires implementation by justice or mental health partners or would require executive or legislative branch action.

Partnerships

The Implementation Task Force identified 63 recommendations that are outside of the purview of the Judicial Council and the courts. These are recommendations that can be addressed only by mental health and justice partners, by the legislature, or, as in the case of some regulations such as those arising from the Health Insurance Portability and Accountability Act of 1996 (HIPAA), by the federal government.

To facilitate discussion of these recommendations and potential action by criminal justice and mental health partners, as well as to foster those partnerships forged during the work of the TFCJCMHI, the Implementation Task Force leadership reached out to partners around the state. These partners included the Chief Probation Officers of California, California State Sheriffs' Association, Department of State Hospitals, Mental Health Services Oversight and Accountability Commission's Financial Oversight Committee, California Judges Association, California Institute for Behavioral Health Solutions, and the County Behavioral Health Directors Association of California. Outreach efforts resulted in invitations to make presentations to the executive committees or membership of these groups and to develop courses and teach at various educational programs. Educational presentations by Implementation Task Force members were provided to statewide organizations including the Chief Probation Officers of California, the California Institute for Behavioral Health Solutions, and the California Judges Association. These presentations outlined the work of the Implementation Task Force and discussed on specific recommendations made in the final report of the TFCJCMHI.

Outreach to all partners was important but was particularly significant in the case of the Chief Probation Officers of California (CPOC), and the California State Sheriffs' Association with whom discussions took place about jail treatment services, training of jail staff, discharge planning, and the development of common drug formularies. When speaking with CPOC representatives, Implementation Task Force members also discussed options for training probation officers in evidence-based practices for working with probationers with mental illness. Other efforts were primarily educational, wherein the role of the courts and judges was explained and there was an opportunity to engage in discussion about court and treatment evidence-based practices that can help improve outcomes for individuals with mental illness in the justice system.

The response to focusing on the need to improve outcomes for adults and juveniles involved in the criminal justice, delinquency, and dependency court systems has been favorable. Members of the Judicial Council's Trial Court Presiding Judges Advisory Committee have received regular updates about the work of the Implementation Task Force from the task force chair as have the Mental Health Services Oversight and Accountability Commission members. Task Force members have also provided reports to the Judicial Council's Collaborative Justice Courts, Criminal Law, Family and Juvenile Law, and Probate and Mental Health Advisory Committees regarding Implementation Task Force proposals and activities. Mental health and criminal justice partners repeatedly have noted that it is the involvement of judges and the leadership provided by the Judicial Council that has helped bring focused attention to these matters at local and statewide levels. The courts and their mental health and justice partners have come to realize that no single entity can solve the problem or bring about the changes that will improve outcomes. It is clear that improved outcomes for offenders and other court users with mental illness can only be achieved through collaboration and partnership with others.

Section 1: Prevention, Early Intervention, and Diversion Programs

The final report of the TFCJCMHI discusses factors that contribute to the disproportionate number of people with mental illness in the justice system, including the nature of the illness, negative stigmatization, homelessness, and decentralized and often underfunded mental health service delivery systems. The report's early intervention recommendations focus on the coordination of community services and the creation of community-based interventions/prearrest diversion programs to reduce the number of people entering the criminal justice system. The TFCJCMHI final report acknowledges that addressing these recommendations may be best done through local task forces since the recommendations focus on community agencies serving people with mental illness and on local law enforcement. The Implementation Task Force examined these recommendations and agreed with the assessment of the TFCJCMHI: these recommendations are most effectively addressed through collaboration between local justice partners, mental health agencies, other service providers, individuals, and family members.

While the Implementation Task Force did not specifically focus on the recommendations in this section, several of the projects and activities of the Implementation Task Force supported these recommendations, including:

- Amending rule 10.952 of the California Rules of Court to include additional justice system stakeholders involved with address mental health issues in courts' regular meetings concerning the criminal court system. These rule amendments will encourage judicial leadership in facilitating interbranch and interagency coordinated responses to people with mental illness in the criminal justice system.[13] (See further discussion, section 2.)

- Presenting at conferences and symposiums held by organizations such as the California Institute for Behavioral Health Solutions, National Association of Drug Court Professionals, California Association of Collaborative Courts, Chief Probation Officers of California, and the California Association of Youth Courts in order to provide education on how community justice partners and mental health professionals can assist people with mental illness who are, or may become, court involved.[14] (See further discussion, sections 3 and 5.)
- Directing and participating in summits cosponsored with partners such as the Center for Court Innovation and the American Bar Association that focus on community prosecution, diversion, and community policing and are designed to promote effective interface between community-based interventions and the courts.[15] (See further discussion, section 5.)

[13] Recommendations 1, 5, 6, 7.
[14] Recommendations 1, 2, 4, 6, 9, 10.
[15] Recommendations 1, 2, 5.

Improving and increasing the accessibility of services available to people with mental illness, combined with an expansion of pretrial diversion programs, can reduce the number of people with mental illness entering the criminal justice system. Thus, the Implementation Task Force recommends that courts work on the local level to foster connections with justice partners in order to open to branch local dialogues about how community service providers can assist people with mental illness who are currently involved, or at risk of becoming involved, in the justice system.

Section 2: Court Responses

The final report of the Task Force on Criminal Justice Collaboration on Mental Health Issues (TFCJCMHI) acknowledges that cases involving persons with mental illness are often the most challenging for courts to handle appropriately, and often require significant judicial branch resources. The report notes that the traditional adversarial approach is frequently ineffective in cases of defendants with mental illness. The TFCJCMHI indicated that the justice system could improve case processing and outcomes for persons with mental illness or co-occurring disorders by including the justice system partners who are most directly involved with the offenders with mental illness in the courts' criminal justice stakeholder meetings, and by establishing local protocols for these cases. Recommendations concerning court responses were in five primary areas: judicial leadership, case processing, coordination of civil and criminal proceedings, competence to stand trial, and additional court resources.

Judicial Leadership

Recommendations in this area focused on the critical role judicial leaders can play in improving responses to people with mental illness involved in the justice system by facilitating interbranch and interagency collaboration. In support of this, the Implementation Task Force proposed amendments to California Rules of Court, rules 10.951 and 10.952 to encourage judicial leadership in facilitating interbranch and interagency coordinated responses to people with mental illness in the criminal justice system. The proposed rule changes were adopted by the Judicial Council and effective January 1, 2014.[16]

The amendment to rule 10.951 encourages the presiding judge, together with justice partners, to develop local protocols for cases involving offenders with mental illness or co-occurring disorders to help to ensure early identification of and appropriate treatment with the goals of reducing recidivism, responding to public safety concerns, and providing better outcomes for these offenders while reducing costs.

The California Rules of Court are a set of regulations, adopted by the Judicial Council, which govern court procedure in California. Proposed changes to the rules of court are available for public comment prior to Judicial Council action. As a result of the Implementation Task Force's proposal, the Judicial Council made the following amendments to the rules:

- *Added subdivision (c) to rule 10.951, encouraging, but not requiring, the supervising or presiding criminal court judge, in conjunction with justice partners, to develop local protocols for cases involving offenders with mental illness or co-occurring disorders.*

[16] Recommendations 11 and 12.

The amendment to rule 10.952 added the Forensic Conditional Release Program (CONREP), the county mental health director, the county director of alcohol and drug programs, and representatives from the parole, sheriff, and police departments to the list of justice system stakeholders with whom designated judges are required to meet on a regular basis in order to identify and eliminate problems in the criminal court system and to discuss other problems of mutual concern. It is anticipated that, with the addition of these stakeholders, justice system partners on the local level will likely begin to address the complex information-sharing suggestions included in recommendations 13 and 14 of the TFCJCMHI's final report. This will help break down barriers to communicating critical information related to defendants with mental illness to the courts and select court partners, and will facilitate the courts' obtaining information about local agencies that are appropriate and qualified service providers. The Implementation Task Force noted that inclusion of criminal justice partnership will ultimately promote improvements in case processing in other case types such as juvenile, probate, and family law cases, as well as improving criminal case processing.

- *Amended rule 10.952 to add representatives from the following stakeholders to the already mandated meetings that courts hold with justice system partners: parole, the sheriff and police departments; the Forensic Conditional Release Program (CONREP); the local county mental health director; and the local alcohol and drug programs director.*

The full text of these amended rules can be found in the Appendix C of this report.

Case Processing

Recommendations in this section address the idea that courts should use collaborative methods for processing cases involving persons with mental illness. To encourage development of local protocols for those with mental illness, an amendment of rule 10.951 that was adopted by the Judicial Council furthers the recommendations in this section urging that trial courts have a specialized approach, guided by each defendant's mental health needs, to adjudicating cases involving persons with mental illness.[17] Similarly, the amendment of rules 10.951 and 10.952 encourages collaboration between local courts, probation, and mental health professionals, as stated in recommendation 18. Educational materials for judicial officers have been developed by the Implementation Task Force, including sample orders, bench notes, and other resources, to help local courts implement recommendations in this section.[18] These materials were incorporated into CJER On-Line Toolkits in September 2014 with additional materials to be added in the future. Similarly, the need for continued outreach to justice and mental health partners has been identified by the Implementation Task Force as a component that is critical to achieving case processing based upon evidence-based collaborative practices. These partnerships are expected to improve case processing in case types across the court system.

[17] Recommendations 16 and 17.
[18] Recommendations include 17, 20, 22, 23.

Coordination of Civil and Criminal Proceedings

The TFCJCMHI determined that when a court user with mental illness is involved in multiple case types, it is important to coordinate the cases and services. The final report recommended giving judicial officers hearing criminal proceedings the authority to order a conservatorship evaluation and the filing of a petition when there is reasonable cause to believe that a defendant is gravely disabled by a mental illness, and to receive a copy of the conservatorship investigator's report.[19] The Implementation Task Force requested that the Judicial Council sponsor legislation it drafted to increase the options available to courts when handling criminal cases involving potentially gravely ill offenders and improve coordination between the conservatorship court and the criminal court when they have concurrent jurisdiction over a mentally ill individual and the Judicial Council has undertaken such sponsorship.

Competence to Stand Trial

The issues of lengthy delays in case processing and competence restoration were addressed in this section. While most of the recommendations in the TFCJCMHI report concerning competence were found to be outside of judicial branch purview or an issue for judicial education, the Implementation Task Force drafted and requested that the Judicial Council sponsor legislation to amend Penal Code sections 1601(a), 1602(a) and (b), and 1603(a) pertaining to outpatient status for offenders who are gravely disabled as a result of a mental disorder or impairment by chronic alcoholism. The amendments would allow the court, when appropriate, to release conditionally a defendant found incompetent to stand trial to a placement in the community, rather than in a custodial or in-patient setting, to receive mental health treatment until competency is restored. The recommended legislation was accepted for Judicial Council sponsorship in the 2014–2015 legislative sessions and was passed and signed into statute as part of AB 2190. [20]

One of the responsibilities of the Judicial Council is to sponsor legislation consistent with the council's established goals and priorities to support consistent, effective statewide programs and policies. The Implementation Task Force proposed legislation for Judicial Council sponsorship, and two of the proposals are currently being considered by the Legislature. The proposals are designed to:

- *Improve the coordination between conservatorship and criminal courts by allowing the report of a conservatorship investigator to be shared with the criminal court, with the permission of the defendant or defense counsel, if the criminal court orders an evaluation of the defendant's mental condition and that evaluation leads to a conservatorship investigation.*

- *Increase the number of treatment options available for people who have been found incompetent to stand trial by allowing the court to order treatment in the community, thereby giving the court greater discretion in its ability to grant outpatient status to someone who was found incompetent to stand trial or not guilty by reason of insanity.*

The full text of this proposed legislation can be found in the Appendix D of this report.

[19] Recommendations 24–26.
[20] Recommendation 36.

Additional Court Resources

The need for courts to provide additional support to defendants with mental illness through peer support programs and self-help centers was highlighted in this section of the report. It should be noted that in order to fully implement these and other recommendations and to adapt to the changing needs of the justice system in the post-realignment environment, there is a need for restoration of the judicial branch funding in order to have sufficient court resources and staff to implement these changes. The Implementation Task Force acknowledged that, with the challenges of the current fiscal climate, these recommendations may be seen aspirational best practices and will require a joint commitment from courts and their mental health and justice partners system to implement these recommendations fully. However, the Implementation Task Force believes that implementing the recommendations and providing assistance to court users with mental illness and their families through court self-help centers would help with case processing processes and ultimately be cost-saving measures.

Section 3: Incarceration

The recommendations in this section of the TFCJCMHI's final report are focused on ways to provide appropriate care to people who are incarcerated and have mental illness. While recognizing that correctional facilities face a number of challenges in addressing the mental health needs of their inmate populations, including overcrowding, a shortage of qualified mental health professionals, and cultural aspects inherent in the prison and jail environment that pose additional challenges for persons in custody with mental illness, these recommendations seek to provide guidance on how to better serve people with mental illness through all phases of the incarceration process. The first subsection of these recommendations focuses on the jail booking/admission process and the need to identify, assess, and prepare for release individuals with mental illness. The second subsection examines the need for jails and prisons to address the mental health needs of their inmate populations and establish protocols to coordinate continuity of care both during and after incarceration. The Implementation Task Force considered the Section 3 recommendations and agreed with the TFCJCMHI that making the changes suggested in these recommendations is within the purview of county jails and state prisons and is not specific to the judicial branch.

In October 2011, criminal justice realignment (realignment) legislation went into effect and had a significant impact on the manner in which individuals with non-serious, non-violent, and non-sex crimes were incarcerated and supervised. Although the recommendations of the TFCJCMHI were crafted prior to the enactment of this legislation, the Implementation Task Force has taken steps to support the recommendations in this section in the context of realignment by identifying and contacting criminal justice partners in order address these recommendations during this time of significant change in the criminal justice system.

Members of the Implementation Task Force met with representatives from the State Sheriff's Association to identify common areas of interest and potential collaboration. Topics discussed included identifying common formularies and release strategies to maximize utilization of community resources for discharged individuals with mental illness. Implementation Task Force members have participated in joint educational programming with the State Sheriff's Association and other justice system partners that focus on improving outcomes and linkages to community services. It is anticipated that as more inmates with mental illness are housed and supervised on a local level as a result of criminal justice realignment, courts will need to work with their local sheriff's department and law enforcement justice partners to address how county jails can better meet the assessment and treatment needs of these inmates. The Implementation Task Force strongly recommends the establishment of collaborations with criminal justice partners to examine current booking procedures and treatment options, determine the local needs, and seek ways to improve the service to incarcerated people with mental illness. Judges need to provide leadership by communicating the courts' expectations concerning both the offenders with mental illness who appear before them and the treatment these offenders receive while in custody or under supervision of the court.

Section 4: Probation and Parole

The TFCJCMHI examined the issues associated with people with mental illness who are on probation or parole. The final report explained that people with mental illness are overrepresented in the parole and probation populations and are often the most challenging to supervise. People with mental illness have diverse treatment needs, are at a socioeconomic disadvantage, and often they have lost public benefits as a result of their incarceration. The TFCJCMHI determined that the challenges of providing supervision to probationers and parolees is exacerbated by the large caseloads and limited resources of probation officers and parole agents. The TFCJCMHI identified the need for specialized training on mental health issues, including the needs of the population and how mental disorders can interfere with the ability to adhere to supervision requirements, as well as the need to facilitate communication among collaborating treatment and supervision personnel.

The final report's recommendations concerning probation and parole focus on both the need to coordinate mental health treatment and supervision, and also the need for alternative supervision strategies that address public safety concerns and ensure improved outcomes for this population. While many of the recommendations require implementation by criminal justice partners, the Implementation Task Force found several recommendations to be appropriate work for the judicial branch.

Coordination of Mental Health Treatment and Supervision

In order to improve outcomes for probationers and parolees with mental illness, the TFCJCMHI made several recommendations encouraging the use of evidence-based practices that consider the specific treatment and service needs of that population. The Implementation Task Force examined these recommendations and found that education of judges as well as justice and mental health partners is an essential way to achieve the goals stated in the recommendations. In some instances, additional steps were taken to address and implement actions in response to specific recommendations.

The Implementation Task Force wrote an initial draft of legislation that, if adopted, would add a new section to the Penal Code enabling judicial officers to make specific orders about the care, supervision, custody, conduct, maintenance, and support of mentally ill offenders on probation, under mandatory supervision, or placed on post release community supervision. The legislation would also give the court the ability to join in the criminal proceeding any agency or private service provider that the court determines has failed to meet a legal obligation to provide services to the defendant. Consistent with the original recommendation, under the proposed legislation, the agency or service provider would be given advance notice of, and an opportunity to be heard on, the issue of joinder. The Implementation Task Force continues to work with members of other Judicial Council advisory bodies to revise the draft and hopes to finalize proposed legislation, which, if adopted, will increase the options available to the court when handling criminal cases involving offenders with mental illness, thus improving service provider accountability in instances where that is an issue.[21]

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[21] Recommendation 55.

The TFCJCMHI was concerned about the lack of coordination of mental health and other services for probationers, particularly in cases in which probationers committed offenses and sentencing occurred in a county other than the county of residence. This issue was addressed when the Judicial Council amended California Rules of Court, rule 4.530 to add subdivision (f), effective November 1, 2012. This new subdivision to the rule of court governing the jurisdictional transfer of probation cases compelled the court to take into consideration factors that include the availability of appropriate programs, including collaborative courts.[22]

The Implementation Task Force acknowledges that a significant amount of work remains to coordinate mental health treatment and supervision strategies. Members of the Implementation Task Force have met with members of the Chief Probation Officers of California to address these issues further and to develop collaborative approaches to issues of mutual concern. This collaboration is critical for the appropriate mandatory supervision of offenders with mental illness. The Implementation Task Force identified mental health courts as an effective approach for high risk/need offenders requiring intensive supervising and coordination of services. This approach was endorsed for both juveniles and adults. Related collaborative court types, such as veterans' courts, community courts, homeless courts, and reentry courts, were also noted as effective in improving outcomes for offenders with mental illness.

Alternative Responses to Parole and Local Supervision Violations

The TFCJCMHI crafted several recommendations related to responses to supervision violations and advocated that formal violations hearings for mentally ill offenders be conducted only as a last result after the failure of alternative interventions.

Criminal justice realignment legislation transferred the responsibility for hearing the majority of parole violation cases from the Board of Parole Hearings to the local trial courts. It also redistributed funding from the state to local counties to support their new responsibilities and encouraged the use of evidence-based practices. Many counties chose to use this opportunity to expand or establish treatment intervention and/or collaborative justice courts for individuals with mental illness who are supervised by probation or parole. The number of reentry courts in California has expanded from a pilot program of 5 courts during the time that the TFCJCMHI was developing their recommendations to 11 courts in operation today, and several others in planning phases.[23]

The Implementation Task Force has been instrumental in helping provide and shape judicial education in this area; however, this dynamic area of law continues to evolve and there remains a need for the development of additional judicial education opportunities and as well as the development of additional resource materials for judicial officers.

In addition, work still needs to be done in developing services based on evidence-based practices that better support probationers and parolees with mental illness and improve both short-term and long-term outcomes for this population.

[22] Recommendation 56.
[23] Data on the number of reentry and other collaborative justice courts gathered by the Administrative Office of the Courts, February 2014.

Section 5: Community Reentry

Acknowledging that California has one of the highest return-to-prison rates in the nation and that parolees with mental illness are more likely than other populations to face possible revocation, [24] the TFCJCMHI's final report made recommendations for ways to help offenders overcome some of the obstacles to effective transition to the community. These barriers to successful community reentry can include a loss of health or income benefits during incarceration, difficulties in accessing mental health and other services, problems with maintaining continuity of psychiatric medications, and homelessness. Because reentry can happen at many different points after an individual with mental illness has entered the criminal justice system and not just when a prisoner is released, these recommendations encompass issues encountered with reentry after jail diversion programs, mental health court participation, hospitalization, and post-incarceration, as well as through probation. The TFCJCMHI's community reentry recommendations focus on three areas: preparation for release, implementation of the discharge plan, and housing upon release. The recommendations focus on what can be done while the offender is incarcerated to ensure successful reentry and also outline crucial steps for linking offenders to services immediately following release, emphasizing the essential role that stable housing plays in promoting improved outcomes for this population. However the overarching theme of these recommendations is that the careful creation and implementation of discharge plans is critical to ensuring successful community reentry. The Implementation Task Force also noted the importance of community and family support in successful reentry and reintegration. Implementation Task Force members identified the need to address community reentry issues related to this population as an area in which it is important that additional work continue.

Preparation for Release

Because recommendations in this section focused on improving local procedures and services that prepare people with mental illness for release while the individual is still in custody, the Implementation Task Force found that its role in supporting changes on the local level was best effectuated through education and encouraging collaborations and cooperation between justice partners. The Implementation Task Force believes that the modifications to rules 10.951 and 10.952 will encourage the development of local court mental health protocols and that the addition of mental health stakeholders to already mandated meetings with criminal justice partners will facilitate planning and dialogue between the courts and their criminal justice and mental health partners. To advance this goal, Implementation Task Force members conferred with partners and participated in multidisciplinary educational programs with chief probation officers, mental health directors, and county sheriffs to identify the specific needs of offenders with mental illness during the various stages of incarceration, diversion, and reentry.

Recommendations concerning the need to amend legislation, regulations, and local rules to ensure that federal and state benefits are not terminated while an offender with mental illness is in custody[25] and the need to assist these individuals in order to help them obtain benefits immediately upon their reentry into the community[26] have been supported by the implementation of the Affordable Care Act (ACA) and Medicaid

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[24] Ryken Grattet, Joan Petersilia, and Jeffrey Lin, "Parole Violations and Revocations in California" (Washington, DC: National Institute of Justice, October 2008), *www.ncjrs.gov/pdffiles1/nij/grants/224521.pdf*.
[25] Recommendation 75.
[26] Recommendation 76.

eligibility expansion. To support these recommendations the Implementation Task Force has provided education to multiple court stakeholders and partners, including the Judicial Council's Trial Court Presiding Judges Advisory Committee and the Court Executives Advisory Committee, concerning the ACA and Medicaid.

Implementation of the Discharge Plan

Judicial officers are a critical link in the discharge planning process and in promoting the coordination among the court, custody staff, probation, parole, the community mental health system, family members where appropriate, and all necessary supportive services. Accordingly, it is essential that judicial officers communicate their expectations regarding offenders with mental illness to justice partners. The Implementation Task Force believes that the leadership role of the court as convener of integrated community partnerships is as an effective strategy for discharge planning prior to release from custody. As discussed above, the Implementation Task Force laid the foundation for development of such linkages through the rule of court amendments that encourage mental health protocols and bring mental health providers into court-community partnerships. Because this area is so critical to successful outcomes with mentally ill offenders, the Implementation Task Force recommends that additional efforts be made to encourage partners to coordinate efforts to establish discharge planning protocols and to assist courts in identifying their role in such efforts.

The TFCJCMHI and the Implementation Task Force both identified discharge planning as a key element for ensuring success for all offenders, but particularly those with mental illness, upon discharge from jail or prison. Key elements of the post release community plan include outlining the individualized community supervision plan; housing arrangements; transportation needs and options; benefits status; health-care, psychiatric and substance abuse services; and daily activity plans, including employment, job training, school, or other day programming. A sample discharge plan is found at Appendix E of this report.

Housing upon Release

Recommendations in this area focused on the need for every offender with mental illness leaving jail or prison to have in place an arrangement for safe housing. While many of these recommendations fall within the purview of local service providers, education about the important role of housing and the role the courts can play was identified as appropriate for the Implementation Task Force.[27] Thus, members of the Implementation Task Force participated in education programs sponsored by the American Bar Association's Commission on Homelessness and Poverty that specifically addressed homelessness among mentally ill offenders, veterans, and the reentry population. The effective practices to address housing that have been developed by some local courts, through homeless Stand Down, veterans, mental health, and community courts, were identified by the task force and will be included in web-based materials that highlight effective practices. Both the issues of safe housing upon release and effective methods for addressing housing and treatment needs have been included in multidisciplinary education programs in which Implementation Task Force members participated. Ongoing work in the areas of education, partnership development, and identification of effective practices will be needed as part of the follow-up to work initiated by the Implementation Task Force in this area.

[27] Recommendations 82–84.

Section 6: Juvenile Offenders

Citing research indicating that more than a quarter of the youth in the juvenile justice system should be receiving some form of mental health services,[28] the TFCJCMHI identified as a serious concern the prevalence of justice-involved youth with mental health disorders. The final report of the TFCJCMHI identified several challenges faced in handling juveniles in the delinquency system, including obtaining and maintaining appropriate services and medications; having effective procedural guidelines for addressing the restoration / remediation needs of juveniles with competency issues; the need for education, training, and research in the area of juvenile mental health; and the importance of collaboration among stakeholders. This section of the report notes that while some topics overlap with those in other sections of the report, the "uniqueness of juvenile mental health and the juvenile court system necessitates an independent discussion." Recommendations within this section are broken into six focus areas: juvenile probation and court responses, competence to stand trial, juvenile reentry, collaboration, education and training, and research.

Juvenile Probation and Court Responses

Recommendations in this section addressed the need for juveniles with mental illness involved in the delinquency court system to be identified, assessed, and connected to appropriate services. Because most of the specific recommendations in this area were identified as within the purview of, or requiring significant collaboration with, mental health and juvenile justice partners, much of the work of the Implementation Task Force focused on education about the recommendations and discussions with Judicial Council advisory groups that address juvenile issues. The work also focused on developing a framework to prioritize and address mental health issues in juvenile court. The groups that the Implementation Task Force partnered with include the Family and Juvenile Law Advisory Committee, the Collaborative Justice Courts Advisory Committee, and the Center for Judiciary Education and Research's (CJER) Juvenile Law Education and Curriculum Committee. A set of issues was identified that impact juvenile involvement in the justice system. These issues include psychological trauma leading to a variety of mental health issues, developmental disability, or mental illnesses that make juveniles vulnerable to exploitation and involvement in crime, such as human trafficking or gang involvement. Also identified were concerns related to socialization and school experiences that children and youth with mental illness or developmental disability are particularly vulnerable to, such as bullying, school discipline or performance issues associated with truancy, family disruption, and trauma. The Implementation Task Force initiated efforts to address these areas through education, identification of research needs, and specific approaches for future work.

Promising court practices that would benefit from the development of educational material and additional research were identified. They include juvenile mental health courts; girls' courts—especially in the area of human trafficking; and peer/youth courts that address early intervention and issues related to truancy, such as bullying or school discipline. The need for juvenile reentry courts and reentry programs for juveniles and young adult offenders was also noted as part of the consideration of emerging approaches to address

[28] Jennie Shufelt and Joseph Cocozza, "Youth with mental health disorders in the juvenile justice system: Results from a multi-state prevalence study," *Research and Program Brief* (Delmar, NY: National Center for Mental Health and Juvenile Justice, 2006).

juveniles with mental health issues. In general, effective approaches in the court system identify these high risk/high needs youth and provide a coordinated, multidisciplinary approach to assessing treatment needs and ensuring compliance.

Competence to Stand Trial

To support the recommendation that juvenile competency definitions and legal procedures be improved, a joint working group on juvenile competency issues was formed with representatives from the Implementation Task Force, the Collaborative Justice Courts Advisory Committee, and the Family and Juvenile Law Advisory Committee. This working group is considering possible legislative changes that have been proposed by the juvenile court judges of the California Judges Association, as well as additional changes needed to improve the statues relating to juvenile competency.[29]

By encouraging the development of a network of Judicial Council advisory bodies, the Implementation Task Force helped establish a process for a coordinated review of juvenile competency proposal by by Judicial Council advisory committees to assist the council in considering proposals in this key area of juvenile mental health. This network is also engaged in a process of identifying effective local court practices in the area of juvenile competency to inform development of potential court rules in this area and to support the dissemination of effective practices.

Juvenile Reentry

These recommendations focus on the need for the juvenile court and probation to work together to ensure that juveniles have a plan for treatment, have access to medication, and are able to obtain other necessary services when they reenter the community after being in detention or placement. Much of the work on recommendations in this subsection is dependent upon local collaboration and an examination of local procedures. Although the Implementation Task Force identified best practices for courts to include as part of general juvenile court processes and juvenile mental health collaborative court models for high risk/high needs cases, the timing of the task force's sunset and resource constraints leave more work to be done in this area. Future work, guided by the partnership of the Judicial Council advisory committees involved in juvenile and collaborative court issues, will determine how best to support these court models, identify effective practices, and inform courts statewide about strategies to support reentry and reduce recidivism. The Implementation Task Force has noted that work in adult reentry area may help identify effective practices, such as reentry courts, for use in juvenile reentry projects.

Collaboration

Recommendations in this section focused on the need for juvenile courts to collaborate with community agency partners to coordinate resources for mentally ill juveniles who are involved in the delinquency court system. It is hoped that the amendment of rule 10.952 encouraging local courts to include mental health agencies in court-community networks will results in a strengthened relationship between the courts and partner agencies, creating additional coordination and collaboration for juvenile offenders with mental illness.[30] Implementation Task Force members reached out to community partners, including probation

[29] Recommendation 96.
[30] Recommendations 101–106.

departments and mental health directors, in an effort to highlight approaches to address the needs of mentally ill persons in the courts. This outreach focused on both juvenile and adult offenders and included organizations such as the California Judges Association, as well as other justice system partners. The Implementation Task Force also identified a need to interface across court types, including dependency, family, probate, and criminal courts in which families and mentally ill juveniles have current or prior cases. Coordination with Judicial Council advisory groups in these areas was considered a first step in developing protocols to address youth and families involved in multiple case types.

Education and Training

Citing California Government Code section 68553.5, the TFCJCMHI stressed the need for the Judicial Council to provide training and education about juvenile mental health and developmental disability issues to judicial officers and other individuals and agencies who work with children in delinquency proceedings, and crafted recommendations revolving around this concept. In response, the Implementation Task Force highlighted areas for judicial education, including juvenile mental health issues. In partnership with Judicial Council advisory groups that had common concerns, members of the Implementation Task Force participated in planning processes that resulted in inclusion of mental health and developmental disability issues as part of CJER's Juvenile Law curriculum. The Implementation Task Force identified the need for additional educational programming and resource development as a focus for ongoing work in this area. Implementation Task Force members also supported the development of multidisciplinary education programs focused on juvenile mental health issues, such as trauma-informed care, bullying, and human trafficking through Beyond the Bench, Youth Court Summits, and collaborative justice educational programs that include juvenile collaborative courts.[31] The work of the Implementation Task Force served to crystallize the need for mental health content in juvenile court education programs and to provide support for developing this content.

Research

The TFCJCMHI's final report highlights the need for additional research in the area of juveniles in the delinquency system. In response to recommendations on this topic, additional research on juvenile mental health has been added to the California Courts website (*www.courts.ca.gov*), with new reports on juvenile mental health being added regularly.[32] Areas of focus for ongoing research include human trafficking, juvenile mental health courts, and peer/youth courts. The joint working group on competency will consider and advise on the juvenile competency research that should be undertaken by the Judicial Council.[33] To assist delinquency and juvenile mental health courts interested in data collection, the Judicial Council published and distributed a report on juvenile delinquency performance measurement as an evidence-based practice (*www.courts.ca.gov/documents/JD_Performance_asEBP.pdf*). In addition, the Judicial Council worked with the National Center for State Courts to survey all collaborative courts in California and to document preliminary outcome measures for juvenile collaborative justice courts.[34] Outcomes data, where available, have been summarized and provided as part of research briefings and summaries. The Implementation Task Force, along with partnering Judicial Council advisory groups, focused on

[31] Recommendations 107–109.
[32] Recommendation 110.
[33] Recommendation 111.
[34] Recommendation 113.

developing methods to identify and disseminate effective practices in the areas of juvenile competency, juvenile mental health courts, and human trafficking. These efforts of the Implementation Task Force are expected to continue as part of the ongoing work in developing judicial resources, and resources for partners, to address juvenile mental health issues in the court system. For example, Judicial Council staff, with input from the Collaborative Justice Courts Advisory Committee, is developing a briefing on juvenile collaborative court models, including a background in juvenile collaborative justice, the effectiveness and cost-effectiveness of these models, and how they can be replicated. This briefing should be completed by mid 2015.

These efforts begun by the Implementation Task Force are expected to continue as part of the ongoing work in developing judicial resources and resources for partners to address juvenile mental health issues in the court system.

Section 7: Education, Training, and Research

The TFCJCMHI's final report recognizes the need to heighten awareness and to provide the information and knowledge base necessary for improving outcomes for people with mental illness in the criminal justice system. Concluding that education and training for judicial officers, court staff, and mental health and criminal justice partners is critical, the TFCJCMHI's final report indicates that education and training programs should reflect a multidisciplinary and multisystem approach, and recommends that evidence-based practices and current information about mental health treatment and research findings be included in education efforts. The final report specified:

> Training programs should include, at a minimum, information about mental illness (diagnosis and treatment), the impact of mental illness on individuals and families, indicators of mental illness, stabilization and deescalation strategies, legal issues related to mental illness, and community resources (public and private). Training for judicial officers should include additional information about strategies for developing effective court responses for defendants with mental illness. Cross-training between criminal justice, mental health, and drug and alcohol services partners, and training in developing effective collaborations between the courts and mental health and criminal justice partners is critical if effective practices are to be designed and implemented to improve outcomes for individuals with mental illness in courts, jails, and prisons. All training initiatives should be designed to include mental health consumers and family members.

In order to help programs be more effective and to inform government leaders who can affect public policy, the final report calls for additional research to be done to identify best practices in California and to do a cost study, comparing the costs associated with traditional and alternate responses to people with mental illness in the criminal justice system.

The Implementation Task Force examined the recommendations and made efforts to implement those recommendations that were appropriate for judicial branch involvement. It accomplished objectives in all three categories of the TFCJCMHI's recommendations in this section: education and training for court and justice partner staff, collaboration with California law schools, and research.

Education and Training for Judicial Officers, Attorneys, and Criminal Justice Partners

Recommendations in this section center on the need for judicial officers, counsel, and justice partners to receive ongoing mental health education and training in strategies for working effectively with persons with mental illness. A key development in the area of judicial education was inclusion of mental health as an education priority in both the criminal and juvenile delinquency curriculum subcommittees of CJER. This development provides for significant education and materials for judicial education as well as inclusion of mental health content in judicial education programs sponsored by CJER.[35]

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[35] Recommendations 117, 118, and124.

Implementation Task Force members also participated as faculty for CJER's judicial education programs, developing and testing judicial education curricula and materials as part of the work of the Implementation Task Force. Programs were offered at the Cow County Judges Institute, Juvenile Law Institute, Family Law Institute, and Criminal Law Institute. Multidisciplinary education was offered for justice system and treatment partners at Beyond the Bench, Family Law Education Programs, the California Sheriff's Association conference, the Chief Probation Officers of California conference, the County Behavioral Health Directors Association of California conference, the Youth Court Summit, the Community Justice and Homeless Summit, the Reentry Court Summit, the California Judges Association Conference, and the California Association of Collaborative Courts/National Association of Drug Court Professionals conferences.[36]

The Implementation Task Force also worked with CJER to post newly developed judicial mental health resources on the CJER On-Line website.[37] The Implementation Task Force also identified resources that were available outside the court system that address specific issues pertinent to mental health issues in the courts, for adults and juveniles. These resources were cited and catalogued for inclusion in the mental health websites on the judicial branch website. In addition, the Implementation Task Force identified effective practices in the courts, as well as areas where additional materials are needed, and began preparing new materials and cataloguing of effective practices. This area was also identified as an area for follow-up and ongoing maintenance once the project is fully launched.

Collaboration with California Law Schools

The TFCJCMHI's final report recommended that the Judicial Council, California law schools, and the State Bar of California collaborate to promote collaborative justice principles and expand knowledge of issues that arise at the interface of the criminal justice and mental health systems. Implementation Task Force members were invited to present in law schools and individual members included mental health issues and collaborative justice principles as part of their curriculum. Members of the Implementation Task Force also partnered with other advisory committees to reach out to law schools that established externships for law students in collaborative justice and mental health courts.

Research

The TFCJCMHI's final report calls for research to be conducted to evaluate practices aimed at improving outcomes for people with a mental illness who are involved in the justice system and to distribute that research to courts and their partners to better inform their own work. The Implementation Task Force directed or supported several research projects to support these recommendations. The California Courts website (*www.courts.ca.gov*) has been expanded to include links to several resources for juvenile mental health, including the California Department of Health Care Services and the Council on Mentally Ill Offenders, as well as to provide regular updates on juvenile mental health issues and on juvenile mental health courts.[38] Judicial Council staff is providing support for data collection among delinquency and juvenile mental health courts throughout the state and has published a report on juvenile delinquency court

[36] Recommendations 116–121; 124.
[37] Recommendation 115.
[38] Recommendation 132.

performance measurement as an evidence-based practice (*www.courts.ca.gov/documents/JD_Performance_asEBP.pdf*). Additionally Judicial Council staff has worked closely with collaborative justice court coordinators around the state to identify data definitions and standards and is working with the National Center for State Courts to survey all collaborative justice courts in the state and to identify preliminary outcome measures.

The Implementation Task Force has also supported research projects carried out by the Judicial Council. The Judicial Council published a literature review of mental health court–related research in 2012 that is available on the California Courts website at *www.courts.ca.gov/documents/AOCLitReview-Mental_Health_Courts--Web_Version.pdf*. In addition, Judicial Council staff is conducting a process evaluation project on California's mental health courts. This study examines the process and procedures of mental health courts, and identifies preliminary outcomes and promising practices. The project discusses the foundation for understanding California's mental health courts, describing the case study's courts in depth, as well as variations among courts' policies and practices. This report is expected to be published in summer 2015. The final phase is an in-depth study of six specific mental health courts and will include qualitative data from interviews and focus groups and available outcomes from the six study courts. To further this research objective, the Implementation Task Forces recommends that Judicial Council staff seek external grant funding or other potential resources to expand the project and track individual-level data and court-specific outcomes.[39]

A similar study is being done on the effectiveness of reentry courts in California, which includes a focus on reentry of prisoners with mental illness and will include participant data, service data, and outcome data. Although the study's focus is on reentry, it is anticipated that the data collected on prisoners with mental illness will yield useful information on program efficacy and provide data that may be applicable to the broader population of offenders with mental illness.[40] However, the Implementation Task Force recommends that additional studies be conducted to address questions of the effectiveness of treatment programs and barriers to placement.

Judicial Council staff, with direction from the Implementation Task Force, continues to provide technical assistance to collaborative justice courts, including mental health courts, on request to help with their efforts to conduct research on the local level. Staff also works with drug courts, mental health courts, and other collaborative justice courts to identify data elements and evaluation standards. In addition, staff is working with the National Center for State Courts on a nationwide survey of collaborative justice courts, assisting with the California portion. The results of this survey are forthcoming. Implementation Task Force staff also is working with task force members to develop a Resource Guide of Innovative Responses to the Persons with Mental Illness in the Criminal Courts. This guide will highlight programs from across the state, underscoring how each program works, who runs the program, who the program serves, the evidence behind the program, how successful the program has been, how it is funded, how it can be replicated, and who the program's contact person is. This resource should be completed by late 2015.

[39] Recommendation 133.
[40] Recommendation 135.

Finally, research briefings have been developed and disseminated in the areas of human trafficking, mental health courts, drug courts, reentry courts, and evidence-based practices in juvenile courts. The Implementation Task Force identified the need for expanded research and research briefings, specifically addressing outcomes in mental health and other collaborative courts addressing mental health issues, as well as summaries that identify effective practices in local courts as part of needed ongoing follow-up work.

Conclusion

When members of the Implementation Task Force first met in February 2012, there was overwhelming agreement that, even in an era of severe budgetary challenges, the recommendations of the TFCJCMHI remained viable and achievable and implementation of the recommendations would present a unique opportunity to impact the future of people with mental illness in the justice system. It was agreed that, in spite of organizational and fiscal challenges, resolution of long-standing problems is possible through collaborative and innovative efforts that strengthen and expand relationships between the courts and their mental health and justice partners as we begin to work together to improve outcomes for individuals with mental illness in the justice system. Members were also in agreement that the final report of the TFCJCMHI outlined a realistic blueprint for moving forward within the branch and with partners, even in the post realignment environment.

During their first meeting, members of the Implementation Task Force identified as their key priorities the items in the following list. These priorities, in turn, focused the work of the Implementation Task Force over the course of the following 28 months:

1. Monitor, review, and provide input to legislative proposals related to mental health issues and the courts' ability to help improve outcomes for offenders and other court users with mental illness (2012–2014);

2. Develop legislative proposals for recommendations that fall under Judicial Council purview and secure Judicial Council sponsorship of key proposals addressing criminal defendants with mental illness and gravely disabled persons (2012–2013);

3. Develop or amend California's rules of court to emphasize the importance of developing protocols for involving treatment and/or behavioral health representatives in already mandatory criminal justice meetings (2012–2013);

4. Design and craft educational proposals and curriculum outlines for incorporation into existing educational programs (2012–2014);

5. Develop or customize resource toolkits for courts wanting to begin mental health court programs or other specialized programs for improving outcomes for offenders with mental illness; include information related to realignment as needed to enhance the content of such toolkits (2013–2014);

6. Identify ways to ensure that local realignment funding and treatment resources are utilized for persons with mental illness, including offenders and other court users, such as those in juvenile court (2012–2014); and

7. Develop and begin implementation of an outreach plan designed to enhance collaborative efforts with state and local criminal justice and behavioral/mental health partners (2013–2014).

Much has been accomplished: Rules of court have been amended to address expanding partnerships at the local level; legislation has been introduced that should help improve the adjudication of cases involving persons with mental illness; educational materials have been developed, including an online toolkit and 'just in time' educational opportunities for judicial officers; and Implementation Task Force members have worked closely with educational partners at the Judicial Council's Center for Judiciary Education and Research/CJER; with the Center for Children, Families & the Courts/CFCC; with the California Judges Association, and with the California Institute for Behavioral Health Solutions to include specialized mental health content in their own educational curricula and programs. Implementation Task Force members have also individually and collectively met and worked with state and local leaders to stress the importance of effectively serving those individuals in the justice system suffering from mental illness. During these meetings, Implementation Task Force members have provided the judicial leadership needed to address effectively the needs of those who are so often marginalized. Implementation Task Force members continue to work at the national, state, and local levels with judges, justice partners, and mental and behavioral health partners to promote access to services, including treatment, housing, and employment services, as well as access to improved outcomes that benefit each individual, their families, and local communities. Much has been accomplished. However, much still remains to be done to meet the needs of the court users with mental illness. The ongoing fiscal cuts to the judicial branch run the risk of negatively impacting this vulnerable population. This in turn ultimately affects case processing in all case types but with a potentially disproportionate effect on those with mental illness in our criminal courts.

The initial work of the TFCJCMHI focused on criminal justice populations. The Implementation Task Force continued to focus its effort in that area, but has also noted that the entire court system is impacted by individuals with mental illness. Family, dependency, and probate courts have self-represented litigants, some with severe mental health and related issues, who can become easily confused during court proceedings and may require additional assistance. The Implementation Task Force took special note of the needs of children impacted by custody and child support disputes, family and community violence, incarceration of family members, or bullying as areas that should be more fully addressed in future work related to mental health issues and the courts. And there are issues related to veterans or individuals on active duty who may have ended up in our courts with complicated mental health-related conditions that sometime play a role in family violence or pending criminal or family law cases.

In 2014, one of the barriers restricting access to medical and mental health treatment for many of the individuals served by the court appears to have been removed with the implementation of the Affordable Care Act (ACA) and the expansion of Medicaid eligibility. This development appears to be allowing courts, justice system partners, and community treatment providers to explore options that could not even be considered in the past. While the Implementation Task Force has provided educational briefings and materials about the ACA and Medicaid to presiding judges, members recognize that much more information and training is needed if the courts are to engage in the partnerships that will enable mentally ill persons in the courts to take advantage of the new options for treatment that these policy changes offer.

Similarly, realignment brought new populations back into local communities resulting in new responsibilities for the courts. The reentry court evaluation identified a greater incidence of mental health issues among parolees than in the general offender population, thus requiring increased focus on mental

health issues in the court system. In addition, realignment resulted in changes in the delivery of local juvenile services, social services, treatment, and substance abuse services; these comprehensive changes are still being implemented at the local level. To further complicated matters, the passage of Proposition 47 in November 2014 may mean that the court has less influence over the longer term treatment and rehabilitation of some individuals, including those with mental illness and co-occurring disorders, than had been originally contemplated when realignment went into effect. As a result of all these changes—some small—some large, issues related to persons with mental illness in the courts will need to be handled in entirely new ways. The Implementation Task Force has noted that continued work and judicial leadership is required to effectively link the courts with justice system and treatment partners in order to realign the justice and service systems at the local level and respond to monumental statewide policy changes.

Throughout its work, the Implementation Task Force has focused on the unique needs of persons with mental illness who are at risk of entering or who have already entered the justice system. However, members recommend that the experiences and needs of persons with mental illness who are elderly, women, veterans, transition-age youth, lesbian, gay, bisexual, or transgender (LGBT), person and those whose first language is not English, who are from diverse cultures, and who are from minority and underserved populations must also be considered and incorporated into the development of programs and services.[41] The Implementation Task Force noted that gender-specific and trauma-informed services are essential for all served in the courts but especially for incarcerated women with mental illness who often have extensive histories of trauma. Similarly, girls in the juvenile justice system have experienced higher rates of physical neglect and higher rates of physical, sexual, and emotional abuse than boys and they can benefit from specific trauma-informed services.[42] For elderly incarcerated individuals with mental illness, the coordination of medical and mental health services is essential to manage medication needs effectively and to prevent unnecessary and harmful polypharmacy.[43] The nexus of dementia and mental illness among the elderly and elder abuse has been noted in trainings and materials developed with guidance from the Implementation Task Force. However, specific focus on this area, much like juvenile competency, was identified as an area for on-going work and attention. In addition, while promising practices such as elder courts have emerged, more work to evaluate outcomes and to address sustainability issues for these court programs is needed. In addition, Many issues related to individuals with developmental disabilities and limited capacity to understand court proceedings remain unexplored and have been identified by the Implementation Task Force as needing attention and needing to be included in future work plans.

Likewise, veterans have unique experiences and needs often related to posttraumatic stress disorder (PTSD) and traumatic brain injuries (TBI), making it essential to connect veterans with veteran-specific resources and programs. Programs such as veterans' courts, veterans' stand-down courts, and homeless courts have emerged as promising practices that meet these unique needs. However, as in the case of elder courts, issues of sustainability and documenting and evaluating outcomes still need to be addressed, as does

[41] This list is not intended to be exhaustive.

[42] Kristen M. McCabe, Amy E. Lansing, Ann Garland, and Richard Hough, "Gender Differences in Psychopathology, Functional Impairment, and Familial Risk Factors among Adjudicated Delinquents," *Journal of the American Academy of Child and Adolescent Psychiatry 41*(7) (2002), pp. 860–867.

[43] Judith F. Cox and James E. Lawrence, "Planning Services for Elderly Inmates With Mental Illness," *Corrections Today* (June 1, 2010).

alternate sentencing and other relief, such as expungement of records offered to veterans through Penal Code section 1170.9.

The implementation of the recommendations made in the final report of the Task Force on Criminal Justice Collaboration is well underway. Judicial leadership and a concentrated, focused effort has made a real difference in how not only our courts, but how our criminal justice and mental health partners have begun addressing issues related to offenders and other courts users with mental illness.

However, in spite of all that has been accomplished, much remains to be done if we are to achieve our goal of making a real, sustained, lasting, and cost-effective difference in the lives of persons with mental illness who are served by our courts and who sometimes are also our own brothers and sisters, mothers and fathers, children, neighbors, or childhood friends. Only by judges working collaboratively with our mental health, social service, and criminal justice partners can our courts begin or continue to see improved outcomes for offenders and other court users impacted by serious mental illness or having limited capacity for understanding court proceedings. Without that leadership, without that collaborative effort, and without that focus, we will continue to cycle and recycle individuals through our jails, through our prisons, and through our courts creating a burden for ourselves and for our communities. With a commitment to addressing the problem, judicial branch leaders have been and remain uniquely positioned to make a real difference today and well into the future as we continue our work together promoting access to justice and fairness for all.

Appendices

Appendix A: Mental Health Issues Implementation Task Force (MHIITF) Responses to the Recommendations of the Task Force for Criminal Justice Collaboration on Mental Health Issues (TFCJCMHI)

Mental Health Issues Implementation Task Force Responses to the Recommendations of Task Force for Criminal Justice Collaboration on Mental Health Issues		
Recommendation #	**Original Recommendation**	**Mental Health Issues Implementation Task Force Responses**
Section 1: Prevention, Early Intervention, and Diversion Programs ***Coordination of Community Services*** ***To prevent entry or reduce the number of people with mental illness entering the criminal justice system, both public and private services that support this population should be expanded and coordinated. Having a range of available and effective mental health treatment options can help prevent people with mental illness from entering the criminal justice system.***		
1	Community partners should collaborate to ensure that community-based mental health services are available and accessible. Community services should include, but are not limited to, income maintenance programs, supportive housing or other housing assistance, transportation, health care, mental health and substance abuse treatment, vocational rehabilitation, and veterans' services. Strategies should be developed for coordinating such services, such as co-location of agencies and the provision of interagency case management services. Services should be client centered, recovery based, and culturally appropriate.	Identified by the Mental Health Issues Implementation Task Force (Implementation Task Force) as not being under the purview of the judicial branch and more appropriately addressed by local mental/behavioral health and social service partners.
2	State and county departments of mental health and drug and alcohol should design and adopt integrated approaches to delivering services to people with co-occurring disorders that cross traditional boundaries between the two service delivery systems and their funding structures. Resources and training should be provided to support the adoption of evidence-based integrated co-occurring disorder treatment, and information from existing co-occurring disorder work groups (e.g., Co-Occurring Joint Action Council and Mental Health Services Oversight and Accountability Commission) should inform the development of integrated service delivery systems.	Identified by the Implementation Task Force as not being under the purview of the judicial branch more appropriately addressed by state and local mental/behavioral health and substance abuse treatment partners.

Mental Health Issues Implementation Task Force Responses to the Recommendations of Task Force for Criminal Justice Collaboration on Mental Health Issues		
Recommendation #	**Original Recommendation**	**Mental Health Issues Implementation Task Force Responses**
3	Mental health programs, including both voluntary and involuntary services, should be funded at consistent and sustainable levels. Funding should be allocated to programs serving people with mental illness that utilize evidence based practices (e.g., programs established under AB 2034 that serve homeless individuals with mental illness).	Identified by the Implementation Task Force as not being under the purview of the judicial branch and more appropriately addressed by local mental/behavioral health and social service partners.
4	Community mental health agencies should utilize resources such as the California Network of Mental Health Clients; National Alliance on Mental Illness, California (NAMI CA); the United Advocates for Children and Families; local community-based programs that interact with populations most in need; and peer networks to perform outreach and education about local mental health services, drug and alcohol programs, and other programs that serve individuals with mental illness in order to improve service access.	Identified by the Implementation Task Force as not being under the purview of the judicial branch and more appropriately addressed by state and local mental/behavioral health and substance abuse treatment partners.
5	Local task force or work groups composed of representatives from criminal justice and mental health systems should be created to evaluate the local needs of people with mental illness or co-occurring disorders at risk of entering the criminal justice system, to identify and evaluate available resources, and to develop coordinated responses.	Identified by the Implementation Task Force as not being under the purview of the judicial branch more appropriately addressed by local criminal justice, mental/behavioral health and substance abuse treatment partners. The Implementation Task Force noted that local courts could participate or act as conveners of such workgroups.
6	Local mental health agencies should coordinate and provide education and training to first responders about mental illness and available community services as options for diversion (e.g., detoxification and inpatient facilities, crisis centers, homeless shelters, etc.).	Identified by the Implementation Task Force as not being under the purview of the judicial branch more appropriately addressed by local law enforcement and other emergency services, social service, mental/behavioral health, and substance abuse treatment partners.
7	Law enforcement and local mental health organizations should continue to expand the development and utilization of Crisis Intervention Teams (CIT), Mobile Crisis Teams (MCT), and Psychiatric Emergency Response Teams (PERT) to effectively manage incidents that require responses by law enforcement officers. Such teams provide mental health expertise through specially trained police officers or through mental health professionals who accompany officers to the scene. Smaller counties unable to assemble response teams should consider alternative options such as a mental health training module for all cadets and officers.	Identified by the Implementation Task Force as not being under the purview of the judicial branch more appropriately addressed by state and local law enforcement and mental/behavioral health treatment partners.

Mental Health Issues Implementation Task Force Responses to the Recommendations of Task Force for Criminal Justice Collaboration on Mental Health Issues		
Recommendation #	**Original Recommendation**	**Mental Health Issues Implementation Task Force Responses**
8	Community-based crisis centers that operate 24 hours daily, 7 days a week should be designated or created to ensure that law enforcement officers have increased options for people with suspected mental illness in need of timely evaluation and psychiatric stabilization. Local mental health providers, hospitals, and law enforcement agencies should collaborate to designate or create such crisis centers so that individuals are appropriately assessed in the least restrictive setting.	Identified by the Implementation Task Force as not being under the purview of the judicial branch and more appropriately addressed by local law enforcement and other emergency services, social service, mental/behavioral health, and substance abuse treatment partners.
9	People with mental illness, working with their mental health care providers, should be encouraged to create Psychiatric Advance Directives (PADs) to distribute to family members or members of their support system so that vital treatment information can be provided to law enforcement officers and other first responders in times of crisis. The development of PADs should be encouraged for persons discharged from correctional or inpatient facilities. PADs should be included in clients' personal health records and abbreviated PADs could be made available in the form of a wallet card.	Identified by the Implementation Task Force as not being under the purview of the judicial branch and more appropriately addressed by state and local law enforcement and mental health treatment partners along with the National Alliance on Mental Illness California (NAMI CA) and mental/behavioral health consumer groups.
10	Discharge planning protocols should be created for people released from state and local psychiatric hospitals and other residential facilities through collaborations among the hospitals, community-based agencies, and pharmacies to ensure that no one is released to the streets without linkage to community services and stable housing. Discharge planning should begin upon facility entry to support a successful transition to the community that may prevent or minimize future interactions with the criminal justice system. Clients, as well as family members when appropriate, should be involved in the development of discharge plans.	Identified by the Implementation Task Force as not being under the purview of the judicial branch and more appropriately addressed by state and local mental hospitals or other mental health residential facilities, social services, and mental/behavioral health treatment partners.
11	California Rule of Court 10.952 (Meetings concerning the criminal court system) should be amended to include participants from parole, the police department, the sheriff's department, and Conditional Release Programs (CONREP), the County Mental Health Director or his or her designee, and the County Director of Alcohol and Drug Programs or his or her designee.	Identified by the Implementation Task Force as being under the purview of the judicial branch. To address this issue, the Implementation Task Force proposed revisions to Rule of Court 10.952. The Judicial Council approved the proposed revisions to the rule that became effective January 1, 2014. The revision expanded the list of those involved in regular meetings with criminal justice partners were representatives of the Forensic Conditional Release Program (CONREP), the county mental health director or designee, and the county alcohol and drug director or designee.

Mental Health Issues Implementation Task Force Responses to the Recommendations of Task Force for Criminal Justice Collaboration on Mental Health Issues		
Recommendation #	**Original Recommendation**	**Mental Health Issues Implementation Task Force Responses**
12	Courts and court partners identified under the proposed amendment of California Rule of Court 10.952 should develop local responses for offenders with mental illness or co-occurring disorders to ensure early identification and appropriate treatment. The goals are to provide better outcomes for this population, reduce recidivism, and respond to public safety concerns.	Identified by the Implementation Task Force as being under the purview of the judicial branch. To address this issue, the Implementation Task Force proposed revisions to Rule of Court 10.951. The Judicial Council approved the proposed revisions to the rule that became effective January 1, 2014. The revision added a subsection to the rule of court related to the development of local protocols for cases involving offenders with mental illness or co-occurring disorders to ensure early identification and appropriate treatment of offenders with mental illness or co-occurring disorders with the goal of reducing recidivism, responding to public safety concerns, and providing better outcomes while using resources responsibly and reducing costs.
13	Courts and court partners identified under the proposed amendment of California Rule of Court 10.952 should identify information-sharing barriers that complicate collaborations, service delivery, and continuity of care for people with mental illness involved in the criminal justice system. Protocols, based on best or promising practices, and in compliance with Health Insurance Portability and Accountability Act (HIPAA), and other federal and state privacy protection statutes, rules, and regulations, should be developed to facilitate effective sharing of mental health–related information across agencies and systems. Agencies should be encouraged to maintain mental health records electronically and to ensure compatibility between systems.	Identified by the Implementation Task Force as being under the purview of the judicial branch. It is anticipated that the amendment of California Rule of Court 10.952 to include additional stakeholders to already mandated meetings will help break down barriers to communicating critical information. In addition, this recommendation was identified by the Implementation Task Force as being a best practice for courts and their state and local mental/behavioral health partners.
14	**LIST OF SERVICE PROVIDERS** The presiding judge, or the judge designated under California Rule of Court 10.952, should obtain from county mental health departments a regularly updated list of local agencies that utilize accepted and effective practices to serve defendants with mental illness or co-occurring disorders and should distribute this list to all judicial officers and appropriate court personnel.	Identified by the Implementation Task Force as being under the purview of the judicial branch. It is anticipated that the amendment of California Rule of Court 10.952 to include additional stakeholders to already mandated meetings will help identify the need for information about mental health resources. In addition, this recommendation was identified by the Mental Health Issues Implementation Task Force as being a best practice for courts and their state and local mental/behavioral health partners.

Mental Health Issues Implementation Task Force Responses to the Recommendations of Task Force for Criminal Justice Collaboration on Mental Health Issues		
Recommendation #	**Original Recommendation**	**Mental Health Issues Implementation Task Force Responses**
15	Courts should become involved with local Mental Health Services Act stakeholder teams in order to promote greater collaboration between the courts and local mental health agencies and to support services for people with mental illness involved in the criminal justice system.	Identified by the Implementation Task Force as a best practice for courts and their county mental/behavioral health partners. Local Mental Health Services Act stakeholder meetings are generally convened by county mental/behavioral health partners and courts and other criminal justice partners should be among those invited to attend these meetings. Judicial leaders should work with executive officers or designees to encourage adoption and identification of best practices for the mentally ill offenders.
16	Each California trial court should have a specialized method based upon collaborative justice principles for adjudicating cases of defendants with mental illness, such as a mental health court, a co-occurring disorders court, or a specialized calendar or procedures that promote treatment for the defendant and address public safety concerns. Judicial leadership is essential to the success of these efforts.	Identified by the Implementation Task Force as a best practice. By adopting problem-solving approaches and employing collaborative justice principles, courts can better connect defendants with mental illness to treatment, reduce recidivism and promote public safety. Under the current California Rule of Court 10.951 (effective January 1, 2014) courts are encouraged to develop local protocols for cases involving offenders with mental illness or co-occurring disorders to ensure early identification and appropriate treatment of offenders with mental illness or co-occurring disorders with the goal of reducing recidivism, responding to public safety concerns, and providing better outcomes while using resources responsibly and reducing costs.
17	Information concerning a defendant's mental illness should guide case processing (including assignment to a mental health court or specialized calendar program) and disposition of criminal charges consistent with public safety and the defendant's constitutional rights.	Identified by the Implementation Task Force as a best practice. In addition to information about mental health issues being identified as a topic for judicial education programs, this recommendation is supported by the amendment of California Rule of Court 10.951 by encouraging the development of local protocols for offenders with mental illness, and encouraging trial courts to have a specialized approach, guided by the defendant's mental health needs, to adjudicating cases involving defendants with mental illness Implementation Task Force members have also developed additional teaching tools, bench notes and sample orders along with other resources for use in judicial education programs. Materials will be available late summer 2014.

Mental Health Issues Implementation Task Force Responses to the Recommendations of Task Force for Criminal Justice Collaboration on Mental Health Issues		
Recommendation #	**Original Recommendation**	**Mental Health Issues Implementation Task Force Responses**
18	Local courts, probation, and mental health professionals should collaborate to develop supervised release programs to reduce incarceration for defendants with mental illness or co-occurring disorders, consistent with public safety.	Identified by the Implementation Task Force as not being solely under the purview of the judicial branch, but also as an appropriate area for judicial education and to be addressed in partnership with state and local probation, parole, and mental/behavioral health treatment partners. This recommendation is consistent with California Rule of Court 10.951 and California Rule of Court 10.952 (effective January 1, 2014). The judicial officer should exercise their leadership role and require or encourage this in the context of Rule of Court 10.951 and 10.952. This judicial leadership will be a topic for inclusion in judicial education materials and programs.
19	Prosecutors should utilize, as appropriate, disposition alternatives for defendants with mental illness or co-occurring disorders.	Identified by the Issues Implementation Task Force as not being under the purview of the judicial branch and more appropriately addressed by criminal justice partners.
20	In accordance with the Victim's Bill of Rights Act of 2008 (Marsy's Law), judicial officers should consider direct input from victims in cases involving defendants with mental illness or co-occurring disorders to inform disposition or sentencing decisions, recognizing that many victims in such cases are family members, friends, or associates.	Identified by the Implementation Task Force as being under the purview of the judicial branch and identified as a best practice as well as a topic appropriate for inclusion in judicial education materials and programs.
21	The court system and the California Department of Mental Health cooperatively should develop and implement video-based linkages between the courts and the state hospitals to avoid delays in case processing for defendants being treated in state hospitals and to prevent the adverse consequences of repeated transfers between hospitals and jails. The use of video-based procedures is to be voluntary, and clients should retain the right to request live hearings. Policies and procedures should be in place to ensure that clients have adequate access to private conversations with defense counsel.	Identified by the Implementation Task Force as not being solely under the purview of the judicial branch and more appropriately addressed in partnership with the California Department State Hospitals (formerly the Department of Mental Health) and criminal justice partners including the California District Attorneys Association, the California Public Defenders Association, and the California Sheriffs Association.

Mental Health Issues Implementation Task Force Responses to the Recommendations of Task Force for Criminal Justice Collaboration on Mental Health Issues		
Recommendation #	**Original Recommendation**	**Mental Health Issues Implementation Task Force Responses**
22	Judicial officers should require the development of a discharge plan for defendants with mental illness as a part of disposition and sentencing. Discharge plans should be developed by custody mental health staff, pretrial services, or probation, depending on the status and location of the defendant, in collaboration with county departments of mental health and drug and alcohol or other designated service providers. Discharge plans must include arrangements for housing and ongoing treatment and support in the community for offenders with mental illness.	Identified by the Implementation Task Force as requiring implementation in cooperation with partners such as the Chief Probation Officers Association of California, California Department of Corrections and Rehabilitation (parole), and California Mental Health Directors Association and other partners. This recommendation is consistent with California Rule of Court 10.951 and California Rule of Court 10.952 (effective January 1, 2014). The judicial officer should exercise their leadership role and require or encourage this in the context of Rule of Court 10.951 and 10.952. This judicial leadership will be a topic for inclusion in judicial education materials and programs.
23	Court administrators should develop local policies and procedures to ensure that medical and mental health information deemed confidential by law is maintained in the nonpublic portion of the court file. Mental health information not otherwise a part of the public record, but shared among collaborative court partners, should be treated with sensitivity in recognition of an individual's rights to confidentiality	Identified by the Implementation Task Force as being under the purview of the judicial branch and identified as a best practice as well as a topic appropriate for inclusion in court administration education materials and programs.
24	Conservatorship proceedings and criminal proceedings should be coordinated where a defendant is conserved and has a pending criminal case or a defendant has a pending criminal case and is then conserved. Such coordination could include designating a single judicial officer to preside over both the civil and criminal proceedings. When all parties agree, or a protocol for how such proceedings can be coordinated, when heard by different judicial officers. If a judicial officer presides over both civil and criminal proceedings, he or she should have training in each area.	Identified by the Implementation Task Force as being under the purview of the judicial branch and identified as a best practice as well as a topic appropriate for inclusion in judicial education materials and programs. Initial work in this area was begun through Judicial Council sponsored legislation drafted by the Implementation Task Force by requesting that the Judicial Council sponsor legislation it drafted to increase the options available to courts when handling criminal cases involving potentially mentally ill offenders, and improve coordination between the conservatorship court and the criminal court when they have concurrent jurisdiction over a mentally ill individual. This legislative proposal has been incorporated into AB 2190 (Maienschein) – Criminal defendants: gravely disabled persons: http://www.leginfo.ca.gov/pub/13-14/bill/asm/ab_2151-2200/ab_2190_bill_20140220_introduced.pdf

Mental Health Issues Implementation Task Force Responses to the Recommendations of Task Force for Criminal Justice Collaboration on Mental Health Issues		
Recommendation #	**Original Recommendation**	**Mental Health Issues Implementation Task Force Responses**
25	Legislation should be enacted that allows judicial officers to join the county conservatorship investigator (Welf. & Inst. Code, § 5351), the public guardian (Gov. Code, § 27430), private conservators and any agency or person serving as public conservator to criminal proceedings, when the defendant is conserved or is being considered for conservatorship.	Identified by the Implementation Task Force as being most appropriately addressed in conjunction with the state legislature. Initial work in this area was begun through Judicial Council sponsored legislation drafted by the Implementation Task Force by requesting that the Judicial Council sponsor legislation it drafted to increase the options available to courts when handling criminal cases involving potentially mentally ill offenders, and improve coordination between the conservatorship court and the criminal court when they have concurrent jurisdiction over a mentally ill individual. The legislative proposal has been incorporated into AB 2190 (Maienschein) – Criminal defendants: gravely disabled persons: http://www.leginfo.ca.gov/pub/13-14/bill/asm/ab_2151-2200/ab_2190_bill_20140220_introduced.pdf
26	Existing legislation should be modified and new legislation should be created where necessary to give judicial officers hearing criminal proceedings involving defendants with mental illness the authority to order a conservatorship evaluation and the filing of a petition when there is reasonable cause to believe that a defendant is gravely disabled within the meaning of Welfare and Institutions Code section 5008(h). The conservatorship proceedings may be held before the referring court if all parties agree. Judicial officers should have training in the area of LPS law if ordering the initiation of conservatorship proceedings.	Identified by the Implementation Task Force as being under the purview of the judicial branch. Therefore, the Mental Health Issues Implementation Task Force drafted a legislative proposal that was approved as part of the Judicial Council's 2014-2015 legislative agenda. The legislative proposal has been incorporated into AB 2190 (Maienschein) – Criminal defendants: gravely disabled persons: http://www.leginfo.ca.gov/pub/13-14/bill/asm/ab_2151-2200/ab_2190_bill_20140220_introduced.pdf
27	When the criminal court has ordered the initiation of conservatorship proceedings, the conservatorship investigation report should provide recommendations that include appropriate alternatives to conservatorship if a conservatorship is not granted.	Identified by the Implementation Task Force as being under the purview of the judicial branch and identified as a best practice as well as a topic appropriate for inclusion in judicial education materials and programs. In addition, this recommendation was identified as being appropriate address with county partners.
28	There should be a dedicated court or calendar where a specially trained judicial officer handles all competency matters. Competency proceedings should be initiated and conducted in accordance with California Rule of Court 4.130 and relevant statutory and case law.	Identified by the Implementation Task Force as being under the purview of the judicial branch and identified as a best practice as well as a topic appropriate for inclusion in judicial education materials and programs.

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Recommendation #	**Original Recommendation**	**Mental Health Issues Implementation Task Force Responses**
29	Each court should develop its own panel of experts who demonstrate training and expertise in competency evaluations.	Identified by the Implementation Task Force as being under the purview of the judicial branch and identified as a best practice as well as a topic appropriate for inclusion in judicial education materials and programs.
30	Mental health professionals should be compensated for competency evaluations in an amount that will encourage in-depth reports.	Identified by the Implementation Task Force as being under the purview of the judicial branch and identified as a best practice. However, the Implementation Task Force recognizes that because of the current uncertain fiscal situation for the courts, implementation of this recommendation will likely need to be deferred. This recommendation was also identified as being appropriate to address with legislative and county partners.
31	California Rule of Court 4.130(d) (2) should be amended to delineate the information included in the court-appointed expert report in addition to information required by Penal Code section 1369. The report should include the following: a. A brief statement of the examiner's training and previous experience as it relates to examining the competence of a criminal defendant to stand trial and preparing a resulting report; b. A summary of the examination conducted by the examiner on the defendant, including a current diagnosis, if any, of the defendant's mental disorder and a summary of the defendant's mental status; c. A detailed analysis of the competence of the defendant to stand trial using California's current legal standard, including the defendant's ability or inability to understand the nature of the criminal proceedings or assist counsel in the conduct of a defense in a rational manner as a result of a mental disorder; d. A summary of an assessment conducted for malingering, or feigning symptoms, which may include, but need not be limited to, psychological testing; e. Pursuant to Penal Code section 1369, a statement on whether treatment with antipsychotic medication is medically appropriate for the defendant, whether the treatment is likely to restore the defendant to mental competence, a list of likely or potential side effects of the medication, the expected efficacy of the medication, possible alternative treatments, whether it is medically appropriate to administer antipsychotic	Identified by the Implementation Task Force as being under the purview of the judicial branch and identified as a best practice. The Implementation Task Force recommends work continue to amend California Rule of Court 4.130(d) as stated in this recommendation. In addition, this recommendation was identified as being appropriate to address with state and local partners and the Forensic Mental Health Association of California.

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	medication in the county jail, and whether the defendant has capacity to make decisions regarding antipsychotic medication; f. A list of all sources of information considered by the examiner, including, but not limited to, legal, medical, school, military, employment, hospital, and psychiatric records; the evaluations of other experts; the results of psychological testing; and any other collateral sources considered in reaching his or her conclusion; g. A statement on whether the examiner reviewed the police reports, criminal history, statement of the defendant, and statements of any witness to the alleged crime, as well as a summary of any information from those sources relevant to the examiner's opinion of competency; h. A statement on whether the examiner reviewed the booking information, including the information from any booking, mental health screening, and mental health records following the alleged crime, as well as a summary of any information from those sources relevant to the examiner's opinion of competency; and i. A summary of the examiner's consultation with the prosecutor and defendant's attorney, and of their impressions of the defendant's competence-related strengths and weaknesses.	
32	An ongoing statewide working group of judicial officers, the Administrative Office of the Courts, Department of Mental Health, CONREP, and other stakeholders should be established to collaborate and resolve issues of mutual concern regarding defendants found incompetent to stand trial.	Identified by the Implementation Task Force as needing to be implemented in cooperation with partners such as the California Department State Hospitals (formerly the Department of Mental Health) and the Forensic Conditional Release Program (CONREP). Judicial officers should exercise their leadership role and encourage or require this in the context of Rule of Court 10.951 and 10.952. This judicial leadership will be a topic for inclusion in judicial education materials and programs.
33	State hospitals and mental health outpatient programs should be adequately funded to ensure effective and timely restoration of competency for defendants found incompetent to stand trial in order to eliminate the need to designate jails as treatment facilities (Pen. Code §1369.1).	Identified by the Implementation Task Force as not being under the purview of the judicial branch and more appropriately addressed by the legislature and partners including the California Department of State Hospitals, CONREP, and state and local mental/behavioral health partners.

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Recommendation #	**Original Recommendation**	**Mental Health Issues Implementation Task Force Responses**
34	There should be more options for community placement through CONREP and other community-based programs for felony defendants found incompetent to stand trial on nonviolent charges so that not all such defendants need be committed to a state hospital for competency restoration.	Identified by the Implementation Task Force as not being under the purview of the judicial branch and more appropriately addressed by partners including the California Department of State Hospitals, CONREP, and state and local mental/behavioral health partners. It is noted that the recommendation comports with the Judicial Council proposed legislation referenced under recommendation 36.
35	Courts are encouraged to reopen a finding of incompetence to stand trial when new evidence is presented that the person is no longer incompetent. If the defendant is re-evaluated and deemed competent he or she should not be transferred to a state hospital.	Identified by the Implementation Task Force as being under the purview of the judicial branch and identified as a best practice as well as a topic appropriate for inclusion in judicial education materials and programs.
36	Existing legislation should be modified or new legislation be created to give judicial officers hearing competency matters access to a variety of alternative procedural and dispositional tools, such as the jurisdiction to conditionally release a defendant found incompetent to stand trial to the community, where appropriate, rather than in a custodial or hospital setting, to receive mental health treatment with supervision until competency is restored.	Implementation Task Force as being under the purview of the judicial branch. Therefore, the Implementation Task Force drafted a legislative proposal that was approved as part of the Judicial Council's 2014-2015 legislative agenda. The legislative proposal has been incorporated into AB 2190 (Maienschein) – Criminal defendants: gravely disabled persons: http://www.leginfo.ca.gov/pub/13-14/bill/asm/ab_2151-2200/ab_2190_bill_20140220_introduced.pdf
37	Care and treatment of defendants with mental illness should be continued after restoration of competence. Penal Code section 1372(e) should be expanded, consistent with *Sell v. United States,* to ensure that competence is maintained once restored and that medically appropriate care is provided to defendants until such time that a defendant's incompetent-to-stand-trial status is no longer relevant to the proceedings. In an effort to maintain a defendant's competence once restored, courts, state hospitals, and the California State Sheriff's Association should collaborate to develop common formularies to ensure that medications administered in state hospitals are also available in jails.	Identified by the Implementation Task Force as not being solely under the purview of the judicial branch and more appropriately addressed in partnership with the California Department of State Hospitals, the California Sheriffs Association and local criminal justice and mental/behavioral health partners.

Mental Health Issues Implementation Task Force Responses to the Recommendations of Task Force for Criminal Justice Collaboration on Mental Health Issues		
Recommendation #	**Original Recommendation**	**Mental Health Issues Implementation Task Force Responses**
38	Forensic Peer Specialist Programs should be utilized within the courts, particularly in mental health courts to assist defendants with mental illness in navigating the criminal justice system.	Identified by the Implementation Task Force as promising practice not solely under the purview of the judicial branch but more appropriately addressed in partnership with local mental/behavioral health partners. The Substance Abuse & Mental Health Services Administration's (SAMSHA) Gains Center reports that case studies clearly suggest that using Forensic Peer Specialists is a promising cost-effective practice: http://www.mhselfhelp.org/storage/resources/tu-clearinghouse-webinars/ForensicPeerGAINSCenter%201.pdf.
39	Court Self-Help Centers should provide materials to defendants with mental illness, family members, and mental health advocates about general court processes, mental health courts or other court-based programs and services for defendants with mental illness, and community and legal resources.	Identified by the Implementation Task Force as a best practice that should be carried out on the local court level insofar as funding allows. Materials should be developed, potentially in partnership with local mental/behavioral health and justice system partners.
40	At the time of initial booking or admission, all individuals should be screened for mental illness and co-occurring disorders through a culturally competent and validated mental health screening tool to increase the early identification of mental health and co-occurring substance use problems of incarcerated individuals.	Identified by the Implementation Task Force as not being under the purview of the judicial branch and more appropriately addressed by partners including local criminal justice and mental/behavioral health partners. The Implementation Task Force encourages the judiciary to engage with partners, as determined appropriate at the local level, to support efforts to implement recommendations 40-45.
41	The California State Sheriff's Association, California Department of Corrections and Rehabilitation, Corrections Standards Authority, California Department of Mental Health, California Department of Alcohol and Drug Programs, County Alcohol and Drug Program Administrators in California, California Mental Health Directors Association, and the Chief Probation Officers of California should collaborate to develop and validate core questions for a Mental Health and Co-occurring Disorder Initial Screening instrument based on evidence based practices and consistent with the defendant's constitutional rights. All jails and prisons in California should adopt the screening instrument to standardize procedures statewide and to promote consistency and quality of information across counties. The content of such a screening instrument can be expanded upon or automated by local programs.	Identified by the Implementation Task Force as not being under the purview of the judicial branch and more appropriately addressed by partners including state and local criminal justice and mental/behavioral health partners.

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Recommendation #	**Original Recommendation**	**Mental Health Issues Implementation Task Force Responses**
42	The adopted screening instrument should inquire about the individual's mental health and substance use history, history of trauma, other co-occurring conditions (including physical and metabolic conditions), and military service status, as well as his or her current housing status and any history of homelessness. The screening should be conducted in the incarcerated individual's spoken language whenever possible, the instrument must be sensitive to cultural variations, and staff administering the tool must understand inherent cultural biases.	Identified by the Implementation Task Force as not being under the purview of the judicial branch and more appropriately addressed by partners including local criminal justice and mental/behavioral health partners.
43	If the initial screening indicates that an individual in custody has a mental illness or co-occurring disorder, a formal mental health assessment should be administered to determine the level of need for treatment and services while in custody. The assessment should be conducted by a qualified mental health practitioner as close to the date of the initial screening as possible.	Identified by the Implementation Task Force as not being under the purview of the judicial branch and more appropriately addressed by partners including local criminal justice and mental/behavioral health partners.
44	Mental health staff should be available at jail-booking and prison admission facilities at all times.	Identified by the Implementation Task Force as not being under the purview of the judicial branch and more appropriately addressed by partners including local criminal justice and mental/behavioral health partners.
45	Upon booking or admission, individuals with mental illness should be housed in an appropriate setting within the jail or prison based on their medical and mental health needs as identified in the mental health screening and evaluation.	Identified by the Implementation Task Force as not being under the purview of the judicial branch and more appropriately addressed by partners including local criminal justice and mental/behavioral health partners.
46	A discharge plan should be developed for incarcerated individuals with mental illness or co-occurring disorders. The discharge plan will build upon information gathered from the mental health screening and assessment instruments and will document prior mental health treatment and prescribed psychiatric medications to ensure continuity of essential mental health and substance abuse services in order to maximize psychiatric stability while incarcerated as well as after being released. Treatment and services outlined in the discharge plan should be culturally appropriate (e.g., according to ethnicity, race, age, gender) for the individual with mental illness.	Identified by the Implementation Task Force as not being under the purview of the judicial branch and more appropriately addressed by partners including local criminal justice and mental/behavioral health partners. While not under the purview of the judicial branch, the Implementation Task Force identified that is it a best practice for judicial officers to have access to the discharge plan. Judicial officers should exercise their leadership role and require or encourage this in the context of Rule of Court 10.951 and 10.952. This judicial leadership will be a topic for inclusion in judicial education materials and programs.

Mental Health Issues Implementation Task Force Responses to the Recommendations of Task Force for Criminal Justice Collaboration on Mental Health Issues		
Recommendation #	**Original Recommendation**	**Mental Health Issues Implementation Task Force Responses**
47	Discharge plans should follow the individual across multiple jurisdictions, including local and state correctional systems and mental health and justice agencies to ensure continuity of care. Information sharing across agencies and jurisdictions must follow criminal justice, HIPAA, and other federal and state privacy protection statutes, rules, and regulations.	Identified by the Implementation Task Force as not being under the purview of the judicial branch and more appropriately addressed by partners including local criminal justice and mental/behavioral health partners. The Implementation Task Force encourages the judiciary to engage with partners, as determined appropriate at the local level, to support efforts to implement recommendations 48-54.
48	Jails and prisons should have sufficient resources and staff to ensure access to mental health treatment services. Assessment and treatment services must begin immediately upon entry into jail or prison and should include, but not be limited to, the following: an assessment and discharge plan developed by custody mental health and psychiatric staff, appropriate psychotherapeutic medications, psychiatric follow up, custody mental health staff to monitor treatment progress, and behavioral and counseling interventions, including peer-based services.	Identified by the Implementation Task Force as not being under the purview of the judicial branch and more appropriately addressed by partners including local criminal justice and mental/behavioral health partners.
49	Jails and prisons should implement therapeutic communities or other evidence based programming for incarcerated individuals with mental illness or co-occurring disorders where clinically appropriate.	Identified by the Implementation Task Force as not being under the purview of the judicial branch and more appropriately addressed by partners including local criminal justice and mental/behavioral health partners.
50	Custody nursing and mental health staff should be available 24 hours a day in order to sufficiently respond to the needs of incarcerated individuals with mental illness or co-occurring disorders.	Identified by the Implementation Task Force as not being under the purview of the judicial branch and more appropriately addressed by partners including local criminal justice and mental/behavioral health partners.
51	Custody mental health staff should continue the treating community physician's regimen in order to prevent relapse and exacerbation of psychiatric symptoms for incarcerated individuals assessed as having a mental illness, unless a change in treatment regimen is necessary to improve or maintain mental health stability.	Identified by the Implementation Task Force as not being under the purview of the judicial branch and more appropriately addressed by partners including local criminal justice and mental/behavioral health partners.

Mental Health Issues Implementation Task Force Responses to the Recommendations of Task Force for Criminal Justice Collaboration on Mental Health Issues		
Recommendation #	**Original Recommendation**	**Mental Health Issues Implementation Task Force Responses**
52	The California Department of Mental Health, California Department of Corrections and Rehabilitation, California State Sheriff's Association, and California Department of Health Care Services — Medi-Cal should coordinate, to the greatest extent possible, drug formularies among jail, prison, parole, state hospitals, and community mental health agencies and establish a common purchasing pool to ensure continuity of appropriate care for incarcerated individuals with mental illness. The coordination of formularies should not further restrict the availability of medications.	Identified by the Implementation Task Force as not being under the purview of the judicial branch and more appropriately addressed by partners including state and local criminal justice and mental/behavioral health partners.
53	In the absence of a common drug formulary, jails, prisons, parole, state hospitals, and community mental health agencies should obtain expedited treatment authorizations for off-formulary medication to ensure psychiatric stabilization and continuity of care when necessary.	Identified by the Implementation Task Force as not being under the purview of the judicial branch and more appropriately addressed by partners including state and local criminal justice and mental/behavioral health partners.
54	The California State Sheriff's Association and California Department of Corrections and Rehabilitation should consider utilizing the NAMI California Inmate Mental Health Information Form for use in all California jails and prisons. Both the original jail form and its more recent adaptation by the prison system provide family members an opportunity to share diagnosis and historical treatment information with correctional clinical staff.	Identified by the Implementation Task Force as not being under the purview of the judicial branch and more appropriately addressed by partners including state and local criminal justice and mental/behavioral health partners.
55	The court should have jurisdiction to join to the proceedings those agencies and providers that already have legal obligations to provide services and support to probationers and parolees with mental illness. Before joining, any agency or provider should have advance notice of and an opportunity to be heard on the issue.	Identified by the Mental Health Issues Implementation Task Force as needing to be addressed in partnership with the state legislature. The Mental Health Issues Implementation Task Force has drafted a legislative proposal for consideration by the Judicial Council and its advisory committees that addresses this recommendation.

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56	In cases where the offense is committed and sentencing occurs in a county other than the probationer's county of residence, before the court grants a motion to transfer jurisdiction to that county (pursuant to Pen. Code, § 1203.9), judicial officers should give very careful consideration to the present mental stability of the probationer and determine whether or not the probationer will have immediate access to appropriate mental health treatment and other social service supports in the county of residence. The court must ensure that adequate discharge planning has taken place, including referral to a mental health court if appropriate, to ensure a direct and immediate connection with treatment and services in the county of residence.	Identified by the Mental Health Issues Implementation Task Force as being under the purview of the judicial branch. This recommendation is consistent with California Rule of Court Rule 4.530 regarding the inter-county transfer of probation and mandatory supervision. Effective November 1, 2012, this rule of court was modified to require courts to consider certain factors including the availability of services such as collaborative courts when making their transfer decisions. *(Rule 4.530 amended effective February 20, 2014; adopted effective July 1, 2010; previously amended effective November 1, 2012.)*
57	Probation and parole supervision should follow the discharge plan approved by the judicial officer as part of the disposition of criminal charges or by California Department of Corrections and Rehabilitation at the time of release. The discharge plan should include probationers' or parolees' treatment and other service needs as well as risks associated with public safety, recidivism, and danger to self. Individuals with low risk or needs may require no supervision and early termination of probation or parole, whereas individuals with high risk or needs may need to receive intensive supervision joined with intensive mental health case management.	Identified by the Implementation Task Force as not being under the purview of the judicial branch and more appropriately addressed by state and local criminal justice partners, including parole and probation, in collaboration with mental/behavioral health partners. Judicial officers should exercise their leadership role and require or encourage this in the context of Rule of Court 10.951 and 10.952. This judicial leadership will be a topic for inclusion in judicial education materials and programs.
58	Probation and parole conditions should be the least restrictive necessary and should be tailored to the probationers' or parolees' needs and capabilities, understanding that successful completion of a period of community supervision can be particularly difficult for offenders with mental illness.	Identified by the Implementation Task Force as not being under the purview of the judicial branch and more appropriately addressed by state and local criminal justice partners, including parole and probation in collaboration with mental/behavioral health partners. Implementation Task Force members met with representatives of the Chief Probation Officers of California to specifically discuss this recommendation. As a result, CPOC created a working group to investigate and address issues related to individuals with mental illness on their caseload. Judicial officers should exercise their leadership role and encourage or require this in the context of Rule of Court 10.951 and 10.952. This judicial leadership will be a topic for inclusion in judicial education materials and programs.

Mental Health Issues Implementation Task Force Responses to the Recommendations of Task Force for Criminal Justice Collaboration on Mental Health Issues		
Recommendation #	**Original Recommendation**	**Mental Health Issues Implementation Task Force Responses**
59	Probationers and parolees with mental illness or co-occurring disorders should be supervised by probation officers and parole agents with specialized mental health training and reduced caseloads.	Identified by the Implementation Task Force as not being under the purview of the judicial branch and more appropriately addressed by parole and probation departments. Implementation Task Force members met with representatives of the Chief Probation Officers of California to specifically discuss this recommendation. As a result, CPOC created a working group to investigate and address issues related to individuals with mental illness on their caseload. Judicial officers should exercise their leadership role and encourage or require this in the context of Rule of Court 10.951 and 10.952. This judicial leadership will be a topic for inclusion in judicial education materials and programs.
60	Specialized mental health probation officers and parole agents should utilize a range of graduated incentives and sanctions to compel and encourage compliance with conditions of release. Incentives and positive reinforcement can be effective in helping offenders with mental illness stay in treatment and follow conditions of probation or parole.	Identified by the Implementation Task Force as not being under the purview of the judicial branch and more appropriately addressed by parole and probation departments. Implementation Task Force members met with representatives of the Chief Probation Officers of California to specifically discuss this recommendation. As a result, CPOC created a working group to investigate and address issues related to individuals with mental illness on their caseload.
61	Specialized mental health probation officers and parole agents should conduct their supervision and other monitoring responsibilities within the communities, homes, and community-based service programs where the offender with mental illness spends most of his or her time. This approach should reorient the supervision process from enforcement to intervention.	Identified by the Implementation Task Force as not being under the purview of the judicial branch and more appropriately addressed by parole and probation departments. Implementation Task Force members met with representatives of the Chief Probation Officers of California to specifically discuss this recommendation. Judicial officers should exercise their leadership role and encourage or require this in the context of Rule of Court 10.951 and 10.952. This judicial leadership will be a topic for inclusion in judicial education materials and programs.

Mental Health Issues Implementation Task Force Responses to the Recommendations of Task Force for Criminal Justice Collaboration on Mental Health Issues		
Recommendation #	**Original Recommendation**	**Mental Health Issues Implementation Task Force Responses**
62	Specialized mental health probation officers and parole agents should work closely with mental health treatment providers and case managers to ensure that probationers and parolees with mental illness receive the services and resources specified in their discharge plans, and that released offenders are connected to a 24-hour crisis service.	Identified by the Implementation Task Force as not being under the purview of the judicial branch and more appropriately addressed by parole and probation departments in collaboration with mental/behavioral health and social service partners. Implementation Task Force members met with representatives of the Chief Probation Officers of California to specifically discuss this recommendation. Judge should exercise their leadership role and encourage or require this in the context of Rule of Court 10.951 and 10.952. This judicial leadership will be a topic for inclusion in judicial education materials and programs.
63	Working agreements and relationships should be developed between community-based service providers and probation and parole to increase understanding and coordination of supervision and treatment goals and to ensure continuity of care once supervision is terminated.	Identified by the Implementation Task Force as not being under the purview of the judicial branch and more appropriately addressed by parole and probation departments in collaboration with mental/behavioral health and social service partners.
64	Probationers and parolees with mental illness or co-occurring disorders should receive mental health and substance abuse treatment that is considered an evidence based or promising practice.	Identified by the Implementation Task Force as not being under the purview of the judicial branch and more appropriately addressed by parole and probation departments in collaboration with mental/behavioral health and social service partners. Judge should exercise their leadership role and encourage or require this in the context of Rule of Court 10.951 and 10.952. This judicial leadership will be a topic for inclusion in judicial education materials and programs.
65	Judicial officers should avoid stating fixed sentencing terms that mandate state prison for an offender with mental illness upon violation of probation conditions regardless of the seriousness of the violation.	Identified by the Implementation Task Force as being under the purview of the judicial branch and identified as a topic appropriate for inclusion in judicial education materials and programs.

Mental Health Issues Implementation Task Force Responses to the Recommendations of Task Force for Criminal Justice Collaboration on Mental Health Issues		
Recommendation #	**Original Recommendation**	**Mental Health Issues Implementation Task Force Responses**
66	Judicial officers hearing probation violation calendars and deputy commissioners of the Board of Parole Hearings should carefully review the offender's discharge plan and consider the seriousness of the alleged violation(s) as well as the offender's progress or lack thereof in mental health treatment. Absent new serious criminal behavior by the probationer or parolee, alternative responses short of reincarceration should be considered. Incarceration should be reserved for those violations that demonstrate a threat to public safety.	Identified by the Issues Implementation Task Force as being under the purview of the judicial branch, as it relates to courts, and identified as a topic appropriate for inclusion in judicial education materials and programs.
67	Specialized calendars or courts for probationers and parolees with mental illness at risk of returning to custody on a supervision violation should be established in every jurisdiction. Such courts (e.g., reentry courts) or calendars should be modeled after collaborative drug and mental health courts. If an individual is a participant in a mental health court and violates probation, he or she should be returned to the mental health court for adjudication of the violation.	Identified by the Implementation Task Force as being under the purview of the judicial branch and identified as a topic appropriate for inclusion in judicial education materials and programs. The Judicial Council hosted a summit on April 19, 2014, "Court Programs and Practices for Working with Reentry, PRCS and Mandatory Supervision Populations." Although the program was not specifically focused on mental health issues, a task force member advised the planning group to include information on treatment options and programs for individuals with mental illness, as well as evaluation results focusing on participants with mental illness and the Rule of Court10.952 provide vehicle to address this recommendation and will be a topic for inclusion in judicial education materials and programs.
68	Immediate treatment interventions should be made available to a probationer or parolee with mental illness who considerably decompensate after his or her release or appears to be failing in community treatment.	Identified by the Implementation Task Force as not being under the purview of the judicial branch and more appropriately addressed by parole and probation departments in collaboration with mental/behavioral health partners.
69	Probation officers and parole agents should utilize graduated sanctions and positive incentives and work with mental health treatment providers to increase the level of treatment or intervention or initiate new treatment approaches when probationers and parolees with mental illness violate conditions of supervision.	Identified by the Implementation Task Force as not being under the purview of the judicial branch and more appropriately addressed by parole and probation departments in collaboration with mental/behavioral health partners.
70	Probation officers, parole agents, and treatment providers should provide pertinent treatment information to custody staff for those probationers or parolees with mental illness who are returned to jail or prison to ensure continuity of care.	Identified by the Implementation Task Force as not being under the purview of the judicial branch and more appropriately addressed by parole and probation departments in collaboration with mental/behavioral health and social service partners.

Mental Health Issues Implementation Task Force Responses to the Recommendations of Task Force for Criminal Justice Collaboration on Mental Health Issues		
Recommendation #	**Original Recommendation**	**Mental Health Issues Implementation Task Force Responses**
71	A community mental health care manager should initiate person-to-person contact with the incarcerated individual in jail who has a mental illness prior to his or her release from custody through an in-reach process in order to engage the individual in the development of his or her community treatment plan, and to provide a "bridge" to the community, thereby increasing the probability that the individual will follow up with treatment upon release. The community health care manager should also work with those involved in the development of the discharge plan to find appropriate stable housing for the incarcerated individual upon release.	Identified by the Implementation Task Force as not being under the purview of the judicial branch and more appropriately addressed by parole and probation departments in collaboration with mental/behavioral health and social service partners. In-reach projects have been established in several jurisdictions including Santa Clara where both the mental health case managers and the veterans' mental health liaison go into the jail to engage the defendants who are being released. In the event of a re-arrest, they go back into the jail in an effort to re-engage the defendant. This helps bridge the gap between jail and community treatment and supervision. San Diego's Probation Department has implemented a policy of individually picking up all Post-release Community Supervision (PRCS) offenders who are returned to San Diego including those with a diagnosed mental illness. Individuals processed through the San Diego Community Transition Center (CTC) where they undergo a multi-phased assessment process that includes a mental health screening. The CTC provides temporary housing during the transition period and transportation is also provided to any residential program to which they might be referred. These best practices will be a topic for inclusion in judicial education materials and programs.
72	A formal jail liaison should be designated by local mental health departments and local correctional facilities to improve communication and coordination between agencies involved in the discharge planning and post adjudication services for offenders with mental illness. Jail liaisons provide a single point of access within each system for problem identification and resolution regarding care of specific individuals as well as coordination of systems.	Identified by the Implementation Task Force as not being under the purview of the judicial branch and more appropriately addressed by parole and probation departments in collaboration with mental/behavioral health and social service partners. Jail liaison services have been developed in several counties including in the El Dorado jail where two transitional case managers from the Public Guardian Office and a Public Health Nurse from Public Health coordinate the release of inmates with mental illness. Current plans are to expand this service to all inmates. While the inmates are in custody, their care is handled by the jail's medical vendor. Both offices are under the umbrella of the County Health and Human Services Agency. These best practices will be a topic for inclusion in judicial education materials and programs.

Mental Health Issues Implementation Task Force Responses to the Recommendations of Task Force for Criminal Justice Collaboration on Mental Health Issues		
Recommendation #	**Original Recommendation**	**Mental Health Issues Implementation Task Force Responses**
73	Peer support services, through an in-reach process, should be offered to offenders in jail with mental illness while incarcerated and upon release to help ensure successful community reentry.	Identified by the Implementation Task Force as not being under the purview of the judicial branch and more appropriately addressed by probation departments in collaboration with mental/behavioral health partners.
74	Legislation and regulations, as well as local rules and procedures, should be modified or enacted to ensure that federal and state benefits are suspended rather than terminated while offenders with mental illness are in custody. Administrative procedures should be streamlined to ensure that benefits are reinstated immediately after offenders with mental illness are released from jail or prison.	Identified by the Implementation Task Force as not being under the purview of the judicial branch and more appropriately addressed by Congress and the California legislative and parole and probation departments in collaboration with health care and social service partners. The Affordable Care Act has provided a new avenue to address this issue and the Implementation Task Force has made it a part of a presentation to Presiding Judges and judicial education materials and programs.
75	Offenders with mental illness who do not have federal and state benefits, or have lost them due to the length of their incarceration, should receive assistance from jail or prison staff or in-reach care managers in preparing and submitting the necessary forms and documentation to obtain benefits immediately upon reentry into the community.	Identified by the Implementation Task Force as not being under the purview of the judicial branch and more appropriately addressed by parole and probation departments in collaboration with health care and social service partners. The Affordable Care Act has provided a new avenue to address this issue and the Task Force has made it a part of a presentation to Presiding Judges and judicial education materials and programs.
76	The discharge plan for release from jail, approved by the judicial officer as part of the disposition of criminal charges, should be implemented immediately upon release. The discharge plan should include arrangements for mental health treatment (including medication), drug and alcohol treatment, case management services, housing, applicable benefits, food, clothing, health care, and transportation.	Identified by the Implementation Task Force as not being solely under the purview of the judicial branch and needing to be addressed in partnership with local criminal justice, mental/behavioral health, and social service partners. This was identified by the Implementation Task Force as a best practice as well as a topic appropriate for inclusion in judicial education materials and programs.
77	Offenders with mental illness should be released during daytime business hours rather than late at night or in the early morning hours to ensure that offenders can be directly connected to critical treatment and support systems.	Identified by the Implementation Task Force as not being under the purview of the judicial branch and more appropriately addressed by local criminal justice, including sheriff departments, mental/behavioral health, and social service partners.

Mental Health Issues Implementation Task Force Responses to the Recommendations of Task Force for Criminal Justice Collaboration on Mental Health Issues		
Recommendation #	**Original Recommendation**	**Mental Health Issues Implementation Task Force Responses**
78	Upon release from jail, the sheriff's department should provide or arrange the offender's transportation to the location designated in the discharge plan. CDCR should utilize similar procedures, to the greatest extent possible, when releasing an offender to parole.	Identified by the Implementation Task Force as not being under the purview of the judicial branch and more appropriately addressed by local criminal justice, including the sheriff's department, mental/behavioral health, and social service partners; in the event of an offender being released from prison, this is a recommendation to be addressed by CDCR and parole.
79	Upon release from jail, the sheriff's department should facilitate access to an appropriate supply of medication as ordered in the discharge plan, a prescription, and a list of pharmacies accepting the issued prescription. CDCR should utilize similar procedures, to the greatest extent possible, when releasing an offender to parole.	Identified by the Implementation Task Force as not being under the purview of the judicial branch and more appropriately addressed by local criminal justice, including the sheriff, mental/behavioral health, and social service partners; in the event of an offender being released from prison, this is a recommendation to be addressed by CDCR and parole.
80	Upon release from jail, the care manager who engaged the offender through in-reach services while in custody should facilitate timely follow-up care, including psychiatric appointments as outlined in the discharge plan. CDCR should utilize similar procedures, to the greatest extent possible, when releasing an offender to parole.	Identified by the Implementation Task Force as not being under the purview of the judicial branch and more appropriately addressed by local criminal justice, including the sheriff, mental/behavioral health, and social service partners; in the event of an offender being released from prison, this is a recommendation to be addressed by CDCR and parole. Judge should exercise their leadership role and encourage or require this in the context of Rule of Court 10.951 and 10.952. This judicial leadership will be a topic for inclusion in judicial education materials and programs.
81	The sheriff's department should give advanced notice of the offender's release date and time from jail to the offender's community treatment coordinator as specified in the discharge plan as well as to members of his or her family, as appropriate, and others in his or her support system. CDCR should utilize similar procedures, to the greatest extent possible, when releasing an offender.	Identified by the Implementation Task Force as not being under the purview of the judicial branch and more appropriately addressed by local criminal justice partners including the sheriff, mental/behavioral health, and social service partners; in the event of an offender being released from prison, this is a recommendation to be addressed by CDCR and parole.
82	Offenders with mental illness should be released with arrangements for appropriate safe and stable housing in the community as provided in the discharge plan.	Identified by the Implementation Task Force as not being under the purview of the judicial branch and more appropriately addressed by local criminal justice partners including the sheriff, mental/behavioral health, and social service partners. The Implementation Task Force participated in providing education to community partners on these topics.

Mental Health Issues Implementation Task Force Responses to the Recommendations of Task Force for Criminal Justice Collaboration on Mental Health Issues		
Recommendation #	**Original Recommendation**	**Mental Health Issues Implementation Task Force Responses**
83	Courts, prisons, jails, probation, parole, and community partners, including CONREP, should be prepared to assume the role of housing advocate for the release, recognizing that there are explicit as well as implicit prejudices and exclusions based on either mental illness or the criminal history of the release.	Identified by the Implementation Task Force as not being solely under the purview of the judicial branch and more appropriately addressed in partnership with local criminal justice, mental/behavioral health, and social service partners; in the event of an offender being released from prison, this is a recommendation to be addressed by CDCR, CONREP, and parole.
84	Courts, prisons, jails, and community partners, including law enforcement, discharge planners, service providers, probation, and parole, should establish agreements with housing programs, including supportive housing, to develop a housing referral network to coordinate stable housing placements for offenders with mental illness who are returning to the community.	Identified by the Mental Health Issues Implementation Task Force as not being solely under the purview of the judicial branch and more appropriately addressed in partnership with local criminal justice, mental/behavioral health, and social service partners; in the event of an offender being released from prison, this is a recommendation to be addressed by CDCR, CONREP, and parole.
85	Need-based housing options should be available, recognizing that offenders with mental illness and co-occurring disorders require different levels of housing at release that may change over time.	Identified by the Implementation Task Force as not being under the purview of the judicial branch and more appropriately addressed by local criminal justice partners including sheriffs and mental/behavioral health, and social service partners.
86	Legislation should be enacted to provide incentives (e.g., funding, tax credits) to housing developers; providers of supportive housing, including peer-run organizations; and owners of rental units, to support the development and availability of housing to incarcerated offenders with mental illness when they are released to reenter the community.	Identified by the Implementation Task Force as not being under the purview of the judicial branch and more appropriately addressed by the legislature and local criminal justice partners including the sheriff, mental/behavioral health, and social service partners.
87	Mental Health Services Act (MHSA) funding dedicated to housing, per the local stakeholder process, should be leveraged with other funding sources to ensure equal access to housing for offenders with mental illness, including those on probation. The state Director of Mental Health and the Mental Health Services Oversight and Accountability Commission (MHSOAC) should ensure that county plans include provisions to secure equal access to housing paid for with MHSA funding for offenders with mental illness.	Identified by the Implementation Task Force as not being under the purview of the judicial branch and more appropriately addressed by the legislature, state and local criminal justice, including sheriffs, mental/behavioral health, and social service partners, and the Mental Health Services Oversight and Accountability Commission (MHSOAC).

Mental Health Issues Implementation Task Force Responses to the Recommendations of Task Force for Criminal Justice Collaboration on Mental Health Issues		
Recommendation #	**Original Recommendation**	**Mental Health Issues Implementation Task Force Responses**
88	Each presiding judge of the juvenile court should work with relevant stakeholders, including family members, to develop procedures and processes to provide appropriate services to youth in the delinquency system, who have a diagnosable mental illness or a developmental disability, including developmental immaturity, or a co-occurring disorder. These procedures should include collaboration with mental health systems, probation departments, and other community resources.	Identified by the Implementation Task Force as being under the purview of the judicial branch to implement on the local level in partnership with local mental/behavioral health, social services, education, and juvenile probation. Judicial officers should exercise their leadership role and encourage or require this in the context of Rule of Court 10.951 and 10.952. This judicial leadership will be a topic for inclusion in judicial education materials and programs.
89	Every juvenile who has been referred to the probation department pursuant to Welfare and Institutions Code section 602 should be screened or assessed for mental health issues as appropriate.	Identified by the Implementation Task Force as not being under the purview of the judicial branch and more appropriately addressed by state and local criminal justice (including sheriffs), mental/behavioral health, and juvenile probation. Judicial officers should exercise their leadership role and encourage or require this in the context of Rule of Court 10.951 and 10.952. This judicial leadership will be a topic for inclusion in judicial education materials and programs.
90	Protocols should be developed for obtaining information regarding a child's mental health diagnosis and medical history. Emphasis should be placed on acquiring thorough information in an expedited manner. Memorandums of understanding should be utilized to control the use and communication of information.	Identified by the Implementation Task Force as not being solely under the purview of the judicial branch and more appropriately addressed in partnership with local mental/behavioral health, health services, and juvenile probation. Judicial officers should exercise their leadership role and encourage or require this in the context of Rule of Court 10.951 and 10.952. This judicial leadership will be a topic for inclusion in judicial education materials and programs.
91	Juveniles in detention should have a medication evaluation upon intake into the detention center. Any psychotropic medication that a juvenile in detention is currently prescribed should be available to that juvenile within 24 hours of intake into detention unless an evaluating psychiatrist determines that it is no longer in the child's best interest.	Identified by the Implementation Task Force as not being under the purview of the judicial branch and more appropriately addressed by local mental/behavioral health and juvenile probation.

Mental Health Issues Implementation Task Force Responses to the Recommendations of Task Force for Criminal Justice Collaboration on Mental Health Issues		
Recommendation #	**Original Recommendation**	**Mental Health Issues Implementation Task Force Responses**
92	Each court should have informational and educational resources for juveniles and their families, in multiple languages if needed, to learn about juveniles' rights, resources available, and how to qualify for services and benefits as they relate to issues of mental health. Those resources could include specially trained personnel, written materials, or any other sources of information. Each local jurisdiction should develop listings of available support and educational nonprofit organizations to assist families in need.	Identified by the Implementation Task Force as being under the purview of the judicial branch to be implemented on the local level in partnership with local mental/behavioral health, social services, education, and juvenile probation. Judicial officers should exercise their leadership role and encourage or require this in the context of Rule of Court 10.951 and 10.952. This judicial leadership will be a topic for inclusion in judicial education materials and programs.
93	Mental health services should continue to be available to youth upon completion of their involvement with the delinquency system. Specifically, services should be extended in a manner consistent with the extension of services to dependent youth after they turn 18. This includes services provided for systemically appropriate transition age youth (18–25 years of age) who were formerly adjudicated as delinquent wards.	Identified by the Implementation Task Force as not being under the purview of the judicial branch but important to be addressed by the legislature, local mental/behavioral health and juvenile probation. The Implementation Task Force identified this area as part of juvenile reentry services and identified juvenile reentry courts and programs as promising practices to support this recommendation, noting examples of programs such as the juvenile reentry court and the Back on Track Program in San Francisco. Information on these programs can be found at http://www.sfsuperiorcourt.org/divisions/collaborative/jrc and at http://www.sfdistrictattorney.org/
94	Between the delinquency system and the adult criminal justice system should be improved to ensure that if a person once received mental health treatment as a juvenile, the information regarding that treatment is provided in a timely and appropriate fashion if they enter the adult criminal justice system. Information sharing must be in compliance with the Health Insurance Portability and Accountability Act (HIPAA) and other federal and state privacy protection statutes, rules, and regulations. When deemed appropriate upon assessment, treatment should continue in a consistent fashion if a minor transitions into the adult criminal justice system.	Identified by the Implementation Task Force as not being under the purview of the judicial branch but important to be addressed by the legislature, local juvenile and adult mental/behavioral health and juvenile and adult justice system partners. The Implementation Task Force noted examples of programs such as the juvenile reentry court and the Back on Track program in San Francisco as examples of programs that address this recommendation.
95	Experts in juvenile law, psychology, and psychiatry should further study the issue of juvenile competence, including the need for appropriate treatment facilities and services, for the purpose of improving the systemic response to youth found incompetent to stand trial in the delinquency court.	Identified by the Implementation Task Force as not being under the purview of the judicial branch but important to be addressed by universities and other research-based organizations.

Mental Health Issues Implementation Task Force Responses to the Recommendations of Task Force for Criminal Justice Collaboration on Mental Health Issues		
Recommendation #	**Original Recommendation**	**Mental Health Issues Implementation Task Force Responses**
96	Existing legislation should be modified or new legislation should be created to refine definitions of competency to stand trial for juveniles in delinquency matters and outline legal procedures and processes. Legislation should be separate from the statutes related to competency in adult criminal court and should be based on scientific information about adolescent cognitive and neurological development and should allow for appropriate system responses for children who are found incompetent as well as those remaining under the delinquency court jurisdiction.	Identified by the Implementation Task Force as needing to be addressed in partnership with the state legislature and experts in juvenile law and child development. Representatives of three Judicial Council advisory bodies are working together to consider and propose possible changes to juvenile competency legislation and the California Rules of Court, as well as to examine research and resource needs in this area.
97	Youth exiting the juvenile delinquency system, including those returning from out-of-state placements, should receive appropriate reentry and aftercare services, including, but not limited to, stable housing, and a discharge plan that addresses mental health, education, and other needs.	Identified by the Implementation Task Force as not being solely under the purview of the judicial branch and more appropriately addressed in partnership with mental/behavioral health, education, and social service partners. The Implementation Task Force identified this area as part of juvenile reentry services and identified juvenile reentry courts and programs as promising practices as regards recommendations 97-100.
98	Upon release from detention or placement, the probation department should facilitate access to an adequate supply of medication to fill any gap in time before having a prescription filled as ordered in the discharge plan. Upon release juveniles should have a scheduled appointment with a mental health agency.	Identified by the Implementation Task Force as not being under the purview of the judicial branch but important to be addressed by local juvenile mental/behavioral health and juvenile justice system partners.
99	The presiding judge of the juvenile court, working with the probation department, should create memoranda of understanding with local pharmacies and mental health service providers to ensure that juveniles leaving detention or placement have a reasonable distance to travel to fill prescriptions and obtain other necessary mental health services.	Identified by the Implementation Task Force as a best practice to be implemented on the local level in partnership with mental/behavioral health and juvenile justice system partners. Judicial officers should exercise their leadership role and encourage or require this in the context of Rule of Court 10.951 and 10.952. This judicial leadership will be a topic for inclusion in judicial education materials and programs.
100	Administrative procedures should be revised and streamlined to ensure that benefits of youth with mental illness are suspended instead of terminated during any period in detention and that those benefits are reinstated upon an individual's release from detention or placement. A youth's probation officer or mental health case manager should assist youth and their families with any associated paperwork.	Identified by the Implementation Task Force as not being under the purview of the judicial branch but important to be addressed by local juvenile mental/behavioral health, medical and juvenile justice system partners. The Affordable Care Act has provided a new avenue to address this issue and the Task Force has made it a part of a presentation to Presiding Judges and judicial education materials and programs.

Mental Health Issues Implementation Task Force Responses to the Recommendations of Task Force for Criminal Justice Collaboration on Mental Health Issues		
Recommendation #	**Original Recommendation**	**Mental Health Issues Implementation Task Force Responses**
101	The presiding judge of the juvenile court should work collaboratively with relevant local stakeholders to ensure that mental health services are available for all juveniles in the juvenile court system who need such services, including facilitating the delivery of culturally competent and age appropriate psychological and psychiatric services.	Identified by the Implementation Task Force as a best practice to be implemented on the local level in partnership with mental/behavioral health partners. The Implementation Task Force noted juvenile mental health courts as an effective practice to improve outcomes for high risk/high need juveniles with mental health issues. Judicial officers should exercise their leadership role and encourage or require this in the context of Rule of Court 10.951 and 10.952. This judicial leadership will be a topic for inclusion in judicial education materials and programs.
102	The presiding judge of the juvenile court of each county should work collaboratively with relevant agencies to ensure that youth in detention receive adequate and appropriate mental health treatment.	Identified by the Implementation Task Force as a best practice to be implemented on the local level in partnership with local juvenile mental/behavioral health and juvenile justice system partners including juvenile probation. Judicial officers should exercise their leadership role and encourage or require this in the context of Rule of Court 10.951 and 10.952. This judicial leadership will be a topic for inclusion in judicial education materials and programs.
103	The presiding judge of the juvenile court should establish an interagency work group to identify and access local, state, and national resources for juveniles with mental health issues. This work group might include, but is not limited to, stakeholders such as schools, mental health, health care, social services, local regional centers, juvenile probation, juvenile prosecutors, juvenile defense attorneys, and others.	Identified by the Implementation Task Force as a best practice to be implemented on the local level in partnership with local juvenile mental/behavioral health, education, medical, social services, regional centers, and juvenile justice system partners. Judicial officers should exercise their leadership role and encourage or require this in the context of Rule of Court 10.951 and 10.952. This judicial leadership will be a topic for inclusion in judicial education materials and programs.
104	Guidelines for processes and procedures should be created for information sharing among institutions that protects juveniles' right to privacy, privilege, confidentiality, and due process.	Identified by the Implementation Task Force as not being under the purview of the judicial branch but important to be addressed by local juvenile mental/behavioral health, education, medical, social services, regional centers, and juvenile justice system partners. Guidelines and protocols may vary based on local conditions and resource availability.

Mental Health Issues Implementation Task Force Responses to the Recommendations of Task Force for Criminal Justice Collaboration on Mental Health Issues		
Recommendation #	**Original Recommendation**	**Mental Health Issues Implementation Task Force Responses**
105	Counties should uniformly apply standards of care for youth in detention who have mental illness or developmental disabilities. Local jurisdictions should collaborate to develop strategies and solutions for providing services to youth with mental health issues that meet this minimum statewide standard of care utilizing available local and state resources.	Identified by the Implementation Task Force as not being under the purview of the judicial branch but important to be addressed by local juvenile mental/behavioral health, education, medical, social services, regional centers, and juvenile justice system partners. Judicial officers should exercise their leadership role and encourage or require this in the context of Rule of Court 10.951 and 10.952. This judicial leadership will be a topic for inclusion in judicial education materials and programs.
106	The presiding judge of the juvenile court of each county should work collaboratively with relevant local stakeholders to ensure that out-of-custody youth with co-occurring disorders are obtaining community-based mental health services. These stakeholders can include, but are not limited to, schools, mental health, social services, local regional center, juvenile probation, juvenile defense attorneys, drug and alcohol programs, family members, and others.	Identified by the Implementation Task Force as a best practice to be implemented in partnership with local juvenile mental/behavioral health, education, medical, social services, regional centers, and juvenile justice system partners as well as others mentioned in the recommendation. Effective practices, such as juvenile mental health courts, are noted in recommendation 101. Judicial officers should exercise their leadership role and encourage or require this in the context of Rule of Court 10.951 and 10.952. This judicial leadership will be a topic for inclusion in judicial education materials and programs.
107	Education and training related to juvenile development, mental health issues, co-occurring disorders, developmental disabilities, special education, and cultural competency related to these topics should be provided to all judicial officers, probation officers, law enforcement, prosecutors, defense attorneys, court evaluators, school personnel, and social workers. This education and training should include information about the identification, assessment, and provision of mental health, developmental disability, and special education services, as well as funding for those services.	Identified by the Implementation Task Force as not being solely under the purview of the judicial branch but important to be addressed by all partners. In addition, this was identified by the Implementation Task Force as a topic appropriate and necessary for inclusion in judicial education materials and programs. Implementation Task Force members worked with the Juvenile Law Curriculum Committee of the Center for Judiciary Education (CJER), which established juvenile mental health and developmental disabilities are priority areas for judicial education curricula and programs.
108	Education and training that is culturally competent should be provided to judicial officers, juvenile defense attorneys and prosecutors, court evaluators, probation officers, school personnel, and family members on how to assist juveniles and their families in qualifying for appropriate mental health treatment services for youth under the jurisdiction of the juvenile delinquency court (e.g., Medi-Cal, housing, SSI).	Identified by the Implementation Task Force as not being solely under the purview of the judicial branch but important to be addressed by all partners. In addition, this was identified by the Implementation Task Force as a topic appropriate and necessary for inclusion in judicial education materials and programs including education about suicide-risk and the impacts of stigma, discrimination and cumulative trauma.

Mental Health Issues Implementation Task Force Responses to the Recommendations of Task Force for Criminal Justice Collaboration on Mental Health Issues		
Recommendation #	**Original Recommendation**	**Mental Health Issues Implementation Task Force Responses**
109	The Administrative Office of the Courts should disseminate information to the courts regarding evidence-based collaborative programs or services that target juvenile defendants with mental illness or co-occurring disorders.	Identified by the Implementation Task Force as being under the purview of the judicial branch and the Judicial Council, with the recommendation that research in this area by the Judicial Council be encouraged and supported. In addition this was identified by the Implementation Task Force as a topic appropriate and necessary for inclusion in judicial education materials and programs.
110	The California Courts website should include links to national and international research on collaborative justice and juvenile mental health issues, as well as information on juvenile mental health courts, promising case processing practices, and subject matter experts available to assist the courts.	Identified by the Implementation Task Force as being under the purview of the judicial branch and the Judicial Council and recommends ongoing development and maintenance of these materials. The California Courts website (www.courts.ca.gov) currently includes links to several resources for juvenile mental health, including the Council on Mentally Ill Offenders (http://www.cdcr.ca.gov/COMIO/index.html) and the California Department of Health Care Services (http://www.dhcs.ca.gov/services/Pages/MentalHealthPrograms-Svcs.aspx) In addition, current information about juvenile mental health courts and mental illness is added to the Juvenile Mental Health Courts home page at http://www.courts.ca.gov/5990.htm.
111	Assessments and evaluations of the current data, processes, and outcomes of juvenile competence to stand trial in California should be conducted. This research should include, but is not limited to, an assessment of the number of cases in which the issue of competence is raised, the number of youth found incompetent versus competent, and what happens when a youth is found to be incompetent to stand trial.	Identified by the Implementation Task Force as being under the purview of the judicial branch and the Judicial Council. Representatives of three Judicial Council advisory bodies are working together to consider and propose possible changes to juvenile competency legislation and the California Rules of Court, as well as to examine research and resource needs in this area.

Mental Health Issues Implementation Task Force Responses to the Recommendations of Task Force for Criminal Justice Collaboration on Mental Health Issues		
Recommendation #	**Original Recommendation**	**Mental Health Issues Implementation Task Force Responses**
112	Additional research should be conducted related to juvenile mental health issues, including assessments and evaluations of the following: a. The mental health services available to juveniles and transition age youth in each county; and b. Any overlap between youth who enter the delinquency system and youth who are eligible to receive mental health services under a special education program provided by the Individuals with Disabilities Education Act (IDEA, in accordance with AB 3632). c. The prevalence of youth with disabilities or mental illness who enter the criminal justice system later as adults.	Identified by the Implementation Task Force as not being under the purview of the judicial branch but important to be addressed by research, education, social service, and juvenile and adult criminal justice partners.
113	Ongoing data should be collected about juveniles diverted from the juvenile delinquency court to other systems, including, but not limited to, the mental health system or juvenile mental health court.	Identified by the Implementation Task Force as not being solely under the purview of the judicial branch and needing to be addressed in partnership with mental/behavioral health partners and juvenile justice partners. The Judicial Council currently encourages data collection among delinquency and juvenile mental health courts throughout the state. The Judicial Council published and distributed a report on juvenile delinquency performance measurement as an evidence-based practice:(http://www.courts.ca.gov/documents/JD_Performance_asEBP.pdf). In addition, the Judicial Council is working with the National Center for State Courts to survey all collaborative courts in the state and to document preliminary outcome measures.

Mental Health Issues Implementation Task Force Responses to the Recommendations of Task Force for Criminal Justice Collaboration on Mental Health Issues		
Recommendation #	**Original Recommendation**	**Mental Health Issues Implementation Task Force Responses**
114	Funding for education on collaborative justice principles and mental health issues should be sought from local, state, federal, and private sources.	Identified by the Implementation Task Force as not being solely under the purview of the judicial branch and more appropriately addressed in partnership with California trial courts as well as mental/behavioral health and justice system partners. The Judicial Council of California, Center for Families, Children & the Courts currently disseminates funding and technical assistance information to courts through the collaborative courts coordinators' network and the California Association of Collaborative Courts (CACC) in addition to advisory and task force members.
115	The Administrative Office of the Courts should disseminate to the courts, using advanced technology, information regarding evidence-based collaborative programs or services that target defendants with mental illness or co-occurring disorders.	Identified by the Implementation Task Force as being under the purview of the judicial branch and the Judicial Council. In addition, this was identified by the Issues Implementation Task Force as a topic appropriate and necessary for inclusion in judicial education materials and programs including a focus on evidence-based practices in the areas of juvenile and adult mental health, co-occurring disorder, reentry, and veterans' courts. The Judicial Council, Center for Families, Children & the Courts currently disseminates information to courts through the collaborative courts coordinators' network and the California Association of Collaborative Courts (CACC) in addition to posting information on the California Courts website. The Judicial Council, Center for Families, Children & the Courts and through the Center for Judiciary Education (CJER) has increased education programming focusing on mental health issues in the courts and justice system. In addition, a mental health education toolkit with links to traditional CJER mental health resources as well as to education products created specifically for the website by the Implementation Task Force.

Mental Health Issues Implementation Task Force Responses to the Recommendations of Task Force for Criminal Justice Collaboration on Mental Health Issues		
Recommendation #	**Original Recommendation**	**Mental Health Issues Implementation Task Force Responses**
116	The Administrative Office of the Courts, in collaboration with consumer and family groups, the Forensic Mental Health Association, California Institute of Mental Health (CIMH), California Mental Health Directors Association (CMHDA), and other professional mental health organizations, should develop and provide ongoing education for judicial officers, appropriate court staff, and collaborative partners on mental health issues and strategies for responding to people with mental illness or co-occurring disorders in the criminal justice system. Education should include information on diversion programs and community services that target this population.	Identified by the Implementation Task Force as not being solely under the purview of the judicial branch and more appropriately addressed in partnership with state and local mental/behavioral health and justice system partners. During the tenure of the Mental Health Issues Implementation Task Force, outreach and joint educational programming was accomplished in collaboration with the Forensic Mental Health Association of California where task force members and other judges working in mental health courts or with mental health calendars served as faculty; with the California Institute of Mental Health where task force members served a keynote presenters and faculty, and the 2012 and 2013 Words to Deeds Summit where task force members served a keynote presenters and faculty. In addition, several local courts, including the Kern County Superior Court, developed their own mental health training for judges in conjunction with mental health partners. The Implementation Task Force through its chair also held exploratory meetings with the Chief Probation Officers of California and the California Sheriffs' Association to discuss working in collaboration to develop appropriate mental health training for those two organizations that would help support and complement the work of mental health judges throughout the state.
117	Judicial officers should participate in ongoing education on mental illness and best practices for adjudicating cases involving defendants who have a mental illness or co-occurring disorder. An overview of such information should be provided to all judges during judicial orientation and/or judicial college and should be included in a variety of venues for ongoing education.	Identified by the Implementation Task Force as being under the purview of the judicial branch and the Judicial Council. During the tenure of the Implementation Task Force, educational programming offered through the Center for Families, Children & the Courts (CFCC) and the Center for Judiciary Education (CJER) increased. As of 2014, mental health topics have been added to many curriculum plans and mental health education, including evidence-based practice responses, has been included in primary assignment orientations, institutes, and the judicial college. In addition, mental health education has increased in programs offered through CFCC including at Beyond the Bench, in Family Dispute Resolution programs for family court facilitators and mediators, and in programs offered for collaborative court practitioners.

Mental Health Issues Implementation Task Force Responses to the Recommendations of Task Force for Criminal Justice Collaboration on Mental Health Issues		
Recommendation #	**Original Recommendation**	**Mental Health Issues Implementation Task Force Responses**
118	Ongoing training should be provided to judicial officers and attorneys with assignments in collaborative justice courts on collaborative justice principles and all areas related to defendants with mental illness or co-occurring disorders, including diagnoses, communication techniques, and treatment options. Training should include recent outcome research on collaborative court programs.	Identified by the Implementation Task Force as not being solely under the purview of the judicial branch and more appropriately addressed in partnership with the California Judges Association, the State Bar of California, California law schools, and professional organizations, such as the California Association of Collaborative Court Professionals, the American Bar Association Commission on Homelessness and Poverty, and the California Association of Youth Courts.
119	Continuing Legal Education (CLE) courses focusing on mental health law and participation by mental health professionals in the criminal process should be developed.	Identified by the Implementation Task Force as not being solely under the purview of the judicial branch and more appropriately addressed in partnership with the State Bar of California and state and local mental health partners. It is noted that Continuing Education Units for social workers, marriage and family counselors, and psychologists are offered for multidisciplinary education programs at the Judicial Council and that these programs, with participation of Task Force members, have included mental health law and court practices as part of the content.
120	Pretrial services and probation personnel should receive training regarding symptoms of mental illness so that they can refer, or recommend that a judicial officer refer people who may suffer from a mental illness to trained mental health clinicians for a complete mental health assessment.	Identified by the Implementation Task Force as not being solely under the purview of the judicial branch and more appropriately addressed in cooperation with pretrial and probation partners. The Implementation Task Force through its chair held exploratory meetings with the Chief Probation Officers of California to discuss working in collaboration to develop appropriate mental health training for probation officers that would help support and complement the work of mental health judges throughout the state.
121	Probation officers and parole agents should receive education and training about mental illness to increase understanding of the unique challenges facing these offenders and to obtain better outcomes for this population. Education and training should promote a problem-solving approach to community supervision that balances both therapeutic and surveillance goals and includes information regarding communication techniques, treatment options, and criminogenic risk factors.	Identified by the Implementation Task Force as not being under the purview of the judicial branch and more appropriately addressed parole and probation partners. The Implementation Task Force through its chair also held exploratory meetings with the Chief Probation Officers of California to discuss working in collaboration to develop appropriate mental health training for probation officers that would help support and complement the work of mental health judges throughout the state.

Mental Health Issues Implementation Task Force Responses to the Recommendations of Task Force for Criminal Justice Collaboration on Mental Health Issues		
Recommendation #	**Original Recommendation**	**Mental Health Issues Implementation Task Force Responses**
122	Deputy commissioners of the Board of Parole Hearings who are responsible for hearing parole violations should receive education about mental illness and effective methods for addressing violations of supervision conditions by parolees with mental illness.	Identified by the Mental Health Issues Implementation Task Force as now being under the purview of the judicial branch because of changes made through criminal justice realignment. Because courts now do revocation hearings for parolees, judicial or hearing officers making those determinations require training in this area. Moreover, there also remains a need for education of parole officers regarding the mentally ill, and work in this area is best accomplished in partnership with parole and probation partners. Implementation Task Force members participated as faculty and served on the planning team for multidisciplinary education programs that had mental health content, including the Reentry Court, Community Justice, and Homeless Summits. These programs were held at the Judicial Council and cosponsored with the Center for Court Innovation and the ABA Commission on Homelessness and Poverty.
123	Crisis intervention training and suicide prevention training should be provided to law enforcement, including jail custody personnel and correctional officers, on an ongoing basis to increase understanding of mental illness and to improve outcomes for and responses to people with mental illness. CIT training and suicide prevention training should also be part of the standard academy training provided to new officers.	Identified by the Implementation Task Force as not being under the purview of the judicial branch and more appropriately addressed law enforcement and other criminal justice partners. The Implementation Task Force worked with the California Institute of Mental Health to provide information about CIT programs and procedures to state and local mental/behavioral health partners in an effort to encourage local partnerships similar to those in several jurisdictions including the City of Santa Cruz which recently received a Council on Mentally Ill Offenders (COMIO) award in recognition of its MOST team (Making the Most of Collaboration) which focuses on criminal justice system and behavioral health services integration.
124	All mental health training and education should include information on cultural issues relevant to the treatment and supervision of people with mental illness. Custodial facilities, courts, probation, parole, and treatment agencies should be encouraged to actively seek practitioners who have the cultural and language skills to directly relate to people with mental illness.	Identified by the Implementation Task Force as not being solely under the purview of the judicial branch and more appropriately addressed in partnership with mental health and criminal justice partners.
125	Education and training programs for criminal justice partners should utilize mental health advocacy organizations and include presentations by mental health consumers and family members.	Identified by the Issues Implementation Task Force as not being under the purview of the judicial branch and more appropriately addressed by mental/behavioral health and criminal justice partners.

Mental Health Issues Implementation Task Force Responses to the Recommendations of Task Force for Criminal Justice Collaboration on Mental Health Issues		
Recommendation #	**Original Recommendation**	**Mental Health Issues Implementation Task Force Responses**
126	Mental Health Services Act funding should be actively utilized, per the local stakeholder process as applicable, for state and local educational campaigns and training programs for the general public that reduce stigma and discrimination toward those with mental illness. Educational campaigns and training programs should incorporate the recommendations of the California Strategic Plan on Reducing Mental Health Stigma and Discrimination.	Identified by the Implementation Task Force as not being under the purview of the judicial branch and more appropriately addressed by state and local mental/behavioral health partners including the Mental Health Services Oversight and Accountability Commission.
127	All accredited law schools in California should expand their curricula to include collaborative justice principles and methods, including those focused on defendants with mental health issues.	Identified by the Implementation Task Force as not being under the purview of the judicial branch and more appropriately addressed by the State Bar of California and law schools throughout the state. The Collaborative Justice Courts Advisory Committee has undertaken an effort to reach out to California law schools to provide internships for law students in collaborative courts or at the Judicial Council. In addition, presentations have been made by advisory committee members to several law schools throughout the state focusing on collaborative court principles and the ways in which they are applied in the court setting including in mental health courts.
128	The Administrative Director of the Courts should transmit this report to California law school deans and urge them to consider the following strategies: a. Develop effective strategies to institutionalize collaborative justice principles and methods in training programs for law school faculty and staff; b. Provide faculty with access to periodic training that focuses on understanding mental illness and how to best represent those with mental illness based on collaborative justice principles and methods; and c. Encourage faculty to develop teaching methods and engage speakers who can integrate the practical aspects of how collaborative justice principles and methods relate to the reality of legal practice in the substantive areas being taught.	Identified by Implementation Task Force as being under the purview of the judicial branch and the Judicial Council.

Mental Health Issues Implementation Task Force Responses to the Recommendations of Task Force for Criminal Justice Collaboration on Mental Health Issues		
Recommendation #	**Original Recommendation**	**Mental Health Issues Implementation Task Force Responses**
129	The State Bar of California admissions exam should be expanded to include questions testing knowledge of collaborative justice principles and methods, including those focused on defendants with mental health issues. The Board of Governors and the Committee of Bar Examiners of the State Bar of California should collaborate, as appropriate, with law school deans regarding the inclusion of collaborative justice principles and methods into bar examination questions	Identified by the Implementation Task Force as not being under the purview of the judicial branch and more appropriately addressed by the State Bar of California and law schools throughout the state.
130	The Administrative Director of the Courts should transmit this report to the Law School Admissions Council (LSAC) and the Board of Governors of the State Bar of California for its information and consideration.	Identified by the Implementation Task Force as being under the purview of the judicial branch and the Judicial Council.
131	Funding for research initiatives outlined in this report should be sought from local, state, federal, and private sources.	Identified by the Implementation Task Force as being under the purview of the judicial branch and the Judicial Council. The Judicial Council continually seeks external funding for research initiatives and provides technical assistance to courts engaging in their own research and evaluation projects. The reentry court evaluation, which focuses on the incidence of mentally ill participants in reentry courts and outcomes for these participants, is funded in part by the California Endowment.
132	The California Courts website should include links to national and international research on collaborative justice and mental health issues, as well as information regarding mental health court and calendar best practices and subject matter experts available to assist the courts.	Identified by the Implementation Task Force as being under the purview of the judicial branch and the Judicial Council. The California Courts website (www.courts.ca.gov) includes links to several resources focused on mental health issues in the courts including the California Department of Health Services, the California Mental Health Directors Association, the Council on Mentally Ill Offenders, and the Council of State Governments along with a number of federal agencies including Substance Abuse and Mental Health Services Administration and the Bureau of Justice Assistance. The Council of State Governments has a particular robust mental health on-line resource center found at http://csgjusticecenter.org/mental-health. California and its Task Force for Criminal Justice Collaboration on Mental Health Issues was one of the seven initial mental health task force projects supported by the Council of State Governments and its Judicial Leadership Initiative.

Mental Health Issues Implementation Task Force Responses to the Recommendations of Task Force for Criminal Justice Collaboration on Mental Health Issues		
Recommendation #	**Original Recommendation**	**Mental Health Issues Implementation Task Force Responses**
133	There should be further research on the effectiveness of programs that serve people with mental illness involved in the criminal justice system, such as crisis intervention teams, mental health courts, reentry courts, and specialized mental health probation programs. Research should analyze mental health, recidivism, and criminal case outcomes, costs, and savings, as well as the elements of such programs that have the most impact. Research should evaluate outcomes for different subgroups (e.g., according to race, gender, diagnosis, etc.) within the participant population.	Identified by the Implementation Task Force as not being solely under the purview of the judicial branch but important to be addressed with research, law enforcement, education, social service, and juvenile and adult criminal justice partners. Implementation Task Force members have provided guidance for several studies underway at the Judicial Council that are described below. The Judicial Council published a literature review of mental health court related research in 2012 that is available on the Judicial Council website at http://courts.ca.gov/documents/AOCLitReview-Mental_Health_Courts--Web_Version.pdf. In addition, the Judicial Council is conducting a process evaluation project of California's mental health courts. This study examines the process and procedures of mental health courts and identifies preliminary outcomes and promising practices. The project discusses the foundation for understanding California's mental health courts, describing the courts in depth, as well as variations among courts' policies and practices. This report is expected to be published by summer 2014. The final phase of the project will be an in-depth study of six specific mental health courts and will include qualitative data from interviews and focus groups and available outcomes from the six study courts. The Judicial Council will seek external grant funding or other potential resources to expand the project and track individual-level data and court specific outcomes.

Mental Health Issues Implementation Task Force Responses to the Recommendations of Task Force for Criminal Justice Collaboration on Mental Health Issues		
Recommendation #	**Original Recommendation**	**Mental Health Issues Implementation Task Force Responses**
		The Judicial Council is conducting an evaluation of reentry courts that includes outcomes and cost analysis as well as identification of incidence of mentally ill participants in these courts and outcomes for those participants. The Judicial Council provides technical assistance to specific courts, such as reentry courts, to conduct research, and works with drug courts, mental health courts, and other collaborative justice courts to identify data elements and evaluation standards. In addition, the Judicial Council is working with the National Center for State Courts on a nationwide survey of collaborative justice courts, including California's mental courts. The results of this survey are forthcoming. The Judicial Council is also working with the Implementation Task Force to develop a Resource Guide to Innovative Responses to Persons with Mental Illness in California's Criminal Courts (in press).
134	Programs targeting offenders with mental illness should track outcome data. Although programmatic goals will determine the data collected, key data elements should include the following: a. Participant data (e.g., number served and relevant characteristics, such as diagnosis and criminal history); b. Service data (e.g., type of service received, frequency of service, length of service provision); c. Criminal justice outcomes (e.g., number of arrests, types of charges, jail days); d. Mental health outcomes (e.g., number of inpatient hospitalizations and lengths of stay, number of days homeless); and e. Program costs and savings data.	Identified by the Implementation Task Force as not being solely under the purview of the judicial branch but important to be addressed with research, law enforcement, education, social service, and juvenile and adult criminal justice partners. The Judicial Council encourages data collection among delinquency and juvenile mental health courts throughout the state. A report has been published and distributed on juvenile delinquency performance measurement as an evidence-based practice (http://www.courts.ca.gov/documents/JD_Performance_asEBP.pdf). In addition, the Judicial Council has worked closely with collaborative justice court coordinators, including mental health court coordinators, around the state to identify data definitions and standards and is working with the National Center for State Courts to survey all collaborative courts in the state and to document preliminary outcome measures.

Mental Health Issues Implementation Task Force Responses to the Recommendations of Task Force for Criminal Justice Collaboration on Mental Health Issues		
Recommendation #	**Original Recommendation**	**Mental Health Issues Implementation Task Force Responses**
135	Statewide evaluations should be conducted to identify and study the effectiveness of inpatient and outpatient programs that regularly accept forensic mental health clients. Barriers to the placement of individuals under forensic mental health commitments should be identified	Identified by the Implementation Task Force as not being solely under the purview of the judicial branch but important to be addressed with research institutions, CONREP, the Forensic Mental Health Association of California, and juvenile and adult criminal justice partners. The Judicial Council is currently conducting a study on the effectiveness of reentry courts and a study California's mental health courts, both of which include participant data, service data and some outcome data (in progress).
136	Independent researchers should evaluate the effectiveness of competency restoration programs.	Identified by the Implementation Task Force as not being under the purview of the judicial branch and more appropriately addressed by universities, the Department of State Hospitals, and other competency restoration programs.
137	Local public agencies, including law enforcement, should collaborate to create a system in accordance with Health Insurance Portability and Accountability Act (HIPAA) regulations that identifies individuals involved in the criminal justice system, who frequently access services in multiple public systems in order to distinguish those most in need of integrated interventions, such as permanent supportive housing. Public agencies can use this system to achieve cost savings by stabilizing the most frequent and expensive clients.	Identified by the Implementation Task Force as not being under the purview of the judicial branch and more appropriately addressed by state and local mental/behavioral health, social service, and criminal justice partners.

Appendix B: Mental Health Issues Implementation Task Force Fact Sheet

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FACT SHEET January 2012

Mental Health Issues Implementation Task Force

The Judicial Council's Mental Health Issues Implementation Task Force was appointed to advise the council on ways to implement the recommendations of the Task Force for Criminal Justice Collaboration on Mental Health Issues. These recommendations were designed to improve the response of the criminal justice system to offenders with mental illness by promoting collaboration at the state and local level. The task force focus will be on improving practices and procedures in criminal cases involving adult and juvenile offenders with mental illness, ensuring the fair and expeditious administration of justice, and promoting improved access to treatment for litigants with mental illness in the criminal justice system.

Charge

The task force was charged with developing recommendations for policymakers, including the Judicial Council and its advisory committees, to improve system wide responses to mentally ill offenders and to develop an action plan to implement the recommendations of the Task Force for Criminal Justice Collaboration on Mental Health Issues.

Specifically, the task force is charged with:

1. Identifying recommendations under Judicial Council purview to implement;
2. Identifying potential branch implementation activities; and
3. Developing a plan with key milestones for implementing the recommendations.

History

The Mental Health Issues Implementation Task Force evolved from the Task Force

for Criminal
Justice
Collaboration
on Mental
Health Issues
which was one
of seven

similar projects established by state supreme courts throughout the nation with support from the Council of State Governments (CSG) as part of its criminal justice and mental health initiative encouraging effective leadership from different facets of the criminal justice and mental health systems. Continued funding for this project is supported by California's Mental Health Services Act (MHSA) fund.

Presiding Judge Richard J. Loftus, Jr., of the Superior Court of Santa Clara County serves as chair of the task force. Task force membership currently includes judicial officers and court executive officers from throughout the state. The task force will establish liaison positions with mental health and justice system partners.

The task force, in collaboration with its mental health and justice system partners, will address ways to improve outcomes and reduce recidivism rates for offenders with mental illness while being mindful of cost and public safety considerations. The work of the task force will be based on the final recommendations submitted to the Judicial Council by the Task Force for Criminal Justice Collaboration on Mental Health Issues.

The recommendations are designed to:

- Promote innovative and effective practices to foster the fair and efficient processing and resolution of cases involving mentally ill persons in the criminal justice system;
- Expand education programs for the judicial branch, State Bar of California, law enforcement, and mental health service providers to address the needs of offenders with mental illness;
- Foster excellence through implementation of evidence-based practices for serving persons with mental illness; and
- Encourage collaboration among criminal justice partners and other stakeholders to facilitate interagency and interbranch efforts that reduce recidivism and promote improved access to treatment for persons with mental illness.

Contacts:

Karen Moen, Senior Court Services Analyst, Center for Families, Children & the Courts, karen.moen@jud.ca.gov

Additional resources:

Criminal Justice/Mental Health Consensus Project http://consensusproject.org/; and

Criminal Justice/Mental Health Consensus Project Leadership Initiative:

http://consensusproject.org/judges-leadership-initiative

California Department of Mental Health/Mental Health Services Act Information: http://www.dmh.ca.gov/Prop_63/MHSA/State_Interagency_Partners.asp

Appendix C: Rules of Court

2014 California Rules of Court

Rule 10.951. Duties of supervising judge of the criminal division

(a) Duties

In addition to any other duties assigned by the presiding judge or imposed by these rules, a supervising judge of the criminal division must assign criminal matters requiring a hearing or cases requiring trial to a trial department.

(Subd (a) amended effective January 1, 2007.)

(b) Arraignments, pretrial motions, and readiness conferences

The presiding judge, supervising judge, or other designated judge must conduct arraignments, hear and determine any pretrial motions, preside over readiness conferences, and, where not inconsistent with law, assist in the disposition of cases without trial.

(Subd (b) amended effective January 1, 2008; previously amended effective January 1, 2007.)

(c) Mental health case protocols

The presiding judge, supervising judge, or other designated judge, in conjunction with the justice partners designated in rule 10.952, is encouraged to develop local protocols for cases involving offenders with mental illness or co-occurring disorders to ensure early identification of and appropriate treatment for offenders with mental illness or co-occurring disorders with the goals of reducing recidivism, responding to public safety concerns, and providing better outcomes for those offenders while using resources responsibly and reducing costs.

(Subd (c) adopted effective January 1, 2014.)

(d) Additional judges

To the extent that the business of the court requires, the presiding judge may designate additional judges under the direction of the supervising judge to perform the duties specified in this rule.

(Subd (d) relettered effective January 1, 2014; adopted as subd (c).)

(3) Courts without supervising judge

In a court having no supervising judge, the presiding judge performs the duties of a supervising judge.

(Subd (e) relettered effective January 1, 2014; adopted as subd (d); previously amended effective January 1, 2007.)

Rule 10.951 amended effective January 1, 2014; adopted as rule 227.2 effective January 1, 1985; previously amended and renumbered effective January 1, 2007; previously amended effective January 1, 2008.

Rule 10.952. Meetings concerning the criminal court system

The supervising judge or, if none, the presiding judge must designate judges of the court to attend regular meetings to be held with the district attorney; public defender; representatives of the local bar, probation department, parole office, sheriff department, police departments, and Forensic Conditional Release Program (CONREP); county mental health director or his or her designee; county director of the California Department of Alcohol and Drug Programs or his or her designee; court personnel; and other interested persons to identify and eliminate problems in the criminal court system and to discuss other problems of mutual concern.

Rule 10.952 amended effective January 1, 2014; adopted as rule 227.8 effective January 1, 1985; previously amended and renumbered effective January 1, 2007.

Appendix D: 2014 Legislative Proposal

Mental Health Issues Implementation Task Force
2014 Legislative Proposals Accepted for Judicial Council Sponsorship

Proposal 1:

Section 5354 of the Welfare and Institutions Code would be amended to read as follows:

Section 5354.

(a) The officer providing conservatorship investigation shall investigate all available alternatives to conservatorship and shall recommend conservatorship to the court only if no suitable alternatives are available. This officer shall render to the court a written report of investigation prior to the hearing. The report to the court shall be comprehensive and shall contain all relevant aspects of the person's medical, psychological, financial, family, vocational and social condition, and information obtained from the person's family members, close friends, social worker or principal therapist. The report shall also contain all available information concerning the person's real and personal property. The facilities providing intensive treatment or comprehensive evaluation shall disclose any records or information which may facilitate the investigation. If the officer providing conservatorship investigation recommends against conservatorship, he or she shall set forth all alternatives available. A copy of the report shall be transmitted to the individual who originally recommended conservatorship, to the person or agency, if any, recommended to serve as conservator, and to the person recommended for conservatorship. The court may receive the report in evidence and may read and consider the contents thereof in rendering its judgment.

(b) When a court with jurisdiction over a person in a criminal case orders an evaluation of the person's mental condition pursuant to section 5200, the officer providing the conservatorship investigation shall serve the report required under subdivision (a) upon the defendant or the defendant's counsel. Upon request of the defendant or defendant's counsel, the officer providing the conservatorship investigation shall also submit a copy of the report to the court hearing the criminal case, the district attorney, and the county probation department. The conservatorship investigation report and the information contained therein, shall be kept confidential and shall not be disclosed to anyone without the prior written consent of the defendant. After disposition of the criminal case, the court must place all copies of the report in a sealed file, except that: (1) the defendant or defendant's counsel may retain their copy, and (2) if the defendant is placed on probation by the court, the county probation department may retain a copy of the report for the purpose of supervision of the defendant until probation is terminated, at which time the probation department must return the copy to the court for placement in the sealed file.

Proposal 2:

Sections 1601, 1602 and 1603 of the Penal Code are amended, effective January 1, 2015, to read:

Penal Code Section 1601

(a) In the case of any person charged with and found incompetent on a charge of, convicted of, or found not guilty by reason of insanity of murder, mayhem, aggravated mayhem, a violation of Section 207, 209, or 209.5 in which the victim suffers intentionally inflicted great bodily injury, robbery or carjacking with a deadly or dangerous weapon or in which the victim suffers great bodily injury, a violation of subdivision (a) or (b) of Section 451, a violation of paragraph (2), (3), or (6) of subdivision (a) of Section 261, a violation of paragraph (1) or (4) of subdivision (a) of Section 262, a violation of Section 459 in the first degree, a violation of Section 220 in which the victim suffers great bodily injury, violation of Section 288, a violation of Section 18715, 18725, 18740, 18745, 18750, or 18755 or any felony involving death, great bodily injury, or an act which poses a serious threat of bodily harm to another person, outpatient status under this title shall not be available until either (1) that person has actually been confined in a state hospital or other treatment facility for 180 days or more after having been committed under the provisions of law specified in Section 1600 or (2) the court finds a suitable placement, including, but not limited to, an outpatient placement program, that would provide the person with more appropriate mental health treatment and would not pose a danger to the health and safety of others.

(b) * * *

Penal Code Section 1602

(a) Before any person subject to the provisions of subdivision (b) of Section 1601 may be Placed on outpatient status,~~ if all of the following conditions are satisfied:~~ the court shall consider the following criteria:

(1) In the case of a person who is an inpatient, the director of the state hospital or other treatment facility to which the person has been committed advises the court that the defendant will not be a danger to the health and safety of others while on outpatient status, and will benefit from such outpatient status. (2) In all cases, the community program director or a designee advises the court that the defendant will not be a danger to the health and safety of others while on outpatient status, will benefit from such status, and identifies an appropriate program of supervision and treatment.

(b)~~(3) After~~ Before determining whether to place the person on outpatient status, the court shall provide actual notice to the prosecutor and defense counsel, and ~~after~~ hold a hearing at which the court may ~~in court, the court~~ specifically order ~~approves the recommendation and plan for~~ outpatient status for the person.

(c~~b~~)–(d~~e~~) * * *

Penal Code Section 1603.

(a) Before any person subject to subdivision (a) of Section 1601 may be placed on outpatient

39 status, ~~if all of the following conditions are satisfied:~~ the court shall consider the following criteria:
40 (1) The director of the state hospital or other treatment facility to which the person has been
41 committed advises the committing court and the prosecutor that the defendant would no longer

1 be a danger to the health and safety of others, including himself or herself, while under
2 supervision and treatment in the community, and will benefit from that status.
3 (2) The community program director advises the court that the defendant will benefit from that
4 status, and identifies an appropriate program of supervision and treatment.
5 (b)~~(3)~~ The prosecutor shall provide notice of the hearing date and pending release to the victim
6 or next of kin of the victim of the offense for which the person was committed where a request
7 for the notice has been filed with the court, and after a hearing in court, the court specifically
8 approves the recommendation and plan for outpatient status pursuant to Section 1604. The
9 burden shall be on the victim or next of kin to the victim to keep the court apprised of the party's
10 current mailing address.
11 In any case in which the victim or next of kin to the victim has filed a request for notice with the
12 director of the state hospital or other treatment facility, he or she shall be notified by the director
13 at the inception of any program in which the committed person would be allowed any type of day
14 release unattended by the staff of the facility.
15 (c~~b~~)–(d~~e~~) * * *

Appendix E: Discharge plan

Sample Jail/Prison Discharge and Community Re-entry Plan (J/PDCRP)

Client Name ______________________________

Contact Information ______________________________

Family/others contact information : *Provide names contact information for family other key support persons*

- ______________________________

Staff/Person Completing the Initial J/PDCRP:

Name: ____________________ Title: ____________________

Agency: ______________________________

1. **Community Supervision**

Judicial Supervision: Judge/Court: ______________________________

Probation/Parole program

Supervising Agent Name/unit: ______________________________

Phone & e mail contact : ______________________________

After hours/emergency contact: ______________________________

Community Supervision Plan

Pre-release contact with Supervising Agent?

Describe ______________________________

____

Anticipated type/frequency of contact post-release

- Within 72 hours post-release: ______________________________
- First 30 days post-release: ______________________________
- First supervision appointment:

Date: ____________________ Time: ____________________

Location: ______________________________

2. **Post Release Housing/living Arrangement**

Address: ______________________________

Phone: ______________________________

Type of housing/facility:

☐ Temporary Shelter ☐ Family Residence ☐ Other

☐ Supervised/Treatment Facility ☐ Independent

Staff contact if supervised housing: ______________________________

3. **Transportation** *Describe immediate post-release transportation needs/arrangements*

____

4. **Benefits:** *Describe financial/health benefit status*

- Income/financial**:** ______________________________
- Health Coverage**:** ______________________________

Plan for applying for or reinstating health care and other benefits**:** ____________________

____

5. **Community Services Plan**

Services Coordinator name/agency: ______________________________

Phone & e mail contact: ______________________________

After hours/emergency contact: ______________________________

Services Coordination and Plan

Has Services Coordinator met with offender? Yes ☐ No ☐

Immediate post-release Services Coordination Plan: ______________________________

____

Medications & Psychiatry follow-up

Medications:

# of days of medications provided: ______________________________

Prescription(s) to be filled by date: ______________________________

Name/location of pharmacy: ______________________________

List of current medications and directions attached: Yes ☐ No ☐

Services Plan: mental health, substance abuse treatment and other services (Include peer recovery, support groups, etc.) *Describe:* ______________________________

Psychiatry:

Name of Provider: ______________________________

Appointment date: ______________ Contact information: ______________

Other services: *(service, program location, appointment information)*

- ______________
- ______________

Daily activity (Employment, job training, school, etc.) Describe: ______________________________

____

Healthcare *(Indicate any known health care providers and needs for follow-up referrals and appointments)*

- ______________
- ______________

6. Recovery Plan: Strengths, Triggers for relapse, Actions to Address Triggers

Strengths:

- ______________
- ______________

Triggers--Indicators of risk of relapse/crisis:

- ______________
- ______________

Actions to Address Triggers:

- ______________
- ______________

Other needs: *Indicate if the individual has needs or requires additional support re: family/ parenting role, etc. Describe:* ______________________________

Staff/Person(s) Completing the Final J/PDCRP

Name: ______________ Agency: ______________

Signature: ______________ Date: ______________

Individual to be Released

Name: ______________________________

I have discussed and agree with this plan for my release: Yes ☐ No ☐

I have discussed this plan: *(comment):* : ______________________________

Signature : ______________ Date: ______________

Appendix F: Counties with Collaborative Courts

California Counties With Collaborative Justice Courts as of July 28, 2014*

*California has more than 370 collaborative justice courts in 54 of its 58 counties. Collaborative justice courts are defined as those that have a dedicated calendar and judge and use a collaborative justice model (i.e., drug court model) that combines judicial supervision with social and treatment services to offenders in lieu of detention, jail, or prison. This includes using a multidisciplinary, nonadversarial team approach with involvement from justice system representatives, treatment providers, and other stakeholders. Data have been voluntarily provided by the courts in an ongoing effort to maintain a roster of all collaborative justice courts in California. This chart provides information on select collaborative justice courts that meet the above definition of collaborative justice court; not all court types may be represented here. There may be multiple courts of the same type within one county.

Superior Court of California, County of	COMMUNITY	DRUG - ADULT	DRUG - JUVENILE DELINQUENCY	DRUG - DEPENDENCY	DUI	ELDER	HOMELESS	MENTAL HEALTH - ADULT	MENTAL HEALTH - JUVENILE	REENTRY	STAND-DOWN	TRUANCY	VETERANS	YOUTH/PEER
Alameda		X		X		X	X	X	X	X	X	X	X	X
Alpine														
Amador		X												X
Butte		X		X	X									X
Calaveras		X												
Colusa														
Contra Costa		X				X	X	X		X				
Del Norte		X												
El Dorado		X	X	X				X					X	X
Fresno		X	X	X		X		X	X		X			X
Glenn		X	X											
Humboldt		X					X		X					X
Imperial														
Inyo		X												
Kern		X					X							
Kings		X											X	
Lake			X	X										
Lassen		X												X
Los Angeles	X	X	X	X			X			X			X	X
Madera		X												
Marin	X	X	X					X						X
Mariposa		X												
Mendocino		X	X	X										X
Merced		X	X	X				X						

Superior Court of California, County of	COMMUNITY	DRUG - ADULT	DRUG - JUVENILE DELINQUENCY	DRUG - DEPENDENCY	DUI	ELDER	HOMELESS	MENTAL HEALTH - ADULT	MENTAL HEALTH - JUVENILE	REENTRY	STAND-DOWN	TRUANCY	VETERANS	YOUTH/PEER
Modoc		X	X	X										
Mono														
Monterey		X	X					X	X		X			
Napa		X	X	X				X						X
Nevada		X	X		X		X	X						X
Orange	X	X	X		X		X	X				X	X	X
Placer		X	X				X	X					X	X
Plumas		X												
Riverside		X		X				X					X	X
Sacramento		X	X	X				X		X	X	X	X	
San Benito		X												
San Bernardino		X	X					X	X				X	X
San Diego		X	X	X			X	X	X	X	X		X	X
San Francisco	X	X	X	X				X		X [44]	X	X	X	
San Joaquin		X		X	X		X	X		X				
San Luis Obispo	X	X	X	X				X					X	
San Mateo		X	X					X					X	X
Santa Barbara		X	X	X			X	X		X			X	X
Santa Clara	X	X	X	X			X	X	X	X			X	
Santa Cruz		X	X	X										X
Shasta		X	X					X		X				X
Sierra		X												
Siskiyou		X	X	X										
Solano		X	X										X	
Sonoma		X		X	X			X						X
Stanislaus		X	X					X						X
Sutter		X												
Tehama		X		X										X
Trinity														
Tulare		X						X					X	X
Tuolumne		X		X										X
Ventura	X	X	X	X		X	X	X	X	X	X		X	X
Yolo		X						X			X		X	
Yuba		X												

[44] San Francisco has a juvenile reentry court, no adult reentry

JUDICIAL COUNCIL OF CALIFORNIA

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MEMORANDUM

Date
September 25, 2015

To
Mental Health Issues Implementation Task Force Members

From
Hon. Richard J. Loftus, Jr.
Superior Court of California, County of Santa Clara

Subject
Sunset of the Mental Health Issues Implementation Task Force

Action Requested
Please Review

Deadline
September 29, 2015

Contact
Carrie Zoller
Supervising Attorney
415-865-8829 phone
415-865-7217 fax
carrie.zoller@jud.ca.gov

Summary

In January 2012, Chief Justice Tani Cantil-Sakauye appointed the Mental Health Issues Implementation Task Force (Implementation Task Force) to review the 137 recommendations of the Task Force for Criminal Justice Collaboration on Mental Health Issues (TFCJCMHI) and to develop a plan for implementing the recommendations of that report. As such, the Implementation Task Force developed a blueprint for effectively addressing mental health issues in criminal cases to improve outcomes in those cases. It also became apparent during the work of the task force that, in addition to criminal justice cases, mental health issues need to be addressed in a wide range of case types across the court system. Having developed a blueprint for mental health cases in criminal justice, there is now an identified need for a blueprint to address mental health issues across a broad range of case types in the court system, including conservatorship and guardianship cases, unlawful detainer and civil harassment cases, family law and child custody cases, family violence cases, cases involving veterans, and juvenile dependency and delinquency cases. The term of the Implementation Task Force is ending on

December 31, 2015 and the Implementation Task Force is submitting a report on its work. As detailed in the report, while significant progress has been accomplished since the Implementation Task Force's inception, there are still unresolved challenges for the courts when handling cases involving persons with mental illness, and the issue of continuing the efforts to improve case processing for matters involving court users with mental illness needs to be addressed. It is recommended that the Probate and Mental Health Committee expand its membership to include additional members with expertise in mental health, utilizing a co-chair model with one chair responsible for Probate issues and one for Mental Health issues.

Recommendation

It is recommended that the Judicial Council receive the final report of the Mental Health Issues Implementation Task Force. As detailed in that report, while the Implementation Task Force achieved significant success in its initial work addressing the recommendations, additional work to improve the California court system for cases involving persons with mental illness still needs be done. In order to help meet the on-going and emerging needs of the courts, it is recommended that the Probate and Mental Health Advisory Committee's membership be increased to include additional members with expertise in mental health; that the work of the Implementation Task Force be integrated into the work of the Probate and Mental Health Advisory Committee; and that this expanded committee work with an inter-committee collaborative made up of representatives of other interested and appropriate Judicial Council advisory committees to serve as the ongoing body providing oversight and coordination of work on mental health issues affecting the courts.

The charge of the Probate and Mental Health Advisory Committee is to make ". . . recommendations to the council for improving the administration of justice in proceedings involving: (1) Decedents' estates, trusts, conservatorships, guardianships, and other probate matters; and (2) Mental health and developmental disabilities issues." (California Rules of Court, Rule 10.44. See attached.) Thus far, the focus of this advisory committee has been primarily on the first part of their charge.

With the Implementation Task Force concluding, there is a unique opportunity to increase the focus and work done in the areas of mental health and developmental disabilities by utilizing existing resources. It is recommended that some of the members of the Mental Health Issues Implementation Task Force be appointed to the Probate and Mental Health Advisory Committee. This would take advantage of the expertise of the Implementation Task Force members and help maintain the momentum of the critical work that the Implementation Task Force is doing. It would also be an effective and efficient way to help the Probate and Mental Health Advisory Committee meet all the requirements of Rule 10.44, and it will provide much needed support to the courts in their efforts to meet the challenges posed by court users with mental illness. Rule

10.44 does not establish a maximum number of positions on the Probate and Mental Health Advisory Committee, thereby it currently allows flexibility for expanding the membership. However, modifying Rule 10.44 might be considered at a later date as that will allow for codification of the expanded membership as well as a reconsideration of the other committees with whom the Probate and Mental Health Advisory Committee coordinates activities and work.

If the work of the Implementation Task Force is folded into the existing advisory committee, it is anticipated that the Probate and Mental Health Advisory Committee would utilize a division of labor based upon subject matter expertise. Specifically, it is recommended that:

1. Four to six new committee member positions be established on the Probate and Mental Health Advisory Committee for work focusing on the area of mental health and developmental disabilities. Modification to the rule to reflect this expanded membership may be considered at a future time. Current Implementation Task Force members should be made aware of the ability to apply to be committee members.

2. In addition to the current chair who focuses primarily on probate, a co-chair or vice-chair be appointed out of the committee membership to lead the mental health and developmental disabilities portion of the committee.

3. Other Judicial Council advisory bodies that address areas significantly impacted by mental health issues, including Criminal Law Advisory Committee, Family and Juvenile Law Advisory Committee, and Collaborative Justice Courts Advisory Committee, should consider appointing a liaison from their membership to collaborate with other committee liaisons to serve as the body providing oversight and coordination of the work in this area. It is also recommended that at least two members that have mental health expertise be appointed to each of those committees, and that the Implementation Task Force members be encouraged to apply for those positions. It is also recommended that the existing efforts of the Criminal Law Advisory Committee related to forensic mental health be enhanced.

4. Where it is more appropriate for a different advisory committee to take the lead in implementation efforts for any particular area or recommendation, a liaison from the Probate and Mental Health Advisory Committee, as well as liaisons from any other appropriate Judicial Council advisory bodies, be provided an opportunity to collaborate on the work in that area. Specific committee work on recommendations should be determined as part of the Annual Agenda process for all committees.

5. Staff from the Center for Families, Children, & the Courts (CFCC) that had been supporting the work of the Implementation Task Force continue work in this area, staffing the Mental Health portion of the committee and working in cooperation with current Probate and Mental

Health Advisory Committee staff. This staffing model is similar to the joint staffing of the Collaborative Justice Courts Advisory Committee by staff from CFCC and the Criminal Justice Courts Services Office.

Previous Council Action

The Task Force for Criminal Justice Collaboration on Mental Health Issues was established in 2008 as a Chief Justice led initiative that was part of a national project of the Council of State Governments. The project was designed to assist state judicial leaders in their efforts to improve responses to people with mental illnesses in the criminal justice system. The TFCJCMHI was charged with exploring ways to improve practices and procedures in cases involving adult and juvenile offenders with mental illness, to ensure the fair and expeditious administration of justice, and to promote improved access to treatment for defendants with mental illness. The TFCJCMHI developed 137 recommendations designed to improve outcomes for offenders and other individuals with mental illness in the justice system and presented these recommendations to the Judicial Council. The Judicial Council received the final report on April 29, 2011, and at that time requested that the Chief Justice appoint an implementation working group. In January 2012, Chief Justice Tani Cantil-Sakauye appointed the Mental Health Issues Implementation Task Force, chaired by Hon. Richard J. Loftus, Jr., Judge of the Santa Clara Superior Court, to review the recommendations of the TFCJCMHI and to develop a plan for implementing the recommendations of that report.

The Mental Health Issues Implementation Task Force was charged with:

1. Identifying recommendations under Judicial Council purview to implement;
2. Identifying potential branch implementation activities; and
3. Developing a plan with key milestones for implementing the recommendations.

The Implementation Task Force will sunset December 31, 2015.

Rationale for Recommendation

Although the Implementation Task Force is scheduled to end, local courts are still facing unique challenges when handling cases involving court users with mental illness. Seventy-four of the TFCJCMHI's recommendations address judicial involvement on either the local or branch-wide level. Of those recommendations, approximately half either have been accomplished or have had significant progress made towards achieving their goal. However, even the recommendations that are substantially underway still require additional support and task force member guidance in order to accomplish their objectives. These recommendations include:

- Enhancing judicial and justice partner education;
- Finalizing an online site for judicial officers that will include tools such as scripts and reference materials;
- Continuing work on legislation concerning competency of youth in juvenile delinquency proceedings; and,
- Completing mental health court research projects that are in process.

Some other recommendations, such as drafting proposed legislation regarding joinder of parties in LPS conservatorship matters and amending a Rule of Court to include additional information in trial competency reports, were identified priorities but remained unaddressed due to time and resource constraints. Moreover, emerging issues, such as the realignment of Health and Human Services, criminal justice realignment, expanding awareness of juvenile and family issues involving mentally ill persons in the courts, reentry, homelessness, veterans issues, and implications of the Affordable Care Act, have created new areas of concern to the courts and new opportunities for resources and to improve services, which were not considered in the original TFCJCMHI report.

The Implementation Task Force identified the need for a coordinating body to serve as the lead on ensuring the continued implementation of the recommendations. The Implementation Task Force saw one of the roles of this collaborative to be helping facilitate and coordinate the work of any other committees involved in implementing the recommendations. This need was based on the Implementation Task Force's observation that mental health issues in the courts are, like domestic violence, cross cutting with impacts that interface across the entire court system. For instance, a mentally ill or developmentally disabled adult child may reside with an elder who develops a mental or physical impairment. This scenario can result in conservatorship filings on either the adult child or the elder, and in some circumstances, such as where elder abuse is involved, criminal proceedings may be implicated. Similarly, a guardianship case may involve a child of a mentally ill parent who may also have children in dependency or delinquency court as well as a case in criminal or family court. The Implementation Task Force observed that there are many examples of cases that are cross-cutting and that the case interface may be consecutive, concurrent, or occurring at different points in time. Case types in which mental health issues were identified and discussed by the Implementation Task Force include probate guardianships and conservatorships, juvenile dependency and delinquency, criminal, family, housing, and civil harassment and domestic violence, as well as others.

Comments, Alternatives Considered, and Policy Implications

Alternatives the Implementation Task Force previously considered for moving forward included sunset of the Implementation Task Force without assigning ongoing work to a committee. The Implementation Task Force members strongly indicated that the scope of the follow-up work

required coordination by an ongoing body, and that the work required expertise across the full range of case types in the court system.

The Implementation Task Force also considered whether a new Mental Health Advisory Committee was needed because of the identified scope of the outstanding and emerging issues. However, this proposal was not recommended because of the existence of the Probate and Mental Health Advisory Committee, whose scope and membership could be expanded with less cost and greater efficiency.

Likewise, the proposal of assigning the work to other advisory committees involved in case types that include mental health issues or identifying another committee, such as the Collaborative Justice Courts Advisory Committee as the primary site for the on-going work, was also considered. However, the need to coordinate across case types might be lost unless a single entity with a primary mental health focus was identified to provide such coordination.

As noted above, much of the pending work involves issues which involve more than one case type, making it impractical to try to carve out a single advisory body to take responsibility for decision making. In instances involving substantial cross-court impacts, determining how to address these issues would be better served by having them examined by dedicated committee members from several advisory committees who represent a broad range of expertise and experience and who have extensive knowledge and experience in the area of mental health. Moreover, committee members with a strong focus on mental health are more likely to become aware of and anticipate emerging issues that will affect court case processing. The Implementation Task Force did indicate a need to include task force members or other members with mental health related expertise on several Judicial Council advisory committees, such as the Family and Juvenile Law Advisory Committee, Criminal Law Advisory Committee, and Collaborative Justice Courts Advisory Committee, in addition to the expanded Probate and Mental Health Advisory Committee. Liaisons from these advisory committees could be appointed to an inter-committee collaborative that would serve as the ongoing body to provide oversight and coordination of work impacting mental health issues in a broad range of case types across the courts.

Implementation Requirements, Costs and Operational Impacts

The recommendation will require expansion of the membership of the Probate and Mental Health Advisory Committee, without additional costs for staffing, in that the current Implementation Task Force staff in CFCC will staff the mental health work of the Probate and Mental Health Advisory Committee with the probate related work to be staffed by current committee staff. There will be minimal increased cost from addition of six members to the Probate and Mental Health Advisory Committee, although there are external funding sources related to mental health projects that can absorb those costs. Overall, the recommendation is the

most cost effective and operationally neutral of all proposed alternatives for addressing the need for follow-up work in the area of mental health issues in the courts.

Mental Health Protocols for California Courts

A Guide for Implementing California Rule of Court 10.951 (c), (d) and 10.952

California Rule of Court 10.951 (c), (d)
(c) Mental health case protocols
The presiding judge, supervising judge, or other designated judge, in conjunction with the justice partners designated in rule 10.952, is encouraged to develop local protocols for cases involving offenders with mental illness or co-occurring disorders to ensure early identification of and appropriate treatment for offenders with mental illness or co-occurring disorders with the goals of reducing recidivism, responding to public safety concerns, and providing better outcomes for those offenders while using resources responsibly and reducing costs.

(d) Additional judges
To the extent that the business of the court requires, the presiding judge may designate additional judges under the direction of the supervising judge to perform the duties specified in this rule.
(Subd (d) relettered effective January 1, 2014; adopted as subd (c).)
Rule 10.951 amended effective January 1, 2014; adopted as rule 227.2 effective January 1, 1985; previously amended and renumbered effective January 1, 2007; previously amended effective January 1, 2008.

Rule 10.952. Meetings concerning the criminal court system
The supervising judge or, if none, the presiding judge must designate judges of the court to attend regular meetings to be held with the district attorney; public defender; representatives of the local bar, probation department, parole office, sheriff department, police departments, and Forensic Conditional Release Program (CONREP); county mental health director or his or her designee; county alcohol and drug programs director or his or her designee; court personnel; and other interested persons to identify and eliminate problems in the criminal court system and to discuss other problems of mutual concern. Rule 10.952 amended effective January 1, 2015; adopted as rule 227.8 effective January 1, 1985; previously amended and renumbered effective January 1, 2007; previously amended effective January 1, 2014.

These Rules of Court not only make it clear that judges have the responsibility for the oversight and placement of individuals with mental illness who appear in their courts but also provide a mechanism for assisting judges with this responsibility. When bringing together the criminal justice and behavioral health partners noted in Rule of Court 10.952, California courts have the opportunity to address the issue of offenders with mental illness in the criminal justice system. Although only 5.7 percent of the general population has a serious mental illness,[1] 14.5 percent of male and 31 percent of female jail inmates have a serious mental illness.[2] Similar to jail populations, approximately 23 percent of California's prison inmates have a serious mental illness.[3] It is noted that inmates with serious mental illness often need the most resources and can be the most challenging to serve while incarcerated.[4]

Of special concern to the courts is the fact that persons with mental illness are also overrepresented in the courtroom. One study found that 31 percent of arraigned defendants met criteria for a psychiatric diagnosis at some point in their lives and 18.5 percent had a current diagnosis of serious mental illness.[5] In many instances, the traditional adversarial approach is ineffective when processing cases in which the defendant has a mental illness. Connecting the defendant to mental health treatment and support services is often essential to changing behavior and reducing recidivism. This, in turn, may require courts to adopt new collaborative approaches in working more closely with criminal justice partners and other community agencies if outcomes for offenders with mental illness are to be improved.

This Guide for Implementing California Rule of Court 10.951 (c) and 10.952 has been designed by the

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[1] Ronald Kessler, Wai Tat Chiu, Olga Demler, and Ellen Walters, "Prevalence, severity, and comorbidity of twelve-month DSM-IV disorders in the National Comorbidity Survey Replication (NCS-R)," *Archives of General Psychiatry* 62(6) (2005), pp. 617–627.
[2] Henry J. Steadman, Fred C. Osher, Pamela C. Robbins, Brian Case, and Steven Samuels, "Prevalence of Serious Mental Illness among Jail Inmates," *Psychiatric Services* 60 (2009), pp. 761–765.
[3] Per e-mail correspondence with Division of Correctional Health Care Services, California Department of Corrections and Rehabilitation, May 24, 2009.
[4] Treatment Advocacy Center and the National Sheriffs' Association, *More Mentally Ill Persons Are in Jails and Prisons Than Hospitals: A Survey of the States* (May 2010).
[5] Nahama Broner, Stacy Lamon, Damon Mayrl, and Martin Karopkin, "Arrested Adults Awaiting Arraignment: Mental Health, Substance Abuse, and Criminal Justice Characteristics and Needs," *Fordham Urban Law Review 30* (2002–2003), pp. 663–721.

members of the Mental Health Issues Implementation Task Force to assist presiding and supervising judges of the criminal divisions of California courts develop local guidelines and protocols for responding to the challenges posed by individuals with mental illness who appear as defendants in criminal courts statewide and builds upon the recommendations of the Task Force for Criminal Justice Collaboration on Mental Health Issues presented to the Judicial Council in April 2011.

Key Steps in Developing Local Protocols

During the regularly scheduled meetings with criminal justice and mental/behavioral health partners, discuss with the following issues.

1. Do custodial officers who oversee mentally ill prisoners in the jail have Crisis Intervention Training (CIT)? How are prisoners with mental illness treated in jail? Are they segregated or put the general population? Is there a special treatment unit in the jail? Have any particular problems been noted when dealing with prisoners with mental illness in the jail? Are prisoners with mental illness receiving their usual medications while in jail (if taking medication on a regular basis)? Are offenders who are mentally ill and in custody being given a supply of medication(s) upon release from jail? Are they given a prescription for medication(s)? Where is the nearest pharmacy that will fill this prescription and when is it accessible? Is it near public transportation? Getting medications? Is there continuity of care for both medical and mental health services including medications once released from jail? Who is responsible for following up to confirm adherence to the plan? Who oversees the continuity of care plan and updates it as necessary?

2. Does the probation department take into account an offender's mental illness when making disposition recommendations? *If yes, please answer the following questions.*

    - What training is given to probation officers who supervise the mentally ill so that those offenders are not placed on unreasonable terms of probation?

    - Are probations with mental illness being "violated" based on terms and conditions of probation that are unreasonable given their illness? ("Unreasonable" being defined as terms that a mentally ill offender cannot satisfy)?

3. Does this county/court have a problem with admission to the Department of State Hospitals for restoration to competency services*? If yes, please answer the following questions.*

    - How long does an incompetent defendant wait to be transported to the state hospital for treatment to restore competence?

    - Is there a way to expedite the transportation of the incompetent to stand trial to the state hospitals?

    - Does your court address delays in the same way across the board/in every location? If not, why not?

    - Is there an option for developing local competency restoration programs?

    - Does the jail or some local mental health agency in your county prepare a discharge plan for those defendants who are released after being found incompetent to stand trial?

    - Is there a protocol in your county by which the public guardian is advised by jail authorities of those defendants who may be suitable for LPS proceedings?

4. What training are your judges getting with respect to resources in the community as options for sentencing or conditions of diversion?

5. Once issues in your county are identified, a schedule for continuing review should be established: i.e. monthly or bi-monthly meetings, written reports, annual audits, etc. In addition, judges and criminal justice and mental health partners should maintain a current list of community based organizations (CCBOs) available in your community to provide services to persons with mental illness or co-occurring disorders. Additional questions: Who maintains the list? To whom is the list distributed? How frequently it is updated? Does the presiding judge of supervising judge of the criminal division of the court have access to this list and is he/she on the distribution list for updated information?

6. Other: you may find your county's collaborative partners may have other questions as you work together to fashion a local response for addressing the needs of persons with mental illness in the criminal justice system or at high risk of recidivism.

Mental Health Courts[6]

Once concerns and issues have been identified related to addressing challenges related to offenders with mental illness in the criminal court system, many courts and local criminal justice and mental/behavioral health partners have worked together to develop and implement Mental/Behavioral Health Courts for both misdemeanants and felons addressing issues related to recidivism reduction and improving overall outcomes for offenders with mental illness. In some instances, defendants in criminal court may also be involved in other court case types including cases in family and dependency courts and improved outcomes in the criminal court may favorably impact outcomes in other court case types as well.

Key Steps and Planning Process

Planning is key to developing a successful justice system response to the problems that often result in recidivism and treatment failure. Many courts find that they can build upon the success of pre-existing collaborative courts, including drug and/or veterans' courts, while others find that they can build upon other types of local collaborative partnerships. Key steps in the planning effective and evidence based responses to the problem are outlined below.

1. ***Develop a core mission and goal statement. Goals need to be practical, specific and measurable.***
Goals may include reducing the number of jail bed days, reducing occurrence or frequency of new offenses, reducing psychiatric inpatient bed days, reducing days of homelessness or life on the streets, increasing treatment compliance, achieving a more consistent level of sobriety (if applicable), increasing pro-social activities, and resolving outstanding legal issues.

2. ***Define team member roles.***
Teams typically are comprised of the judge, mental/behavioral court coordinator, mental health forensic supervisor, case manager(s), court probation officer(s), court district attorney, court defense counsel, county sheriff's office, and community treatment provider(s). Each team member has a specific role and responsibilities to the individual participant and to the team.

3. ***Develop participant eligibility requirements.***
These might include all or some of the following: the type of diagnosis, impairment levels, eligibility to have an assigned case manager, receiving psychiatric treatment and medication for his/her disorder, eligibility for

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[6] This guide for addressing the needs of offenders with mental illness in the courts is based on the Behavioral Health Court design developed by the Superior Court of California, County of Santa Cruz with additional input from the members of the Judicial Council's mental Health issues Implementation Task Force in September 2015.

county Medi-Cal (or other insurance), and being subject to formal probation terms. Although clients/participants must meet all or most of the diagnostic, functional and criminal justice requirements, participation is voluntary.

4. ***Develop and outline referral process guidelines.***
Develop or approve forms for mental/behavioral health court use including the following: Consent for Release of Confidential Information, Sample Treatment Plan, Jail and Probation Discharge Forms, Certificates, and other forms/documents that may assist in the processing of referrals, intake, or discharge.

5. ***Address confidentiality and information sharing issues.***
Determine how information will be shared among team members and for what purposes. Identify information that cannot or should not be expected to be shared.

6. ***Develop standard terms of probation.***
While conditions of probation may vary, the mental/behavioral court should develop some standard probation terms that apply in most cases. These standard probation terms might include: complying with county mental health directives (program placement, approved house, work programs, support groups, and counseling).

Other directives might include medication adherence, abstaining from alcohol, intoxicants/controlled substances not prescribed by a medical doctor; submitting to regular testing for from alcohol, intoxicants/controlled substances; submitting to search and seizure of person, residence, vehicle and other areas under the client's domain without a warrant (including weapons if appropriate and determined by sentencing); signing a release of information/release of confidentiality.

7. ***Develop client requirements.***
Client requirements often include permission to share protected client information for use by mental/behavioral court team members. Generally, clients are subject to program requirements including adherence to mental health treatment recommendations, adherence to taking all psychotropic medications as prescribed, participation in residential treatment if recommended, compliance with drug and alcohol testing if appropriate, following all terms of probation, attending mental/behavioral health court as directed, fulfilling any community service requirements, and providing proof of treatment compliance as requested (proof of attendance, group sign-off sheets, etc.).

8. ***Outline team decision process and expectations.***
Team members may meet weekly, bi-weekly or monthly depending on the size of the program and, typically, will receive the treatment plan with updates noting program or concerns for each participant when on the calendar. Ideally this team meeting is in person but some courts handle this successfully through teleconference and/or videoconference meetings. The team decision-making process takes into consideration clinical needs while keeping community safety and victims' rights as a priority. Team decision approaches are typically collaborative and treatment oriented.

9. ***Develop treatment plan templates and expectations for completion.***
Treatment plan templates and commonly accepted expectations will be useful to clinical and probation staff for team during reviews prior to each staffing to discuss each participant's progress or areas of clinical/probation concern.

10. ***Develop commonly understood and agreed upon incentives and sanctions*****.**
Incentives might include verbal praise from the court, gift cards, applause, less restrictive treatment

recommendations, reduced frequency of court appearance, randomized incentives/prizes, certificates of completion, and graduation. In some jurisdictions, the court may suspend, reduce or convert fines and fees based on individual participation in the program. Support may be available for individualized pro-social activities or employment and community service house may be used as a means of paying off court ordered fines and fees.

Sanctions may include verbal reprimands from the court, more restrictive treatment recommendations, increased frequency of court appearances, drug testing, bench warrants, short-term remands, or termination from the mental/behavioral court and return to regular criminal court.

11. ***Develop a plan for responding to violations of probation.***
Allegations of probation violations are typically presented to the court as well as to counsel in written form along with written recommendations regarding the violation(s) and impact on the defendant's ability to continue participation in the program. The report also typically includes recommendations for the next steps in handling the defendant's case.

12. ***Develop Completion/Graduation Criteria.***
Typically a participant becomes eligible to graduate if he/she complies with his/her probation terms for the designated term and achieves his/her rehabilitative goals. The length of mental/behavioral court participation may vary depending on the term of probation, each individual's program needs and his/her ability to adhere to the treatment plans as well as his/her ability to achieve rehabilitative goals. Consideration for early termination may arise based on the participant's commitment and success in treatment and his/her ongoing needs.

13. ***Develop termination protocols.***
Participation in mental/behavioral health court is voluntary and the defendant may terminate his/her participation at any time. Typically, defendants who choose to terminate participation will have his/her case transitioned back to the department where the case originated. Termination may also be triggered by allegations of a new crime.

14. ***Identify additional resources that may be required.***
Additional resources may be needed by the team including assessment/treatment services for an individual who is in custody as well as for an individual who is out of custody. Create information cards for all team members and update as needed.

MENTAL HEALTH ADVISORY BOARD REPORT
A BLUEPRINT FOR CHANGE

JACKIE LACEY
District Attorney

August 4, 2015

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CRIMINAL JUSTICE MENTAL HEALTH ADVISORY BOARD REPORT

STATEMENT OF PURPOSE

In Los Angeles County, mentally ill offenders may be incarcerated in the county jail for significant periods of time. Many of these offenders also suffer from co-occurring substance abuse disorders and chronic homelessness. For lower-level crimes, when mental health treatment can appropriately take place somewhere other than the jail while preserving the safety of the public, continued incarceration may not serve the interests of justice. The jail environment is not conducive to the treatment of mental illness.

As stated in this Board's Motion, dated May 6, 2014, ***"Diversion can address the untreated mental illness and substance abuse that is often the root cause of crime. By providing appropriate mental health services, substance abuse treatment, and job readiness training, as well as permanent supportive housing when it is needed, the mentally ill are stabilized and less likely to commit future crimes."*** Such positive interventions can not only change the lives of mentally ill offenders but also others, including family members, victims whose future harms can be prevented and the community as a whole.

In addition to the ethical implications of incarcerating mentally ill offenders, there are also fiscal ones. Our jail is a scarce resource which must be used wisely to house those who pose a danger to public safety, or for whom incarceration is otherwise necessary and appropriate.

Our jail should not be used to house people whose behavior arose out of an acute mental health crisis merely because it is believed—whether correctly or otherwise—that there is no place else to take that person to receive treatment instead. Indeed, even in instances in which it could arguably cost more to divert such mentally ill persons from the jail, it is still the right thing to do.

Mental health diversion is not a jail reduction plan. Although a successful mental health diversion program could result in some reduced need for jail beds in years to come, there will always be a need for mental health treatment to take place within the jail. That is because offenders at all levels of the criminal justice continuum can find themselves afflicted by mental illness, including those charged with serious and violent crimes including the ultimate crime of murder. Due to the nature of charges pending and their level of dangerousness, violent offenders may need to be housed at the county jail while they receive mental health treatment. Indeed, under current jail conditions, those mentally ill offenders must be carefully handled and monitored to prevent them from posing a danger to themselves and other inmates while they are incarcerated.

Mental health diversion also must not come at the price of victims' rights. It is not just a priority, but a given, that the rights of victims will be preserved while efforts are being made to enhance mental health diversion.

Should any future reduction in the jail population occur as a result of the mental health diversion project, it would enable serious and violent felony offenders who are not mentally ill to serve a

longer percentage of their sentences. Such a result would enhance public safety, but would not reduce the need for jail beds.

In the criminal justice system, the term “diversion” is often used as a legal term of art to describe alternative programs which prevent someone from suffering a criminal conviction. This report uses the term “diversion” more broadly. As used in this report, diversion includes all circumstances ranging from pre-arrest to post-conviction, in which mentally ill persons can be prevented from entering the jail at all, can be redirected from the jail into treatment, or can receive linkage to services (during and after incarceration) to help prevent them from returning to custody.

Viewed through this lens, mental health diversion is not new, but is alive and well in Los Angeles County. For some years, various key individuals, public entities, and community based organizations have planned, developed, and implemented programs that prevent mentally ill individuals from being incarcerated and instead divert them into community-based mental health treatment. However, these efforts have often gone unrecognized, due to a lack of general knowledge. What is new is the current active collaboration and commitment to this project which is shared by all of the stakeholders. A spirit of communication, innovation, and enthusiasm exists for this project which is unprecedented. With the allocation of additional resources, our County will be able to improve upon what is already being done.

Progress is being made on the issue of how to most effectively divert mentally ill offenders from the jail, but it is a large task that will not happen overnight. The experiences of other large jurisdictions which have faced this problem have taught us that steady, incremental progress can and will work over time.

The District Attorney’s Office provides the following report regarding the continuing work of the Criminal Justice Mental Health Advisory Board, as directed by this Board’s Motion dated May 6, 2014. This report will discuss existing efforts, identify gaps in services and suggest priorities for how to improve mental health diversion efforts on an ongoing basis.

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/Arraignment; (3) Courts/Post-Arraignment/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).**

LOCAL STAKEHOLDER DISCUSSIONS AND THE SEQUENTIAL INTERCEPT MODEL

On May 28, 2014, a Countywide Mental Health Summit *(hereafter the "Summit")* was convened. Policy Research Associates was employed as a consultant to assess existing mental health resources in Los Angeles County, identify strengths and weaknesses, and help identify priorities for improvement.

Initial funding for the Summit was provided by the California Endowment and by the Aileen Getty Foundation, and it was hosted by the USC Gould School of Law. The Summit was attended by a myriad of stakeholders, including the District Attorney's Office, the Department of Mental Health ("DMH"), the Sheriff's Department ("LASD"), the Superior Court, the Public Defender's Office, the Alternate Public Defender's Office, the Probation Department, the Executive Director of the CCJCC, the Chief Executive Office, the Los Angeles Fire Department, the Los Angeles Public Health Department, the Los Angeles City Attorney's Office, the United States Attorney's Office, the Los Angeles County Mental Health Commission, the National Alliance on Mental Illness ("NAMI") and dozens of others.

On July 8 and 9, 2014, a smaller series of local stakeholder meetings took place (hereafter, the "Mini-Summit"). The Mini-Summit was convened so that further evaluation of existing mental health resources and recommendations for improvements to services could take place in a more focused setting.

During both the Summit and Mini-Summit, participants were introduced to the *"sequential intercept model"* of mental health diversion planning which has been successfully utilized in other jurisdictions, including Miami-Dade County, Florida. The sequential intercept model identifies all places or *"intercept points"* along the criminal justice continuum where contact with those who suffer from mental illness occurs and appropriate intervention can take place.

Because our system is so large and complex, there has necessarily been a high degree of specialization by individuals whose work takes place at completely different intercept points of this model. The sequential intercept model has clarified and focused local discussion and helped flush out interplay between the different decision points. *For example, a decision made regarding the length of custody imposed as part of a criminal sentence (such as 90 days versus 120 days in the county jail)* can legally foreclose certain public healthcare and housing benefits from being available to a person later upon their release, solely as a result of the length of time spent in custody. Learning more about this type of systemic interplay will help inform policy decisions made in the criminal justice system. The following is an introduction to the sequential intercept model.

❖ ***Intercept One: Law Enforcement/Emergency Services***

Intercept One is the first justice system contact with an offender, before an arrest. First contact may include a call to a 911 operator by a family member, an on-site evaluation by a paramedic, or a law enforcement response to a crime in progress. Pre-booking diversion is essentially an evaluation of whether a situation is truly criminal or non-criminal in nature,

and it occurs at Intercept One. If a person is diverted to treatment instead of jail at this intercept, there will be no arrest and no case will be presented to a prosecutor for consideration.

❖ ***Intercept Two: Post-Arrest/Arraignment***

After first contact, an offender is typically taken to the county jail. Next, the prosecuting agency decides whether to file criminal charges or decline charges. The period of time between an offender's arrest and their first appearance in court at arraignment is locally referred to as "second chance" diversion, because regardless of the original determination in the field, a prosecutor independently reevaluates whether an incident should be handled criminally or non-criminally.

If a prosecutor declines to file a criminal case, the person will be released, possibly without services. This lack of services is problematic, and possible solutions are being explored during ongoing discussions. If criminal charges are brought, the mentally ill offender appears in court at an arraignment, a criminal defense attorney is appointed or retained and a judge will either release a person on their own recognizance or set bail. Diversion at Intercept Two minimizes custody time, because it takes place early in the process, and may or may not include a criminal conviction. Not all offenders are suitable for diversion at Intercept Two, because less information is known at arraignment than later, and some decisions must be made more deliberatively.

❖ ***Intercept Three: Courts/Post-Arraignment/Alternatives to Incarceration***

If a criminal case is not resolved at arraignment, other court proceedings take place. Ultimately, a criminal case may resolve either by a dismissal, a guilty plea or a trial. A sentence may include a combination of custody and supervision.

Depending on the mental health and criminogenic factors involved, some offenders will need the structure provided by formal supervision in order to be successfully diverted from custody. Thus, a dismissal will not be suitable in every case. Instead, diversion efforts at this intercept can also employ alternatives to incarceration as a sentencing choice upon conviction. Within Intercept Three, there is also a special class of offenders who are so acutely mentally ill that they are declared incompetent to stand trial. When that happens, criminal proceedings are suspended and jurisdiction transfers to the Mental Health Court, Department 95. Offenders who are incompetent to stand trial present unique issues which are distinct from other mentally ill offenders.

❖ ***Intercept Four: Community Reentry***

Whether a person is criminally convicted or not, if they are taken into custody, at some point they will be released back into the community. Appropriate discharge planning, including jail "in-reach" efforts, can greatly assist in successful reentry.

Intercept Four issues include where a person will live, whether they will be able to support themselves, what access to mental health and other health services they will have, whether

or not they will be supervised by the criminal justice system and the like. For example, if a person is receiving medication, a plan should be put into place so that they are linked with mental health services and their course of medication can continue uninterrupted.

❖ ***Intercept Five: Community Support***

This Intercept focuses on the person’s continued and permanent access to resources, after the transition from jail to the community. Ongoing peer and family support are important.

The need for permanent supportive housing is another significant policy issue, which will be discussed separately in this report. Although transitional housing can help get a person back on his or her feet, some mentally ill offenders will need more assistance than transitional services can provide. Appropriate needs evaluations can assist in determining the need for more permanent resources.

Using the sequential intercept model, existing programs and priority needs were incorporated into the Policy Research Associates report, which is attached as Attachment 1. Those priorities have continued to inform further discussion during Criminal Justice Mental Health Advisory Board meetings, which have addressed issues relating to each of the intercept points.

CRIMINAL JUSTICE MENTAL HEALTH ADVISORY BOARD AND WORKING GROUPS

Since the District Attorney provided her interim report to this Board on November 12, 2014, she has led the Criminal Justice Mental Health Advisory Board *("Advisory Board")* as the chair of monthly stakeholder meetings. The Advisory Board collaboration has produced significant early successes.

First, a new court diversion pilot project was created at the San Fernando and Van Nuys courts, the Third District Diversion and Alternative Sentencing Pilot Project *("Third District" project)*. The Third District project can assist up to 50 criminal defendants at a time who are chronically homeless and suffer from a serious mental illness. This program is based on the "Housing First" model, which provides supportive housing first, thereby creating an environment conducive to treatment for individuals to combat their mental illnesses and co-occurring substance use disorders. The Housing First model motivates offenders to succeed, because they want to keep the housing provided through the program rather than return to the streets.

Eligible crimes for the Third District program include both misdemeanors and felonies. Defendants charged with misdemeanors earn a full dismissal of their charges following successful completion of a 90 day diversion program, without having to plead guilty. For felony crimes, a defendant must initially enter a plea of guilty or no contest and complete an 18-month program; upon successful completion, an offender earns early termination of probation and dismissal of charges. This ongoing pilot project was a collaboration between the Department of Mental Health, District Attorney, Public Defender, Alternate Public Defender, Indigent Criminal Defense Appointments Program, Los Angeles City Attorney's Office, Superior Court, Probation Department, Department of Public Health, LASD, San Fernando Valley Community Mental Health Center and Department of Veteran's Affairs. In June, 2015, the stakeholders met once again to refine the selection criteria for the program in order to serve more participants.

Also in June, 2015, Los Angeles County was awarded a competitive Mentally Ill Offender Crime Reduction ("MIOCR") grant for $1.8 million dollars. This grant will address the problem of "offender tri-morbidity" by diverting these at-risk offenders from custody. Tri-morbid offenders have three factors which can lead to their early demise: They are mentally ill, suffer from substance abuse and are medically fragile.

The MIOCR grant proposal submitted by Los Angeles was ranked first among all of the jurisdictions which competed for funding. Perhaps the greatest strength of the Los Angeles County grant proposal was the extensive collaboration which went into it. The District Attorney's Office applied for the grant as the lead department on behalf of the collaborative team. The Board of State and Community Corrections ("BSCC") has provided a contract which was received and executed by the District Attorney's Office in accordance with the July 1, 2015 implementation date.

The Advisory Board is currently meeting every other month in order to more effectively deploy and support specialized Working Groups. These Working Groups are practical problem-solvers whose subject areas were deemed worthy of further study in detail. The Working Groups are dynamic in nature, and will evolve over time as current problems are solved and new ones are identified.

❖ ***Law Enforcement Working Group.* (Intercept One)**

This group is chaired by Chief Jim Smith of the Monterey Park Police Department. The Law Enforcement Working Group has developed training for first responders, who include law enforcement officers, dispatch employees, fire department personnel and others. The training is modeled after the Crisis Intervention Team Training ("CIT") model which originated in Memphis, Tennessee. The Law Enforcement Working Group has made substantial progress on CIT training over the past year, which will be discussed separately in this report.

❖ ***Community Based Restoration Working Group.* (Intercept Three)**

The Community Based Restoration Working Group ("Restoration Working Group") is chaired by Judge James Bianco, who is the bench officer assigned to Department 95, Mental Health Court. The Restoration Working Group convened to consider treatment options for offenders who are mentally incompetent to stand trial. These offenders are often actively psychotic, cannot care for themselves, and have been found incompetent to stand trial because their mental illness is so acute that they cannot understand the nature of the criminal charges against them or rationally assist their defense attorneys.

In particular, the Restoration Working Group has focused on the population of misdemeanor incompetent to stand trial ("MIST") defendants. There are currently a total of about 130 MIST defendants in the county jail. The MIST population is a priority because these offenders are being held on misdemeanor charges and but for their mental illnesses, would likely have already completed their criminal cases and been released. On the other hand, criminal charges cannot simply be dismissed for a variety of legal and practical reasons.

The Restoration Working Group is piloting an ambitious project to divert up to 100 MIST defendants from the jail for treatment in the community. At this time, appropriate residential treatment beds are being identified and an individualized plan is being created for each MIST offender, depending on their needs. However, due to the nature of this population, there may not be an appropriate treatment setting for each of these offenders, who require extensive care and monitoring.

The Restoration Working Group will explore whether it would be feasible to place some of these MIST defendants into a skilled part nursing facility, which is a facility akin to a nursing home, but for persons who are anticipated to recover. Los Angeles County does not currently have any skilled part nursing facilities. At this time, it is not yet known if there is a sufficient population which would need such a facility to justify the creation of one in our County.

❖ ***Criminal Justice Working Group.* (Intercepts Two and Three)**

The Criminal Justice Working Group is chaired by Judge Scott Gordon, who is the Assistant Supervising Judge of the Criminal Division. The Criminal Justice Working Group was formed to address court and jail-related issues.

Initially, the group will design a pilot project to divert up to 100 defendants from the county jail into community based treatment options as alternative sentencing. In contrast to the MIST defendants, who are under the jurisdiction of the Mental Health Court, the Criminal Justice Working Group will focus on defendants who remain under the direct jurisdiction of the criminal courts.

The Criminal Justice Working Group will also address justice stakeholder training for prosecutors, defense attorneys and others in the justice system— even judges. These training recommendations will educate stakeholders regarding the benefits of mental health diversion, legal issues, available resources and the like. The Criminal Justice Working Group will also consider related issues such as victims' rights. It is anticipated that the Criminal Justice Working Group will provide a ready forum to address any local procedural or policy issues regarding case processing which will arise during all phases of the mental health diversion project on an ongoing basis.

- ***Treatment Options and Supportive Services Working Group.* (Intercepts One through Five)**

The Treatment Options Working Group is chaired by Flora Gil Krisiloff, Department of Mental Health. It will seek to maximize the use of existing treatment resources and to develop new options in the future.

Available treatment resources are a universal need which is critical for successful diversion efforts at every intercept point. Los Angeles County does not simply need "more beds" but rather, the right kind of beds in the right combination to serve a mentally ill offender population which is very diverse in its needs. Notwithstanding that diversity, the Treatment Options Working Group will identify common problems which are amenable to solution.

The Treatment Options Working Group will consider treatment options broadly, both in the jail as well as upon reentry. This discussion will include the intersection of mental health, substance abuse and the need for supportive housing. One idea to be explored is the development of multi-disciplinary teams to ensure the delivery of integrated services to homeless and mentally ill clients. The Treatment Options Working Group will be empowered to generate recommendations for best practices.

- ***Pre-Booking Diversion Working Group.* (Intercept One)**

The Chair of this group is to be determined. The Pre-Booking Diversion Working Group will address practical issues regarding how offenders can appropriately be selected for pre-booking diversion rather than brought to jail. The Pre-Booking Diversion Working Group will also examine the "second chance" time period for diversion after booking, but before criminal charges have been filed.

This discussion will be more nuanced than merely creating a list of criminal offenses that are either included or excluded for diversion, even if that could be definitively done. Some individualized evaluation of each offender must necessarily take place, such as what circumstances brought them to the attention of law enforcement, the severity of their mental

illness, whether they have housing and available support persons, and the like. The Pre-Booking Diversion Working Group will generate protocol recommendations and discuss strategies for success based on all of the relevant factors.

The Pre-Booking Diversion Group will also critically examine how and why welfare related calls which are initially non-criminal in nature can transform, resulting in a county jail booking and criminal case. Successfully preventing entry into the jail at this intercept point could reduce the incompetent to stand trial population in the jail, and in particular, the MIST population who are booked on misdemeanor charges and can remain in the jail for some time.

- ***Data and Systems Connectivity Working Group.* (Intercepts One through Four)**

This group is chaired by Todd Pelkey, who is the Chief of the District Attorney Systems Division. The Systems Working Group will discuss data collection and data sharing issues, including appropriately maintaining privacy and patients' rights.

Systems solutions can help create better linkage to available services. "Linkage" means more than simply making an appointment. For example, after incarceration, the treatment provider who receives the client needs information about the treatments which were provided to the client while incarcerated, in order to avoid unnecessary duplication and give the person what they need. Equally important, upon return to jail, knowledge about a client's recent clinical history can potentially reduce risk and speed the delivery of services.

In our County, the Sheriff's Department, Probation Department and Department of Health Services all use Cerner Health Information Systems. The Cerner Hub is software which can facilitate transparent exchange of clinical information between participating implementation sites. Netsmart, the health information vendor for the Department of Mental Health, is currently involved in discussions with Cerner to enable Netsmart systems to participate in health information exchange through the Cerner Hub. If successfully deployed, Los Angeles would be among the first sites to use this approach in production. Adding DMH to the Cerner Hub community would greatly simplify the task of coordinating care for clients shared among the participating departments.

By early 2016, the Department of Health Services will complete its implementation of the Online Read-time Centralized Health Information Database ("ORCHID"). ORCHID is an electronic health record system which provides a unique identifier for each patient to track his or her services throughout the clinical specialties and patient care venues. ORCHID is built on a platform that will also be used by the Sheriff's Department Medical Services Bureau and the Probation Department's Juvenile Health Services, to enable real-time access to patient records for their shared patients. In a separately pending motion, this Board is considering whether it would be better to pursue system linkage solutions or to integrate all electronic health record systems into a single platform.

The Systems Working Group will also consider possible use of the Justice Automated Information Management System ("JAIMS"), which was developed after the enactment of AB 109, to possibly store or share anonymized data related to mental health diversion.

Perhaps the most important topic to be discussed by the Systems Working Group will be how data collection and data sharing will inform evidence-based practices. Over the long term, data regarding mental health diversion will be crucial, in order to record what is being done here and preserve it for analysis by outside experts. Indeed, our ongoing mental health diversion efforts must be data driven so that we can quantify our successes, identify trends and learn from our experiences. It is anticipated that in the future, the Systems Working Group will be able to identify systems related gaps which could be remedied by additional fiscal resources.

- ***Long Beach Mental Health Diversion Working Group.* (Intercepts One through Five)**

This group is chaired by Kelly Colopy, who is the Director of the Long Beach Department of Health and Human Services. The Long Beach Working Group was convened to discuss issues specific to Long Beach, which is the second largest city in the County. The group will create and launch a Long Beach pilot project, which is especially appropriate because Long Beach has its own Police Department, City Prosecutor, and Health and Human Services Department. There are 88 municipalities within the County of Los Angeles, and each of these locations feeds mentally ill offenders into the county jail. Therefore, the experiences of cities such as Long Beach are important to the overall mental health diversion project.

CRISIS INTERVENTION TEAM ("CIT") TRAINING

Training is currently the single most important priority, because change cannot be effectuated without it. Law enforcement training will raise awareness of and sensitivity to mental health issues, and provide law enforcement officers with concrete tools to interact more effectively and compassionately with mentally ill persons in the field.

There are several benefits to Crisis Intervention Team training ("CIT" training). First, educating law enforcement officers about community based treatment options will encourage them to use those options instead of booking mentally ill persons into the jail. Skills training in field interactions—in particular, how to defuse potentially violent situations—makes these encounters safer for both law enforcement and mentally ill persons alike, and helps to prevent encounters from turning violent or even fatal.

This is not only a more enlightened approach, but it is also a fiscally wise one. CIT training means that law enforcement officers will be less likely to suffer from workplace related injuries and disabilities. Based on the experiences of other jurisdictions, CIT training will also pay for itself over time, in reduced litigation and judgment costs. The LASD has estimated that up to 40 percent of use of force incidents may involve mentally ill persons.

The original, highly successful CIT training was based on a 40 hour model. However, this can impose a heavy burden on law enforcement agencies. Logistically, CIT training requires law enforcement agencies not only to send personnel to the training for a week, but also to provide backfill coverage while those officers are gone. Indeed, that can be the largest cost involved. This can be quite challenging for law enforcement agencies, whether they are large or small.

The District Attorney fully endorses the full 40 hour CIT training model whenever it can be employed, but recognizes the practical realities involved and the need for flexibility. Accordingly, the Law Enforcement Working Group has developed an alternative 16 hour CIT training program for local implementation in Los Angeles County. In developing the 16 hour CIT training model, the District Attorney's Office contributed technical and resource assistance through the Criminal Justice Institute, which is a training entity administered through the District Attorney's Office. The Law Enforcement Working Group has identified key training priorities, developed a proposed curriculum, and recruited trainers.

On June 3, 2015, the Law Enforcement Working Group staged a successful half day "Train the Trainers" event at the Burbank Fire Department Training Center. Once fully online, local CIT training will be scheduled as two 16 hour training sessions per month, serving a maximum of 25 participants per training session, for a minimum of one year, and is currently planned to continue indefinitely. Due to the sheer scope of this training effort, these sessions will require a multitude of trainers from a variety of agencies and backgrounds, some of whom will work as teams and others who will rotate in and out of service. These trainers will include representatives from DMH, the LAPD, and the National Alliance on Mental Illness ("NAMI") whose family members, close friends, and themselves have been impacted by mental illness.

Also due to the magnitude of this training effort and ancillary issues associated with it, the District Attorney has identified an immediate need for a Training Liaison who would be hired

as a District Attorney employee. Because CIT training is at its heart a law enforcement concern, the Training Liaison would ideally be either a current or retired high-level managerial law enforcement officer. The District Attorney is currently considering candidates for this position. In addition, the District Attorney requests funding for a Management Assistant position. The Management Assistant position is necessary in addition to the Training Liaison to assist with administrative tasks related to scheduling and organizing the training. In addition to the law enforcement aspect of the anticipated training burden, there will also be significant training needs on an ongoing basis for stakeholders such as attorneys and even judges.

The District Attorney's Office is also working directly with the state Peace Officer Standards and Training Commission ("POST") to seek approval of the 16 hour CIT training curriculum. POST approval is anticipated and if granted, actual CIT training programs may be presented as soon as January, 2016.

The value of CIT training is universally recognized by the law enforcement community. In fact, the larger local law enforcement agencies are each already planning to satisfy their own training needs. For example, the District Attorney is informed that the LAPD, which has embraced CIT-type training for some time, plans to present additional training sessions at least once a month during the next year. The CHP already has underway its own plan to provide a 12 hour block of CIT training to each of its officers statewide.

The Sheriff's Department has proposed a comprehensive six-year plan to incrementally train each of its 5,355 patrol deputies in the full 40 hour CIT training. Although deputies receive six hours of mental health training as new recruits in the Academy, this is not adequate to prepare them for the numerous contacts with mentally ill persons that actually occur once they are deployed as deputies. The Sheriff's Department has created a three-part plan to better train its deputies.

First, the Sheriff's Department is currently providing Baseline Training (3 hours) and Intermediate Training (8 hours) to deputies. As of June 8, 2015, more than 1,200 patrol deputies have received the Baseline Training, which provides an overview of mental health issues that first responders encounter in the field and strategies which may apply to specific situations. The Intermediate Training is a mental health awareness class, which provides students with the tools to better recognize symptoms and behaviors associated with mental illness and fundamentally, to understand that behavior engaged in by a mentally ill person relates to a medical condition that the person has not chosen to have. Students are also taught how to better communicate with mentally ill persons. As of June 8, 2015, more than 700 personnel have attended the Intermediate Training. Finally, the Sheriff's Department plans to provide a 40 hour Advanced Training, to be conducted 40 weeks per year with a class size of 24 students. The Advanced Training is true CIT training. Topics covered will include: Mental health signs and symptoms, appropriate medications and their side effects, use of verbal de-escalation techniques, active listening skills, and improved police tactics using safe restraint techniques that result in reduced use of force. During Fiscal Year 2015-2016, the LASD will send 480 patrol personnel to CIT Training. Deputies who complete the training will return to their patrol areas and be available to respond to and assist with incidents involving mentally ill persons when co-deployed Mental Evaluation Teams (discussed in the next section) are not available. The value of this ambitious plan cannot be overstated.

Because each of the larger law enforcement agencies are already planning their own independent CIT training programs, the participants in the 16 hour CIT training sessions sponsored by the District Attorney and Criminal Justice Institute will largely be drawn from the 48 smaller police agencies in the County.

Simply stated, CIT training is a good idea whose time has finally come, one which is worthy of the full support of this Board.

CO-DEPLOYED LAW ENFORCEMENT TEAMS

The Department of Mental Health's Emergency Outreach Bureau has teamed with law enforcement agencies in the field, to provide crisis intervention services throughout Los Angeles, various municipalities, and the unincorporated areas of the County. This co-response model pairs a licensed mental healthcare clinician with a law enforcement officer. Together, they jointly respond to 911 calls and patrol service requests where it is suspected that a person might have a mental illness, make appropriate referrals to treatment facilities, and facilitate hospitalization when necessary.

These specially trained, co-deployed field teams are known as Mental Evaluation Teams ("MET") by the Sheriff's Department and as the System-wide Mental Assessment Response Team ("SMART") by the LAPD. Regardless of the name by which the co-deployed teams are known, the mission and partnership with the Department of Mental Health remain the same. DMH has estimated that these teams may contact over 6,500 mentally ill persons per year.

In addition to partnering with the LASD and LAPD to deploy the MET and SMART teams, DMH has also partnered with a total of fifteen other law enforcement agencies which also employ co-deployed teams: Alhambra Police Department; Bell Gardens Police Department; Burbank Police Department; City of Bell Police Department; City of Vernon Police Department; Downey Police Department; Gardena Police Department; Hawthorne Police Department; Huntington Park Police Department; Long Beach Police Department; Pasadena Police Department; Santa Monica Police Department; Signal Hill Police Department; South Gate Police Department; Torrance Police Department. Also, the Metropolitan Transit Authority ("MTA") contracts with the LASD for four Crisis Response Teams, funded by the MTA. These four teams primarily serve homeless individuals and respond to critical incidents involving mentally ill persons on public transportation such as buses and trains. DMH also has plans underway to partner with six additional law enforcement agencies on co-deployed teams, once appropriate memoranda of understanding are approved and executed.

Co-deployed teams roll out in the field and use their specialized training and experiences to help to defuse potentially violent situations. The teams respond to persons in crisis, barricaded suspects, suicides in progress such as jumpers, and a variety of other volatile situations. The MET teams are praised by both mentally ill persons who have interacted with them, and family members who are grateful to have seen their loved ones appropriately treated with compassion and understanding. Co-deployed teams are a bright spot in the ongoing relationship between law enforcement and the communities that they police.

Unfortunately, the demand for services is so great in Los Angeles that there are never enough co-deployed teams to respond. Because the team coverage areas currently occupy such a large geographic area of the County, there is often a lengthy response time. The co-deployed teams certainly cannot respond to every call which involves a possible mental health issue. That is why, in addition to adding new MET teams, the LASD has also focused on improving mental health training for all of its deputies, a wise investment in the future.

The Sheriff's Department currently has only eight MET teams to cover the entire County, and would need at least a total of twenty-three to provide sufficient coverage and services for the vast

geographic area and population involved. Both the Department of Mental Health and LASD propose the expansion of these teams.

In addition, plans are currently underway for the LAPD to add one additional SMART team per shift per Bureau, for a total of sixteen additional teams. The Department of Mental Health will provide clinicians for each of these teams.

MENTAL HEALTH URGENT CARE CENTERS: THE FIRST 24 HOURS AFTER A MENTAL HEALTH CRISIS

The following problem is presented every day in Los Angeles County. Upon encountering a mentally ill offender in the field, a law enforcement officer faces a choice. The officer could take the person to a crowded hospital emergency room, and possibly wait for an average of 6 to 8 hours there, during which time their assigned patrol area would lack coverage. Or, the officer could take the person to jail, book them there, and be back out on patrol within the hour.

In order to successfully divert mentally ill offenders from the jail, there must be places to take them where they can receive treatment instead. In addition, sufficient resources must be invested into those alternative treatment locations so that they are not overloaded by demand.

Mental Health Urgent Care Centers ("UCCs") are the logical resource to fill this gap. Urgent Care Centers are acute care provider locations, where a mentally ill person can be taken so that their needs can be evaluated. Urgent Care Centers are not residential facilities. In fact, a person can only remain at an Urgent Care Center for a maximum time period which is less than 24 hours.

During that initial 24 hour window of time, a crisis can be averted. A person can be stabilized and allowed to go home, if they have housing and a support system. On the other hand, a person might be unable to care for themselves and need to be civilly committed on a 72 hour hold (commonly called a "5150 hold" since it is authorized by Section 5150 of the Welfare and Institutions Code). Or, the person's mental health needs could fall somewhere in the middle, and they can be linked to other services such as recovery-oriented community-based resources.

Because these UCCs specialize in mental health care, they are capable of making mental health determinations promptly and professionally. Investing in adequate mental health UCCs takes 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. The mental health UCCs provide integrated services, including treatment for co-occurring substance abuse disorders. The Department of Mental Health currently has four UCCs, and a fifth is already slated to be reopened in November, 2015. Of these, two are currently designated under the Lanterman-Petris-Short Act ("LPS designation") and operate twenty-four hours a day, seven days a week. A facility must be designated under the LPS in order for 5150 holds to be made. DMH already has plans in place to have all of the mental health UCCs in the County, both current and future, designated under the LPS. Each of these UCCs are located in close proximity to hospitals.

The Department of Mental Health is planning to add three additional UCCs to be located near Harbor UCLA, the San Gabriel Valley, and the Antelope Valley, which will serve an additional 54 individuals at any given time. These UCCs will operate twenty-four hours a day, seven days a week. It is anticipated by DMH that these three new UCCs will serve approximately 49,275 persons per year. It is estimated that between 15 and 20 percent of those individuals would have otherwise been incarcerated. These three additional UCCs will primarily be used as assessment and staging facilities for the Assisted Outpatient Treatment program (discussed in the following section) and proposed pre-booking diversion.

The mental health UCCs are a prudent and necessary investment of resources, but cannot be used in every situation. For example, mentally ill persons who are actively under the influence may not

appropriately be taken directly to UCCs. Therefore, there is also a significant separate need for stabilization and detoxification services to be offered at Sobering Centers and Residential Detoxification Centers, as well as longer term Residential Drug Treatment, as discussed later in this report in the section entitled, “Impact of Co-Occurring Substance Abuse Disorders.”

OTHER TREATMENT OPTIONS: AFTER THE FIRST 24 HOURS

After a law enforcement officer has transported a mentally ill person to a mental health Urgent Care Center, what happens next—after the first 24 hours—is also important. Ideally, the person would be linked to appropriate mental health treatment, whether inpatient or outpatient. On the other hand, if a gap in services occurs, law enforcement could receive another call about the same person. Clearly, this would increase the likelihood that upon a second or subsequent call, the person might then be transported to the jail instead.

Los Angeles needs the right combination of treatment options to serve the mentally ill population, and good linkage to those services. There are several different types of mental health treatment services currently available, as follows.

Law Enforcement Hospital Beds The Department of Mental Health provides some dedicated acute psychiatric inpatient services, specifically for uninsured individuals who are brought in by law enforcement. These facilities are located at Aurora Charter Oak Hospital in Covina and College Hospital in Cerritos. The law enforcement bed program serves approximately 300 mentally ill individuals per year.

Institutions for Mental Diseases ("IMD" beds) Institutions for Mental Diseases are licensed long term care psychiatric facilities which may be locked, and are similar to hospital beds. The Department of Mental Health contracts with these IMD facilities to provide care for persons who no longer meet the criteria for acute care but are not clinically ready to live in a board and care facility or other less restrictive treatment settings. Most IMD residents have received services in the past, have had failed board and care placements, and have been in and out of County hospitals, jails, or other IMD beds. They include the most severely mentally ill persons who typically may be the subject of conservatorships.

Crisis Residential Treatment Programs Crisis Residential Treatment Programs have been nationally recognized for over 25 years as an effective model for diversion from psychiatric emergency rooms and as a "step-down" from inpatient hospital and jail care. Mentally ill persons can stay at adult crisis residential treatment programs for up to thirty days, but the usual expected stay is ten to fourteen days. These facilities are not locked, but offer augmented supervision and intensive mental health services.

The County currently has only three Crisis Residential Treatment Programs with a total of 34 beds that provide housing and very intensive mental health services and support for those mentally ill individuals who can benefit from additional stabilization and linkage to ongoing community-based services.

The Department of Mental Health is currently using SB 82 funds to develop and implement 35 additional Crisis Residential Treatment Programs for a total increase of 560 beds. DMH estimates that these additional beds will serve an estimated 17,030 additional people per year, based on an average 12 day length of stay.

Full Service Partnerships ("FSP") The Full Service Partnership Program serves individuals with mental illness who need intensive, integrated wrap-around services. These are individuals whose criminal justice and psychiatric histories place them at risk of institutionalization, frequent psychiatric hospitalizations, homelessness and incarceration. FSP services support individuals as they transition to lower levels of care and participants engage in the development of their treatment plan which is focused on wellness and recovery. The treatment team is available to provide crisis services to a client twenty four hours a day, seven days a week. FSP providers may be community based organizations or others who contract with the Department of Mental Health. Though comprehensive, these services cannot be used for everyone due to cost issues.

Field Capable Clinical Services ("FCCS") The Field Capable Clinical Services program is a field-based service program, which assists persons who are either graduating from Full Service Partnerships or were never in need of that level of intensive support and individualized case management. The treatment team is available twenty-four hours a day, seven days a week by telephone to provide crisis services to the client.

Wellness Centers The Wellness Center Program is an outpatient clinical service, for persons who are either graduating from Full Service Partnerships or Field Capable Clinical Services, or were never in need of that level of support. Wellness Center services support individuals in the community.

Assisted Outpatient Treatment Program ("AOT") Assembly Bill 1421 established the Assisted Outpatient Treatment Demonstration Project Act of 2002 ("Laura's Law"). Laura's Law created a process for the courts, probation, and the mental health systems to order supervised outpatient treatment of mentally ill adults who would otherwise resist treatment. The Assisted Outpatient Treatment Program can also be used on a voluntary basis by participants who are engaged in their own treatment.

In May 2015, the Department of Mental Health fully implemented an Assisted Outpatient Treatment program and expanded its intensive Full Service Partnership network by 300 slots and its enriched residential services network by 60 slots. The Assisted Outpatient Treatment Team screens requests, conducts extensive outreach to engage patients, develops petitions and manages the court processes to connect Assisted Outpatient Team enrollees with Full Service Partnerships or enriched residential services that have dedicated funding for these persons.

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 than those who have a stable housing environment. In addition, once they do come into the justice system, they are much more likely to remain in custody than be released on bail or their own recognizance. Because they lack a stable residence, officers are more likely to take them to jail than issue a citation, and judges are more likely to conclude that they will fail to appear for a future court date and order them to remain in custody.

It is also more challenging to consistently engage homeless individuals in treatment services, and too often, their connections with the County's system of care are precipitated by crisis situations and law enforcement contacts rather than being guided by an established treatment plan. The result is high-cost utilization of medical, emergency, and mental health care systems by homeless mentally ill individuals, as well as their increased likelihood of cycling in and out of the criminal justice system.

As such, a discussion of appropriate housing models for mentally ill, justice-involved populations is integral to any mental health diversion and re-entry effort. In particular, the availability of permanent supportive housing is critical to stem the tide of recidivism. The provision of safe, stable, and affordable housing—with necessary supportive services—has been found to be one of the most effective strategies for reducing recidivism.

In response to the direction of this Board's May 6, 2014 motion, the following sections provide an inventory of currently available permanent supportive housing in the County, an assessment of housing service gaps identified for people with severe mental illness, and recommendations for addressing permanent supportive housing needs.

Permanent Supportive Housing Permanent supportive housing is affordable housing with indefinite leasing or rental assistance, combined with supportive services designed to assist homeless persons who suffer from disabling conditions to achieve housing stability. Permanent supportive housing service providers proactively engage tenants and offer treatment plans. The supportive services made available are voluntary and participation is not a requirement of maintaining eligibility for the permanent housing.

The premise of permanent supportive housing is that the effectiveness of mental health, substance abuse disorder, and other treatment interventions is significantly limited when individuals are homeless and in unstable living environments. In contrast, providing homeless, mentally ill individuals with stable, supportive housing promotes better outcomes with regard to health, public safety, and personal dignity among the housed individuals.

There are three types of permanent supportive housing models: Single-site based, mixed-population, and scattered-site models.

A. **Single-Site Model Permanent Supportive Housing** This is traditionally a single multi-family apartment building with all units occupied by supportive housing residents and with the benefit of on-site supportive services.

B. **Mixed-Population Model Permanent Supportive Housing** This is traditionally a single multi-family apartment building where a portion of the units are set aside for supportive housing residents and may include on-sitesupportive services. Both single site and mixed population models of permanent supportive housing are traditionally produced using community development or affordable housing financing.

C. **Scattered-Site Model Permanent Supportive Housing** This is financial rental assistance funds provided directly to residents who then secure rental housing from private landlords in the community. The most common program which provides this form of supportive housing is the federal Housing Choice Voucher ("Section 8" program). Supportive services are then provided directly to tenants through mobile teams in the community.

To provide an inventory of available permanent supportive housing, this report relied upon data reported by the Los Angeles Homeless Services Authority (LAHSA). LAHSA is an independent Joint Powers Authority which was created in 1993 by the City and County of Los Angeles. LAHSA operates as the lead agency for the Los Angeles Continuum of Care and is responsible for collecting an annual Housing Inventory Count information of all beds and units in the Continuum of Care's eight Service Planning Areas.
The 2015 Housing Inventory Count has been completed, but has not yet broken down the data into a detailed analysis. Therefore, this report relies upon both 2014 and 2015 data, as identified below:

- 17,172 total permanent supportive housing beds of varying type (2015 Housing Inventory Count);
- 3,606 permanent supportive housing beds which are expressly set aside for individuals who are chronically homeless, mentally ill, returning from jail, or multi-diagnosed (2014 Housing Inventory Count);
- 4,285 permanent supportive housing beds which are uncategorized, so it is unclear whether or not they would be available to the criminal justice mentally ill offender population (2014 Housing Inventory Count);
- 1,903 "other permanent housing" beds, which do not include supportive services, and are thus not actually considered to be permanent supportive housing in the total count (2014 Housing Inventory Count).

Notwithstanding these figures, there remains a significant gap between the available housing and the demand for housing options for the homeless and mentally ill population. In addition to permanent supportive housing, there are other kinds of housing as well, which are described as follows. However, substituting temporary or transitional housing for permanent housing, when permanent housing is truly necessary, does not solve the ultimate problem and can result in more transition points where people can fall between the cracks.

Bridge Housing Bridge housing is temporary housing for people in need while a housing navigation team works with clients to secure appropriate permanent supportive housing once it becomes available. Bridge housing has no set maximum stay and is generally provided through local, accessible service organizations within the Continuum of Care. By minimizing barriers to participate, clients are encouraged to move from the streets into a safe bed. Having a stable location greatly assists clients to keep meetings and appointments.

Shelter Plus Care Shelter Plus Care provides federally subsidized housing through a services-match grant for individuals and families who meet the Department of Housing and Urban Development's ("HUD") definition of homelessness. The supportive services match must be equal to or greater than the rental assistance award. These grants allow a variety of housing rental situations. To be eligible, a person must be homeless, with a mental illness, substance abuse problem, HIV/AIDS, or a dual diagnosis. Shelter Plus Care does not require a background check.

Department of Mental Health Shelter Plus Care This is similar to Shelter Plus Care housing, but participants must be Department of Mental Health clients. DMH contracts with the Housing Authority of the City of Los Angeles ("HACLA") and the Housing Authority of the County of Los Angeles ("HACoLA"), to provide Shelter Plus Care certificates to eligible clients. To be eligible, individuals must be at least 18 years of age, meet the HUD criteria for homelessness, have a diagnosis of severe and persistent mental illness, including a co-occurring substance use disorder, and agree to maintain active contact with DMH for case management and other mental health services for as long as the certification is valid (at least five years).

HUD-VASH Vouchers This is a veteran's housing program, which combines Section 8 rental assistance vouchers with case management and clinical services, which are provided by the Los Angeles Veterans Affairs Medical Center ("Medical Center"). Clients must be Veterans Affairs Supportive Housing ("VASH") eligible veterans. The Medical Center determines whether homeless veterans and families are eligible for VASH benefits. The local housing authority determines eligibility for the rental subsidy. As a condition of the program, participants must receive case management services from the Medical Center.

Rapid Re-Housing This program is designed to help persons who recently became homeless, not the chronically homeless. It quickly provides housing, so recipients may pursue employment, health and social service needs and get back on their feet.

Mental Health Services Act ("MHSA") Housing Program There are a total of 976 Mental Health Services Act funded units which are an option for some homeless mentally ill offenders returning to the community from custody, but some offenders will not qualify based on their criminal history. If an offender is enrolled in a Full Service Partnership program, they are eligible to receive assistance with their housing needs, and in these situations the Department of Mental Health can provide a subsidy by using MHSA funds to rent a unit from a private property owner. Under this program, DMH requires that the tenant be engaged in mental health treatment, and the housing developments must provide onsite supportive services.

In addition to permanent supportive housing, there are various short term stay beds in the County such as emergency shelters. However, they cannot effectively be used for mental health diversion from the jail since they are too uncertain and short term in nature—since they are usually first-come, first-served, a spot is not certain even on a day-to-day basis.

There are several significant efforts currently in progress within the County, regarding housing services.

Coordinated Entry System The Coordinated Entry System is an effort to capture and electronically input data from clients and landlords to create a real-time list of individuals experiencing homelessness in our communities, and to quickly triage and efficiently match these individuals to available housing resources and services that best fit their needs. Clients are surveyed using an assessment tool known as the "VI-SPDAT," which provides a survey score. Clients identified with the greatest need of a particular housing type are referred to eligible housing opportunities as they become available. The Coordinated Entry System relies on the Homeless Management Information System, which is a federally mandated database used to collect information on homelessness. Housing providers that receive any federal HUD funding are required to input their available units by type, subsidy, eligibility criteria and number of units into the system, to ensure an accurate inventory of beds available for potentially qualifying tenants. All homeless service providers are encouraged to participate even if they do not receive federal funding. As of September 2014, LAHSA reported a participation rate of 65% for emergency shelter programs, 67% for transitional housing programs and 83% for permanent housing programs.

Department of Health Services - Flexible Housing Subsidy Pool The Flexible Housing Subsidy Pool is a rental subsidy program which currently provides permanent supportive housing to patients who are homeless and have experienced two or more hospital visits in one year. This program allows the 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. DHS has established a goal of securing 10,000 permanent supportive housing units for this program.

Breaking Barriers Program Breaking Barriers was jointly launched by the Probation Department and the Department of Health Services in June, 2015. It is a two-year pilot program to provide rapid re-housing and case management services for eligible offenders supervised by the Probation Department. These offenders are homeless, have been identified as moderate to high risk of re-offending, and have expressed a desire to seek full-time employment. Each client is provided intensive case management, employment services, a housing unit and a rental subsidy, with the client contributing a percentage of their monthly income towards the rent. Once stabilized, participants work to successfully "transition in place," eventually taking over the full rental payment amount so that they can continue to reside in their unit once participation in the program expires. The maximum length of program participation is 24 months, with case management aftercare services continuing for 3 months after program completion.

Just In Reach Program This Sheriff's Department program was developed to improve custody discharge planning for homeless individuals who repeatedly cycle through the jail, primarily due to their homelessness. Just In Reach targets individuals who are either currently homeless or at risk of homelessness, repeat offenders, and those who are charged with lower level offenses; specifically, offenders who have been in jail three times in the last three years and who have been homeless three times in the last five years. The program offers participants comprehensive assessments, case plans, and linkage to community services to assist participants to secure permanent supportive housing and remain self-sufficient.

Notwithstanding each of these resources and programs which are currently underway, significant gaps in services remain: Los Angeles County currently has no permanent supportive housing dedicated to the justice-involved population with mental illness.

Permanent supportive housing beds are needed to serve this specific population, who currently face many barriers to successful re-entry, such as housing restrictions based on their history of incarceration and long housing wait lists. This population currently must independently apply for supportive housing through the standard homeless service delivery system.

Even with an investment into additional permanent supportive housing, it is clear that some homeless mentally ill offenders exiting custody would not have immediate access to a permanent supportive housing placement until a spot becomes available in the system that could be matched to meet their individualized service needs.

This is particularly true because there are a myriad of legal definitions and requirements which may apply, especially for federally funded housing programs, which often restrict participation based upon criminal background checks and make it difficult for the justice involved homeless population reentering the community to stabilize.

For example, for programs funded under federal HUD guidelines, the federal definition of homelessness applies. Under that definition, inmates who serve 90 days or more of custody in the county jail do not qualify as homeless, even if they were homeless before they entered the jail. Instead, they would have to reestablish homelessness, such as by going to an emergency shelter, before being processed onto a list for appropriate housing.

There is also a federal housing restriction which would prevent a person who is being released from jail from returning to live at their original home, if it would mean cohabiting with a family member who holds a Section 8 voucher. This means that even when there is a family member of a mentally ill person who is willing to have them, it would prevent them from being welcomed back into the home. Instead, the mentally ill offender would have to compete for their own permanent supportive housing or face homelessness.

To address these gaps, the County should also secure additional bridge housing capacity for this specific population. Bridge housing would provide a safe bed for the population of justice involved homeless individuals exiting custody until appropriate permanent supportive housing can be secured.

Additional investment should also be made into subsidized housing through the Flexible Housing Subsidy Pool, Shelter Plus Care and DMH Shelter Plus Care programs to provide the County with the flexibility to quickly and strategically invest in housing and services based on need and availability. Focusing on connecting these resources to the most difficult to house population would help to break the cycle of returns to custody.

The following housing-related recommendations are made to this Board:

1. Allocate sufficient funding to the Flexible Housing Subsidy Pool for 200 permanent supportive housing scattered site units for a five-year period. These will provide immediate access to housing for the mentally ill population leaving custody;
2. Allocate sufficient funding to the Flexible Housing Subsidy Pool for rapid re-housing rental assistance for 200 people for a five-year period;
3. Allocate sufficient funding to contract for 200 units to be subsidized by the federal Rental Assistance Program that are prioritized for qualifying mentally ill offenders exiting custody in need of permanent supportive housing;
4. Allocate sufficient funding for 400 supportive housing units to be provided through new construction or rehabilitation of single site or mixed population developments;
5. Allocate sufficient funding within the Department of Mental Health Specialized Housing Program to add housing subsidies for approximately 300 individuals to be housed in permanent supportive housing and 200 individuals to be placed in bridge housing while participating in Full Service Partnership, Field Capable Clinical Services and Wellness Center treatment services. It is anticipated that this funding would allow DMH staff to negotiate with private housing providers on behalf of inmates to pay for move-in costs and provide rental assistance.

It is recommended that a Mental Health Diversion County Housing Director position be created to generally oversee housing issues related to mentally ill offenders who are justice involved. Housing issues are often fragmented due to the different entities involved at the city, county, state and federal level; for example, the Housing Authority of the City of Los Angeles ("HACLA"); Housing Authority of the County of Los Angeles ("HACoLA") and the Los Angeles Homeless Services Authority ("LAHSA"). If appointed, the proposed Mental Health County Housing Director would serve as a member of the Permanent Mental Health Diversion Planning Committee, discussed more fully in this report in the section entitled "Proposed Expansion of Mental Health Diversion Related Staffing and Services."

CO-OCCURRING SUBSTANCE ABUSE DISORDERS

As instructed by this Board's motion dated May 6, 2014, the stakeholders have assumed as a goal the diversion of a total of 1,000 mentally ill offenders from the jail into community based treatment options, although that certainly will not happen overnight. According to the Department of Public Health and the Department of Mental Health, approximately 80 percent of those persons may have a co-occurring substance abuse disorder involving drugs, alcohol or both. This would require planning for the appropriate service referrals and placement of approximately 800 additional mentally ill offenders also suffering from substance abuse problems.

The Department of Public Health, the Department of Mental Health and the Sheriff's Department all agree that mental illness with co-occurring substance abuse disorder is a priority problem among this offender population which presents specialized treatment challenges. For example, mentally ill offenders who suffer from substance abuse disorders may need stabilization and/or medically managed care in a Sobering Center, Residential Detoxification or Residential Drug Treatment Program before accessing appropriate mental health treatment. Mentally ill persons suffering from untreated substance abuse disorders are less likely to accept available mental health resources and engage in their own mental health treatment.

The following current programs and resources relate specifically to co-occurring substance abuse disorders:

Alcohol and Drug Free Living Center Services Currently, the Department of Public Health offers alcohol and drug free living center ("ADFLC") services in limited capacity for clients who are enrolled in outpatient substance abuse disorder outpatient services. These are housing facilities where clients recovering from alcohol and drug problems reside, and the presence of and use of alcohol or drugs, other than prescribed drugs, is forbidden. This type of housing environment is suitable for individuals with a stable co-occurring disorder condition.

Co-Occurring Integrated Care Network ("COIN") This court-based program is a collaboration between the Department of Public Health, the Department of Mental Health and the Superior Court. The COIN program serves the needs of AB 109 offenders who have a co-occurring chronic substance abuse disorder coupled with a severe and persistent mental illness, by making intensive, inpatient services available. The Probation Department and the Parole Revocation Court identify offenders who are at a high risk for relapse and would benefit from integrated substance abuse and mental health treatment. The COIN program was established in 2013, but recently expanded in early 2015 to serve clients in an additional two service areas. Twenty beds are reserved specifically for AB 109 supervised persons with co-occurring disorder.

Probation Department Co-Occurring Caseloads The Probation Department has developed Co-Occurring Caseloads. Persons with mental health issues and co-occurring substance abuse disorders who are under court supervision are identified, and provided with a Deputy Probation Officer who specializes in these issues. The Deputy Probation Officers assigned to this caseload are provided additional training in order to build a knowledge base of what services are available in the community for these supervised persons, and how to

more effectively supervise them. The Probation Department developed a 20 hour course on this subject entitled "Case Management of AB 109 Clients with Co-Occurring Disorders" which was available to both Deputy Probation Officers and Supervising Deputy Probation Officers.

Co-Occurring Disorders Court ("CODC") Co-Occurring Disorders court is an option for offenders who have failed at previous attempts at substance abuse treatment and who have a severe or persistent mental illness. Specified low-level felony charges are eligible for this program. The court requires a guilty plea, followed by 90 days at the Antelope Valley Rehabilitation Center and then placement into a full service partnership which includes medication, housing, benefits evaluation, and educational and vocational assistance.

Women's Community Reintegration Services and Education Center ("Women's Center") The Women's Center is a jail in-reach program for women with mental health needs who are being released from jail at the Century Regional Detention Facility. These women struggle with histories of repeated arrests and incarcerations, persistent mental illness and co-occurring substance abuse disorder, domestic and community violence, unemployment, financial instability and children in out-of–home placement. Through the Department of Mental Health, the Women's Reintegration Center provides release planning groups, one-to-one interviews, and outpatient services upon release to equip these women with the life skills necessary to succeed outside of jail.

There currently does not exist an analogous men's program. However, the Department of Mental Health already has a plan underway to add one as follows:

Men's Integrated Reentry Services and Education Center ("Men's Center") The Men's Center will serve men with mental illnesses and co-occurring substance abuse disorders being released from Men's Central Jail or Twin Towers Correctional Facility. The Men's Center will be able to serve up to 40 clients at a time, assuming an average length of stay in the community for 59 1/2 days. The Men's Center will not only provide an innovative model of care for men who struggle with their mental illnesses and other life issues, but will also serve as an education and training center for a variety of integrated care providers and interns.

Four key gaps in services have been identified relating to the co-occurring disorder population, for which additional resources are recommended:

1. **Sobering Centers** Los Angeles County currently does not have any Sobering Centers, which would provide a place for first responders to take mentally ill persons who are not suitable to be brought to an Urgent Care Center, as an alternative option to jail. The typical model for a Sobering Center would be an 8 hour stay before being referred to other services.

2. **Residential Medical Detoxification Services** These residential facilities are directed toward the care and treatment of persons in active withdrawal from alcohol and/or opiate dependence, for up to 14 days.

3. **Residential Treatment Services** Residential treatment facilities provide a structured, 24 hour a day environment which are non-institutional and non-medical, but provide rehabilitation services to clients suffering from substance abuse disorders. Clients can stay for up to 90 days, and more days may be required with clinical justification.

4. **IMD Beds Designated for Co-Occurring Disorders** 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 substance abuse disorder, who are in need of treatment in a secure setting. The Department of Mental Health is requesting funding for 40 additional IMD beds for individuals with co-occurring disorders rather than have them remain in the jail. These beds could serve individuals with criminal justice histories who are placed on conservatorships.

IMPACT OF PROPOSITION 47

On November 5, 2014, Prop. 47 was enacted by the voters of California. Prop. 47 reduced common felony theft and drug possession offenses to misdemeanors. Although the long-term impact of Prop. 47 on the jail population and mental health diversion efforts cannot completely be known at this time, two observations can be made.

First, Prop. 47 did not result in any immediate reduction in the mentally ill population in the jail even though the total jail population has dropped. To the contrary, the mentally ill population has gradually increased. According to the Sheriff's Department, the average jail population mental health count in 2013 was 3,081 total inmates; in 2014, it was 3,467 total inmates; and as of June 16, 2015, it was 3,614 total inmates. This could be the result of an overall increase in the mentally ill population in the County, but may also be a result of more diagnoses being made due to increased attention and sensitivity to this issue. Regardless of the reasons for this increase in the mental health population, the numbers are certainly not any lower after Prop. 47.

Second, Prop. 47 crimes by definition are non-violent and lower-level. Presumably, this could make it more difficult to identify offenders for mental health diversion, since there would be fewer non-violent felony offenders in the county jail to choose from for diversion. It is difficult to reconcile these competing observations. Further analysis of the mentally ill jail population may shed light upon these issue and guide further discussion regarding diversion.

On June 9, 2015, this Board instructed the interim CEO to provide an independent analysis of the actual number of treatment beds and other beds needed at the new Consolidated Correctional Treatment Facility ("CCTF") and to conduct a capacity assessment of all community-based alternative options for treatment including, but not limited to, mental health and substance abuse treatment.

CURRENT JAIL PROGRAMS AND RESOURCES

There are currently a variety of jail programs which provide mental health treatment for those who are currently incarcerated, seek to link them to services upon their release, or are alternative custody programs. In particular, the following current efforts are noteworthy.

LASD Population Management Bureau The Sheriff's Department has enhanced its transitional services systems through collaboration with the Department of Mental Health and Jail Mental Health Services. The LASD works with Jail Mental Health case managers to process vital records such as birth certificates and California ID cards. This is a preliminary step to completing Affordable Care Act (Medi-Cal) enrollment. With the assistance of the Department of Public Social Services, benefits are effective the day of release from custody.

If a mentally ill inmate is entitled to Homeless General Relief, a coordinated release is conducted and the client is driven to the Department of Public Social Services immediately following release to receive their General Relief benefits. Additionally, through a collaborative effort with Jail Mental Health Services, the inmate is linked with services such as emergency shelter before their discharge date, so that they will have someplace to live when they are released.

In fact, the Sheriff's Department has consistently provided transportation assistance to take offenders from the jail directly to a myriad of services, including mental health services, residential substance abuse programs, transitional housing, emergency shelters, employment services, social services, mother-infant residential programs, veteran-specific programs, parolee substance abuse service, HIV services, temporary financial assistance and food benefits to families and individuals. This transportation service has filled a gap to greatly assist offenders to connect with needed services upon their release.

Affordable Care Act Program On July 1, 2014, the Sheriff's Department began the Affordable Care Act ("ACA") Project. This is a two-year grant program in collaboration with the Departments of Mental Health, Public Health, Health Services and Public Social Services. All sentenced inmates who are within 60 days of their release date are contacted and assisted to complete and submit Medi-Cal applications, which are processed within 45 days of their release. Inmates who require hospitalization outside of the custody environment, or who are in community treatment with electronic monitoring, can use their benefits as a source of payment for care. As of May, 2015, a total of 8,175 applications were taken and 1,766 inmates received benefits upon their release from custody.

Jail Mental Evaluation Teams ("JMETs") The JMETs are co-deployed teams where DMH clinicians are paired with Sheriff's personnel within the jail, just as the MET teams are co-deployed teams in the field. The JMETs oversee care of inmates in the general population who are on psychiatric medications but are not severely mentally ill and do not require specialized mental health housing. The JMETs also regularly go through the jail to promptly identify inmates who were not identified as having mental health problems upon their initial intake at the jail, or who have decompensated while incarcerated, so that they can receive services.

AB 109 Mental Health Alternative Custody Pilot Program The Sheriff's Department is currently working with the Department of Mental Health on a new alternative to custody program, which will have a 42 bed capacity. The location, Normandie Village East, is a licensed adult care residential facility which is a "step-down" from higher levels of care.

AB 109 offenders who have been incarcerated for low-level and non-violent offenses that appear to be a result of their mental illnesses will be eligible. Referrals to the program will be accepted from various sources including Jail Mental Health Services, the Department of Mental Health Court Linkage Program and the LASD. Admissions will be authorized through the DMH Countywide Resource Management Center. Program participants will be electronically monitored. Criteria are currently being developed to select participants, and discussions are ongoing regarding appropriate mental health programming. There is a October, 2015 goal for implementation.

LASD Inmate Services Bureau, Education Based Incarceration Unit ("EBI") The Sheriff's Department has expanded its mental health programming services to both the male and female population. Currently, the LASD provides mental health programming to over 200 mentally ill inmates a week. This includes specific life skills classes taught by the Five Keys Charter School and by other outside volunteers. Exploratory discussions are underway regarding how to better organize and present material to optimize time and access to sub-groups within the mentally ill population. The LASD is also deploying "comfort dogs" to visit the mental health floors on a regular basis.

Restoration of Competency "ROC" Program Ordinarily, felony offenders who are mentally incompetent to stand trial receive mental health treatment at a state hospital, to restore them to competency. However, there are so few state hospital beds that there is a waiting list for treatment, resulting in lengthy delays while these persons remain in custody, awaiting treatment. At any given time, Los Angeles may have up to two hundred felony inmates who are incompetent to stand trial. In response to this problem, the LASD has entered into a contract with the San Bernardino County Sheriff's Department and Liberty Healthcare regarding services to restore these defendants to mental competency.

The Restoration of Competency "ROC" Program has a 76 bed capacity and is anticipated to be implemented this summer. The ROC program is an intensive, individualized treatment program comparable to restoration services at a state hospital. Treatment is provided by an array of mental health professionals. The sooner offenders can be restored to mental competency, the sooner they can move through the justice system and complete their criminal cases. This program is entirely funded by the state.

Jail Linkage Program Inmates with mental illness require specialized assistance with release planning. The Department of Mental Health Jail Linkage Program works throughout the jail system with clients who require all levels of release planning assistance, from minimal to comprehensive. Jail Linkage personnel coordinate with Jail Mental Health Services, with Department of Mental Health Countywide Resource Management for AB 109 clients, and with the LASD Community Reentry Resource Center, which was created by the Sheriff's Population Management Bureau in 2014 as an information source for all inmates being released.

Mental Health Forensic Outreach Teams ("FOT") Many inmates with mental illness do not successfully transition to treatment and services in the community, which increases the possibility of recidivism. Forensic Outreach Teams under contract with the Department of Mental Health assist approximately 1,260 inmates annually who are released from county jails upon the completion of AB 109 sentences.

Forensic Outreach Teams can provide both jail in-reach and intensive short-term case management for up to 60 days after release, for persons referred to contracted AB 109 providers. Jail in-reach efforts help to build relationships with inmates before they re-enter the community. Building trust in providers and the health care system can help offenders comply with treatment recommendations regarding health, mental health, and/or substance abuse issues. After release, the Forensic Outreach Teams provide additional assistance for successful linkage to community services.

Public Defender and Alternate Public Defender Jail Mental Health Team The Public Defender has conceived and proposed an innovative new jail program aimed at a broader, more holistic legal representation of detained mentally ill offenders who are housed at the county jail. Public Defender clients would be referred through their existing attorney of record, by the existing Public Defender Mental Health Unit, or otherwise. Once referred, the clients would be evaluated by in-house psychiatric social workers, so that the Public Defender's Office could begin to engage proactively with their clients at the earliest possible stage of the criminal justice process. This type of expert assistance would enable the Public Defender's Office to actively collaborate with other justice stakeholders such as the Sheriff's Department and Department of Mental Health.

The Public Defender has also requested the addition of psychiatric social workers to be housed at their branch offices throughout the County. Both the jail social workers and the branch social workers would be well-placed to efficiently communicate "real-time" information about their clients' mental state to assigned attorneys in courts and therefore address longstanding gaps in communication from county jail to courtroom personnel, including judges and attorneys. This increased communication will reduce case continuances, expedite case processing, better facilitate the delivery of mental health services, reduce jail overcrowding, and improve the overall administration of justice.

The Advisory Board supports this proposed new program not only for Public Defender clients, but also for offenders who are represented by the Alternate Public Defender as well. Clients who suffer from mental illnesses and are interviewed in the jail are much more likely to be willing to be frank and forthcoming with a psychiatric social worker who is assigned to their own legal team, than with a clinician who is not. Indeed, mentally ill clients commonly fail to fully cooperate with Department of Mental Health personnel or admit their active symptoms, such as visual and auditory hallucinations, due to the nature of the jail environment and their own concerns that making such admissions could be used against them and possibly result in additional incarceration.

Therefore, the Advisory Board believes that this proposal has merit and should be supported by this Board.

CURRENT COURT PROGRAMS AND RESOURCES

Department of Mental Health Court Linkage/Court Liaison Program The Court Linkage program is a collaboration between the Department of Mental Health and the Los Angeles County Superior Court. Court Linkage is staffed by a team of 21 mental health clinicians who 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.

Through the Court Linkage Program, there is a specialized program by which offenders can be placed in licensed, long term psychiatric care ("IMD") beds. The specialized Court Linkage IMD bed program serves 50 individuals at any given time who are pre-adjudicated and agree to receive treatment in lieu of sentencing. The program served 112 individuals in Fiscal Year 2013-2014. Although full figures for Fiscal Year 2013-2014 are not yet available, last year's figures show that the Court Linkage Program helped to divert a total of 1,053 persons out of 1,997 possible referrals. This group of about a thousand mentally ill offenders annually is placed across the spectrum of available treatment options, which were discussed in detail in the preceding section entitled, "Other Treatment Options: After the First 24 Hours."

There are several reasons why not every offender who is contacted by the Court Linkage Program can actually be diverted: Some refuse services; some are sentenced by the court to state prison or otherwise in a way that would foreclose treatment; some may not have an available treatment option which matches their mental health needs; some may have an available treatment option from a mental health perspective, but one which is not acceptable to the court and counsel from a public safety perspective. Again, it bears emphasis that not every mentally ill offender can safely be removed from a custodial setting.

However, the fact that more than half of the offenders contacted by the Court Linkage Program are able to be diverted is a significant success, which is worthy of attention. The Court Linkage Program is a resource which may benefit from additional expansion of assigned personnel in future years. The District Attorney's Office is currently preparing a new office policy memorandum to ensure that each of the office's deputies is aware of the efforts made by the Court Linkage Program and appropriately coordinates with the Department of Mental Health so that they can evaluate mentally ill offenders for potential diversion opportunities.
The Court Liaison Program provides ongoing support to families and educates the court and the community at large regarding the specific needs of mentally ill individuals. Mental Health Court Liaison services include on-site courthouse outreach to defendants, individual service needs assessments, providing information to individuals and the court about appropriate treatment options, development of post-release plans, linkage of individuals to treatment programs, expedited mental health referrals, and providing support and assistance to defendants and families in navigating the court system.

Mental Health Court/Department 95 The Los Angeles County Mental Health Court handles matters which are referred from criminal courts throughout the County. The court is staffed with lawyers from the District Attorney's Office, Public Defender and Alternate Public Defender. Department 95 handles a wide range of proceedings, including issues relating to mental incompetence to stand trial, post-conviction defendants who were adjudicated as not guilty by

reason of insanity, or alleged to be a mentally disordered offender ("MDO") and are the subject of a petition for restoration or an extension of a parole commitment.

The 2014 Superior Court Annual Statistics Report provides a snapshot example of the volume of matters handled in Department 95. In 2014, an average of 198 new cases per month were sent to Department 95 upon the issue of incompetence to stand trial; this does not include the cases carried over from 2013. The total number of cases under the supervision of the Mental Health Court during 2014 was 118,551.

Veteran's Court Veteran's Court is a diversion program for veterans charged with felonies who suffer from post-traumatic stress disorder or traumatic brain injury. Most of the veterans in this court have alcohol or drug addiction problems and if these problems were caused or exacerbated by military service, the veteran will be considered for the program. Veterans from all areas of the county are eligible to participate. A guilty plea is required and a dismissal is the usual result for successfully completing the program. All costs of housing, transportation and treatment are borne by the Veterans' Administration.

Santa Monica Homeless Court Program This program, operated by the Santa Monica City Attorney's Office in coordination with the Superior Court, is available to homeless individuals who have quality of life or other minor misdemeanor charges pending. Following the successful completion of a 90 day program, charges are dismissed. Services such as mental health treatment, substance abuse assistance, job placement, and assistance in finding permanent supportive housing are provided through the City of Santa Monica and are largely funded through annual grants.

Homeless Court Clinic This program, operated by the Los Angeles City Attorney in coordination with the Superior Court, serves adults who are either homeless or at risk of homelessness, who may also suffer from mental illness, substance/alcohol addiction, co-occurring disorders, or are veterans. The program helps to resolve legal barriers to care and connect them with appropriate service providers to address the challenges that they face on the road to recovery, including permanent supportive housing. In exchange for community obligation hours worked by participants, certain traffic and quality of life offenses, such as low-level misdemeanor charges, warrants and fines can be resolved. These clinics operate as mobile one-day events where participants are assisted by a myriad of stakeholder representatives and service providers.

EXPANSION OF MENTAL HEALTH DIVERSION RELATED STAFFING AND SERVICES

In addition to the need for additional resources earmarked for CIT training and co-deployed MET teams, as well as expansion of the mental health Urgent Care Centers, Crisis Residential beds and other available treatment services, the following improvements are also proposed.

Criminal Justice Mental Health Diversion Permanent Planning Committee Based upon the experiences of other large jurisdictions, it is anticipated that mental health diversion will be a long-term project for some years to come. The Advisory Board and Working Group participants are committed to the project, but cannot reasonably devote full-time attention to it, since each has other primary job duties which are also important. The District Attorney fully and personally supports this effort and is committed to leading it indefinitely.

It will be necessary to dedicate additional permanent employee positions to fully implement mental health diversion. This cannot be accomplished by any one person given the nature and magnitude of the anticipated workload, and the need for collaborative input. Therefore, 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, to be able to bridge the gap between high-level policy recommendations and actual implementation decisions.

In addition to the employee needs related to the Permanent Planning Committee, both the Sheriff's Department and the Department of Mental Health are requesting additional funding for employees and other costs, as follows:

Sheriff's Department Mental Evaluation Bureau In future years, the Sheriff's Department proposes to establish a new Mental Evaluation Bureau in order to enhance current services to mentally ill persons. For example, a serious problem exists involving mentally ill persons who are the subject of repeated calls for service, which cost the County millions of dollars in emergency resources without positive outcomes.

The new Mental Evaluation Bureau would operate 24 hours a day, seven days a week. Upon encountering a mentally ill person in crisis, patrol deputies could communicate with Desk Operations Triage to coordinate service calls and determine whether the co-deployed MET teams would roll out. If the Triage Desk determined that a call involves a person who was the subject of frequent calls for intervention, a referral to a Consolidated Case Management Team would be made.

The Sheriff's Consolidated Case Management Team would help manage cases that involve persons with a history of violent criminal activity caused by mental illness, and cases that involve persons whose mental illness has caused numerous responses by law enforcement or the deployment of substantial resources. The Consolidated Case Management Team would be the liaison point with the Homicide Bureau-Missing Persons Unit to determine whether a missing

person had been placed on a 5150 hold. The Consolidated Case Management Team would also manage a database to track and update contacts with mentally ill persons and other data which would help to evaluate and improve departmental crisis responses. Finally, the Consolidated Case Management Team would attempt to link mentally ill offenders with available resources.

The Mental Evaluation Bureau would also include a Crisis Negotiations Team, Training Unit and Community Relations Unit. The Crisis Negotiations Team would handle situations involving hostage takers, barricaded suspects, and other persons who pose an immediate, violent threat to themselves or the community.

The Training Division would create and maintain a Mental Health Training Manual, review use of force incidents involving mentally ill persons, review and revise office policies regarding contacts with mentally ill persons, and conduct both basic mental health training and CIT training. The Community Relations Unit would act as a liaison with the Department of Mental Health, other stakeholders and the community in implementing jail diversion programs.

The Mental Evaluation Bureau would be co-supported by the Department of Mental Health. The total staffing request for the Mental Evaluation Bureau is currently estimated at 68 Sheriff's Department personnel and 32 Department of Mental Health personnel. However, funding will be requested from the County no sooner than Fiscal Year 2016-2017.

Countywide Adult Justice Planning and Development Program The Department of Mental Health also requests four additional administrative staffing items to help conceptualize, develop and implement the jail diversion plan. This program infrastructure would help ensure that a wide range of mental health programs are made available at all intercepts in the criminal justice system, and to oversee the existing Mental Health Jail Linkage Program and Court Linkage Programs, which have been discussed separately in preceding sections of this report.

Forensic Additions to Existing Mental Health Programs As previously described, the Department of Mental Health already has services which were designed for the non-criminal population, but proposes to expand with separate "Forensic" or "Justice Involved" versions of the same programs, which would permit a specialized focus on the criminal justice population: Full Service Partnership, Field Capable Clinical Services and Wellness Centers.

Reentry Referral and Linkage Network of Care This proposal is a computer systems network solution designed for the Department of Mental Health, building on existing Jail Linkage and Countywide Resource Management Programs. Ideally, this would be an easily accessible online resource which could: (1) capture and store the assessments of post-release needs of mentally ill inmates; (2) identify service providers to meet the needs; (3) consolidate referral information for each inmate in a format that can be easily printed and shared with an inmate; (4) communicate electronically with service providers to make the referrals; (5) receive electronic responses back from service providers regarding referrals, such as acknowledgement of receipt and confirmation of placement; (6) allow electronic communication with the clients upon their release.

RECOMMENDATIONS

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

1. CIT Training

- Train 5,355 patrol deputies in the full 40 hour CIT Training over the next six years;
- Support the 16 hour CIT training program under the auspices of the District Attorney and Criminal Justice Institute;
- District Attorney Training Liaison and District Attorney Management Assistant.

2. Mental Health Treatment Resource Expansion, Priority

- Add three new Department of Mental Health Urgent Care Centers;
- Add 35 new Crisis Residential Treatment Programs;
- Add "Forensic" or "Justice Involved" versions of Full Service Partnerships, Field Capable Clinical Services and Wellness Centers; in the alternative, increase the staffing of current programs to support anticipated pre-booking diversion of mentally ill offenders;
- 40 additional IMD beds designated for co-occurring disorders;
- Four Additional DMH administrative staffing items;
- Additional Court Linkage personnel.

3. Permanent Mental Health Diversion Planning Committee

- Create and maintain the Permanent Planning Committee.

4. Public Health/Health Services Treatment Resource Expansion

- Sobering Centers;
- Residential Medical Detoxification Services;
- Residential Substance Abuse Treatment Facilities.

5. Housing Services Enhancements

- Create Mental Health Diversion County Housing Director position.
- 200 permanent supportive housing beds through Flexible Housing Subsidy Pool for five years;
- 200 rapid re-housing beds through Flexible Housing Subsidy Pool for five years;
- 200 units to be subsidized by federal monies;
- 400 supportive housing units through new construction or rehabilitation;
- Fund within the Department of Mental Health Specialized Housing Program, 300 housing subsidies for permanent supportive housing and 200 housing subsidies for bridge housing.

6. Co-deployed teams

- MET team expansion of 15 additional teams to a minimum total of 23 teams.
- SMART team expansion of 16 additional teams, to a minimum total of 34 teams.

7. Data improvements

- Development of Cerner Hub inter-departmental interface or other solution to data sharing problems;
- Department of Mental Health Reentry Referral and Linkage Network of Care.
- Based upon these data sharing solutions, set aside funds for a consultant to be employed which can assist the County with metrics which will allow management by outcomes to take place.

8. Public Defender and Alternate Public Defender Jail Mental Health Teams

- Jail based psychiatric social workers and supervisors;
- Branch based psychiatric social workers and supervisors.

9. Mental Health Treatment Resource Expansion, Lower Priority

- Men's Integrated Reentry Services and Education Center;
- Co-deployed Department of Mental Health personnel at Probation offices, to be commenced on a pilot project basis at five offices which span the geographic boundaries of the county.

10. LASD Mental Health Bureau

- Establish the new Mental Health Bureau. (Fiscal Year 2016 - 2017)

CONCLUSION

Various counties, municipalities, and metropolitan areas across the country have commenced the journey towards improving the interface between the low level mentally ill criminal offender and the criminal justice system. The keys to their success have been making modest, pragmatic first steps to improve systemic responses to the problem; the "all in" collaboration of the pertinent criminal justice system partners; and the willingness to make a long term commitment to the goal of improving the plight of mentally ill offenders in the criminal justice system.

Through the work of the Criminal Justice Mental Health Advisory Board, unprecedented collaboration has been demonstrated by the criminal justice system partners. Further, the many efforts to date by public and private entities to treat mentally ill persons in Los Angeles County has been laudable. What is needed at this critical juncture is the integration, coordination, and expansion to scale of these resources. This report represents a plan for going forward. Being ever mindful of public safety and victims' rights, it is time to take the next steps in the long journey.

Los Angeles County District Attorney's Office

Sequential Intercept Mapping Report – LA County, CA

Executive Summary

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The Los Angeles County District Attorney's Office contracted with Policy Research Associates, Inc. (PRA) to develop behavioral health and criminal justice system maps focusing on the existing connections between behavioral health and criminal justice programs to identify resources, gaps and priorities in Los Angeles County, CA. On May 28, 2014, approximately 100 participants attended a county-wide summit/kickoff held to begin this process and address the significant issue of persons with behavioral health disorders involved in the criminal justice system. Additionally, there were 46 cross-systems partners from mental health, substance abuse treatment, health care, human services, corrections, advocates, consumers, law enforcement, health care (emergency department and inpatient acute psychiatric care), and the courts that participated in the Los Angeles County Sequential Intercept Mapping and priority planning on July 8, 2014.

There is a longstanding recognition that persons with behavioral health disorders are over-represented in the criminal justice system. The Sequential Intercept Mapping workshop has three primary objectives:

1. Development of a comprehensive picture of how people with mental illness and co-occurring disorders flow through the criminal justice system along five distinct intercept points: Law Enforcement and Emergency Services, Initial Detention and Initial Court Hearings, Jails and Courts, Re-entry, and Community Corrections/Community Support.

2. Identification of gaps, resources, and opportunities at each intercept for individuals in the target population.

3. Development of priorities for activities designed to improve system and service level responses for individuals in the target population.

The recommendations that follow are informed by the work of PRA over the last 18 months in Chicago, Illinois; New Orleans, Louisiana; New York City, New York; as well as Miami, Florida. In addition, PRA has provided training and technical assistance to over 100 jurisdictions, Tribes, and states across the United States. The recommendations stemming from the Los Angeles County Sequential Intercept Mapping are timely, as they also support many of the recommendations set forth in the 2011 Administrative Office of the Courts Task Force for Criminal Justice Collaboration on Mental Health Issues: Final Report. Additionally, the California Mental Health Wellness Act of 2013 supports the work and recommendations of the cross-systems Sequential Intercept Mapping group in that it ensures key behavioral health and criminal justice collaborators are involved in the planning and implementation of key strategic initiatives needed to improve the lives and outcomes of justice involved individuals with behavioral health disorders.

The products of the Sequential Intercept Model workgroup culminated with the recommendation of formalizing a county wide planning body to address the needs of justice involved persons with co-occurring mental health and substance use disorders being the number one priority. PRA concurs with this as the top priority, as formalized planning bodies promote the needed communication, collaboration and coordination which must be present in order for quality diversion programs and efforts to occur. Los Angeles County currently has a number of mental health and criminal justice initiatives that already involve criminal justice partners and can either directly support the work of the county wide planning body or that can be integrated with the work of the planning body. Existing efforts include, but are not limited to: Integrated Behavioral Health Information Systems (IBHIS); The Corporation for Supportive Housing (CSH) Mental Health, Jail Diversion and Supportive Housing Proposal; CSH/Department of Mental Health (DMH) funded Emergency Room diversion programs; and Advancing Safe and Healthy Homes Initiatives/DMH Healthy Homes Initiative. It will be critical for this county wide planning body to not only consider how it will relate to these on-going planning efforts, but also how it will influence the planning and implementation of future efforts.

The quality and growth of this formalized planning body is strongly supported by the second priority, which calls for the utilization of data analysis and data matching to better inform decisions regarding diversion opportunities for justice involved persons with behavioral health disorders. Additionally, the second priority recommends the creation of a criminal justice/mental health technical assistance/resource center. PRA concurs with the priority level of this recommendation and has extensive experience working with Centers of Excellence, including those in Ohio, Illinois, Florida and Pennsylvania. Los Angeles currently has a number of key experts county-wide who can be utilized to implement its specialized center for communication, coordination and collaboration.

At the conclusion of the Los Angeles County systemwide summit and Sequential Intercept Mapping workshop, PRA took note that there are several on-going initiatives, some of which have been identified above, that currently address identified gaps or can increase access to care for justice involved individuals with behavioral health disorders if awareness is raised and needs identified. Rather than taking a heavy focus on the development of new initiatives and resources, PRA is instead utilizing an "adapt and expand" approach to the priorities and recommendations stemming out of the gaps identified during the Sequential Intercept Mapping workshop. This "adapt and expand" approach is designed to not only improve county-wide system response to justice involved persons with behavioral health disorders, but also to create additional capacity to better reach and engage this underserved population of individuals in Los Angeles County.

At **Intercept 1**, PRA recommends that Los Angeles County enhance/expand law enforcement's specialized response and mental health crisis response, such as Systemwide Mental Assessment Response Teams (SMART), Mental Evaluation Teams (MET), and Crisis Intervention Teams

(CIT). There are also insufficient resources available for Los Angeles County's Psychiatric Mobile Response Teams (PMRT). Participants in the Summit Workshop and Mapping Workshop were satisfied with the quality of these law enforcement specialized response and mental health crisis response teams; however, multiple participants cited examples noting the need for additional resources and expansion to better serve and have a broader impact for justice involved individuals with behavioral health disorders. PRA makes this recommendation based upon our extensive nationwide work with specialized law enforcement and mental health crisis response systems such as CIT, as well as our current work with Intercept 1 Early Diversion Substance Abuse and Mental Health Services Administration (SAMHSA) grantees in Colorado, Tennessee and Connecticut. It will be important for Los Angeles County to include criminal justice/behavioral health partners such as law enforcement, crisis stabilization centers, and psychiatric emergency departments in these enhancement/expansion planning meetings.

At **Intercept 2**, PRA recommends the expansion of diversion opportunities at arraignment and the improvement of screening efforts for diversion at later stages. The DMH Mental Health Court Linkage Program is an innovative resource that Los Angeles County has operated for 10 years. Mapping workshop participants reported that the program's capacity to serve persons has not increased during that same period. Utilization of this program was uneven across the county and there was a lack of alignment between the judiciary, prosecutors and the Court Linkage Program regarding diversion philosophy. It is also recommended at Intercept 2, that Los Angeles County implement a Probation Pre-Trial Release program. There is a notable absence of Intercept 2 diversion opportunities present for justice involved persons with behavioral health disorders in Los Angeles County. PRA has seen the value of diversion efforts at this Intercept based upon our work over the last dozen years with just under 20 SAMHSA grantees from across the United States engaged in Targeted Capacity Expansion (TCE) jail diversion efforts.

At **Intercept 3**, PRA recommends the expansion of post-arraignment diversion opportunities for defendants with behavioral health disorders who are charged not only with misdemeanors, but also low level felony offenses. Strategies listed above in Intercept 2 also apply for this Intercept. Expanding capacity for the DMH Court Linkage Program, improving stakeholder alignment regarding diversion and implementing a pre-trial supervision program can increase potential diversion opportunities at Intercept 3. In addition, adding a jail diversion screening component at the jail can increase identification of potential diversion candidates. Jail diversion staff can work with the Court Linkage Program and defense counsel to present a diversion plan to the courts. Diversion strategies at this Intercept should seek to minimize collateral sanctions, such as the housing and employment barriers which are often present for individuals post-incarceration. For justice involved persons with behavioral health disorders, these collateral sanctions also impede recovery. Specialty courts are not required for Intercept 3 diversion. Pre-trial supervision or periodic status updates by providers to the court for proscribed time frames can be very effective as well. For more serious felony level charges, persons can be sentenced to probation with conditions tailored to mental health treatment if appropriate.

At **Intercept 4**, PRA recommends expanding the capacity of the DMH Jail Navigator program as well as the capacity of existing reentry programs found through providers such as: Just In Reach, the Los Angeles City Attorney's Office HALO Program, Women's Reentry Court, and the Los Angeles Sheriff Department's Community Reentry Center. Both the Summit and Mapping workshop participants identified extensive resources devoted to reentry planning. Many of these programs reported being able to service additional individuals with additional funding. The DMH Jail Navigators in particular were identified as needing more resources to keep pace with the high volume of referrals and short time frames with which to link individuals to needed services at the point of reentry, including behavioral health and support services.

At **Intercept 5**, PRA recommends the provision of training on the Risk, Need, Responsivity (RNR) and Cognitive Behavioral Health Interventions. Other than housing, which was a gap across all Intercepts, there were not any specific gaps or priorities identified in this Intercept. There are many Best Practices and innovative programs operating within Los Angeles County at this Intercept, including specialized mental health Probation Department caseloads, co-location of mental health staff in Probation Department offices and peer-run programs for Probation clients. The Probation Department performs risk assessments to determine supervision and program needs utilizing RNR principles to manage caseloads. It is important to uniformly share risk assessment information with behavioral health providers and to expand RNR training and Cognitive Behavioral Training to include behavioral health providers in order to insure that criminogenic needs are addressed in behavioral health settings.

The prevalence of individuals with behavioral health disorders in jails and prisons is higher than in the general population. PRA has seen that, on a national level, alternatives to incarceration have gained momentum as a humane and cost effective strategy to reduce criminal justice costs and improve access to needed services and supports without compromising public safety. The early identification of individuals with behavioral health needs at each level or Intercept of contact with the criminal justice system can improve not only their access to care, but also long-term treatment outcomes. The effects of these types of interventions are increasingly showing promise with benefits to society and the potential for long term cost savings.

Los Angeles County District Attorney's Office

Sequential Intercept Mapping Report – LA County, CA

Prepared by: Policy Research Associates, Inc.
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Travis Parker, M.S., L.I.M.H.P., C.P.C

Acknowledgement

PRA wishes to thank the Los Angeles County District Attorney's Office for the assistance with the coordination of this event.

Introduction:

The Los Angeles County District Attorney's Office contracted with Policy Research Associates (PRA) to develop behavioral health and criminal justice system maps focusing on the existing connections between behavioral health and criminal justice programs to identify resources, gaps and priorities in Los Angeles County, CA.

Background:

The *Sequential Intercept Mapping workshop* has three primary objectives:

1. Development of a comprehensive picture of how people with mental illness and co-occurring disorders flow through the criminal justice system along five distinct intercept points: Law Enforcement and Emergency Services, Initial Detention and Initial Court Hearings, Jails and Courts, Re-entry, and Community Corrections/Community Support.

2. Identification of gaps, resources, and opportunities at each intercept for individuals in the target population.

3. Development of priorities for activities designed to improve system and service level responses for individuals in the target population.

The participants in the workshops represented multiple stakeholder systems including mental health, substance abuse treatment, health care, human services, corrections, advocates, individuals, law enforcement, health care (emergency department and inpatient acute psychiatric care), and the courts. Dan Abreu, M.S., C.R.C., L.M.H.C., and Travis Parker, M.S., L.I.M.H.P., C.P.C., Senior Project Associates for SAMHSA's GAINS Center for Behavioral Health and Justice Transformation and Policy Research Associates, Inc., facilitated the workshop session.

Forty-six (46) people were recorded present at the LA County SIM.

Follow-Up to Mental Health Summit
Sequential Intercept Mapping and Action Planning Workshop
Los Angeles County District Attorney's Office
July 8, 2014

8:00- 8:30a.m.	**REGISTRATION AND CONTINENTAL BREAKFAST**
8:30 – 8:45 a.m.	**WELCOME BY DISTRICT ATTORNEY JACKIE LACEY**
8:45 – 9:45 a.m.	**REVIEW SUMMIT BREAKOUT GROUP PRIORITIES**
9:45 – 10:00 a.m.	**BREAK**
10:00 a.m. – 12:00 p.m.	**MAPPING L.A. EXCERCISE FOR INTERCEPTS I, II/III, AND IV/V**
12:00- 1:00 p.m.	**LUNCH**
1:00- 2:30 p.m.	**MAPPING L.A. (Cont.)**
2:30 – 2:45 p.m.	**BREAK**
2:45 – 3:15 p.m.	**REFINE AND VOTE ON PRIORITIES**
3:15- 4:00 p.m.	**ACTION PLANNING IN INTERCEPT GROUPS**
4:00 – 4:30 p.m.	**REPORT-OUTS TO FULL GROUP**

Special thanks to the California Endowment and the Aileen Getty Foundation for their generous support.

Los Angeles County Sequential Intercept Map

Intercept 1
Law enforcement / Emergency services

Dispatch 911
Similar to CIT training

211 Services Hotlines

New Directions VA each time a LE sweep is done

LASD
serves unincorporated LA County, and 42 of the 88 cities

Approx. 45 police depts. in LA County (including LAPD)

Patrol officer dispatched

Fire

EMS

MEU

Triage Desk

LEMHSA DHS

LA County MET
8 teams to cover 4,000 sq. miles

LAPD SMART
61 officers; 8-12 teams
Need DMH people

DMH Liaisons County Hospitals
wait for LE is 3-6hrs or closed

5150
70-80% LE drop-offs

Detox ER Medical Cleared

IP Units

Detox

3 Psychiatric EDs
Olive View; Harbor; USC (can be 2-6 hour wait for officers)

Urgent Care 23hrs

Shelters

Other Hospitals:
Providence; Torrance; North Ridge

Non-LPS Hospitals:
85 hospitals
1,800 MH beds
County & fee-for-service

Mental Eval Teams:
LA Comm. Hospital;
College Med Center;
Aurora Charter Oak
Many co-occurring med conditions
6-8hrs wait; limited urgent care

Intercept 2
Initial detention / Initial court hearings

Arrest

Local lock-ups have limited capacity

Use local lock-up vs. county jail

LASD: Inmate Reception Center (IRC)
Booking to arraignment: 2-5 days

Pre-Trial Services for Bail/Bond
200/day

Local Lock-up
Stay here unless problematic
No meds
PMRT

Arraignment

Public defenders standard screen- MH, meds, Veteran status
Liaison with VA reps at County Jail

Disposition pre-trial
Request for competency eval

SMPD will release to service providers if individual is already connected to services

MET Transport elsewhere in County

Intercept 3
Jails / Courts

Specialty Courts
Pre-plea Prop 36 Drug Court
Pre-plea city atty misdemeanor
CODMH Court
Womens Reentry
Veterans Court
SUDC
6 months

Court linkage
14 staff
55 locked beds in 22 courts;
17 beds, 42 forensic beds in County

LA County Jail
19,000 capacity
Local ER Medical Agency regulates services
Sheriff's Medical
Initial screen (3 questions)- meds/medical/harm, then in depth screen (15 questions)- referral to MH (300 referrals/day)
VA rep present; Housing

Jail MH Services
Psychiatric coverage 24/7; w/in 72hrs
DMH: 342 MH staff; 38 psychiatrists
IRC- housed level of acuity & care
4 triage destinations: 45 forensic inpatient; 400 high observation housing; 1,600 service area/step down; 800 general population/special handles

CRDF- Women
FIP- 27 men; 8 women (7/8/14)
FIP- same as men; out of cells 5-8hrs/day; fundamental groups- rec/occ therapy; current events groups
200- high observation housing- 10hrs outdoor rec; weekly 10hr pgm tailored to individuals; SA/MI/comm mtgs; 400- service area- med support, life skills, SS, indiv therapy, moral recognition SUD, comm groups, MI, discharge

Homeless Community Services
15/at once;
53 housing beds

Intercept 4
Reentry

Prison Reentry

Division of Adult Parole Operations (DAPO) provides parolees with access to community resources through the individual Agent of Record

Jail Reentry
Patriotic Hall for Vets by end of July 2014; discharge planning groups
Many programs doing in-reach
IRC- discharge plan begins; longer they stay = more detailed
If Probation is revoked, DMH will work with partners w/linkage for discharge plan
Sheriff's Dept Community Reentry Center: pharmacy, Dept. Health svcs, trying to implement
8 service areas in LA County- 1 Navigator for each area to help w/jail releases
Corporation for Supportive Housing

Revocation Court

Intercept 5
Community corrections/ Community support

Violation

Parole

Violation

Probation
48,000 total;
3,000 misdemeanors- DMH; Public Health
Specialized probation- 10,000; 8 of 14 offices are covered; 20:1 caseloads
AB109: non-serious, non-violent, non-sexual
DMH training
MH clinicians at the hubs
LS/CMI used

Non-AB109
SB678- predates AB109
day report
40:1 caseloads
CBT; intense supervision

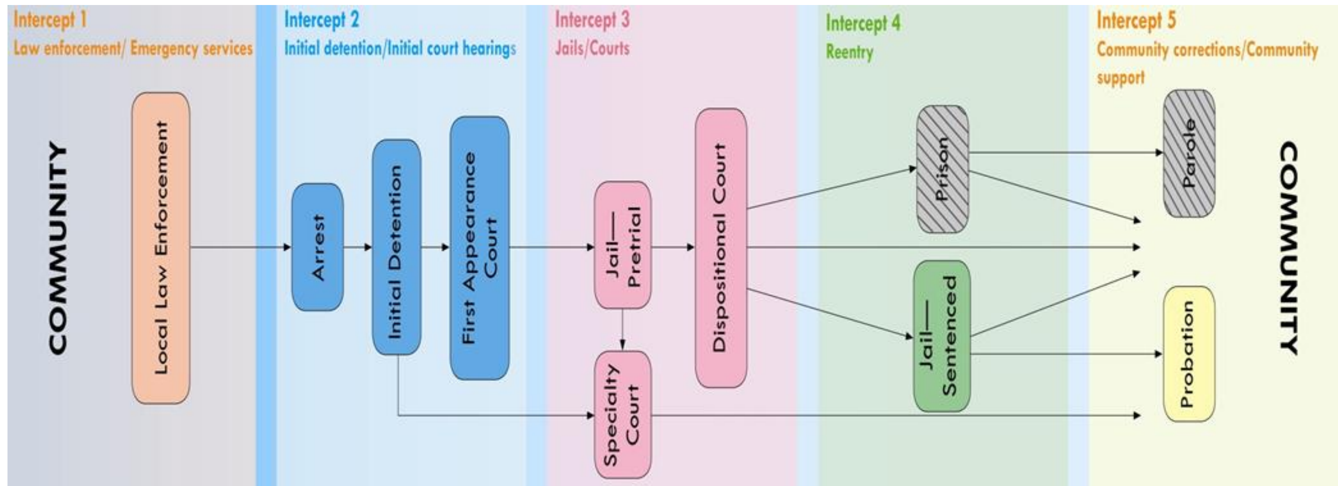
Community Resources

Behavioral
Cornerstones Full Service Partnership (FSP); Harbor UCLA FSP; Project 180; Prototypes; Social Model Recovery/River Community; Tarzana Treatment Center; Gateways; Olive Vista; Domiciliary; New Directions

Substance Abuse
Asian American Drug Abuse Program (AADAP); Antelope Valley Rehabilitation Center; BHS/American Recovery; Clare Foundation; Impact; Latino Family Services; Mid-Valley Recovery; Prototypes; Shields for Families; Tarzana Treatment Center; Volunteers of America (Hollywood Center)

Housing/Shelter
Bell Shelter; Corporation of Supportive Housing; Salvation Army; San Fernando Valley Community Mental Health Center; Union Rescue Mission; Weingart Center; Midnight Mission; SRO Housing Corporation; U.S. Vets.; Veterans Affairs Supported Housing (VASH)

Intercept 1



Resources

- Long Beach Police Department has one Mental Evaluation Team (MET) available per day (usually for one shift between 7 a.m. and 1 a.m. depending upon the day of the week).
- Local police departments or the Sheriff's Department will "triage" calls as they come in and determine if the fire department, Emergency Medical Services, etc. is needed for a response as well.
- LA County: 23 Sheriff's stations to serve 42 out of the 88 cities in LA County. Eight (8) MET teams, but only 2-3 on at any given time
- The LAPD dispatcher received Critical Incident Team-like training course. Thirty (30) or more are on duty in the San Fernando Valley.
  - SMART Team can be dispatched upon patrol's request; 8-12 teams per day; 61 staff members.
  - Patrol must contact EMS for direction.
- There are 99 hospitals scattered throughout LA County.
- Long Beach has hospitals; however they have limited psychiatric capacity.
- The Urgent Care Center is a possible alternative to the Emergency Department, although there are capacity issues.
- Private hospitals (Providence) cannot release individuals, which is easier for law enforcement.

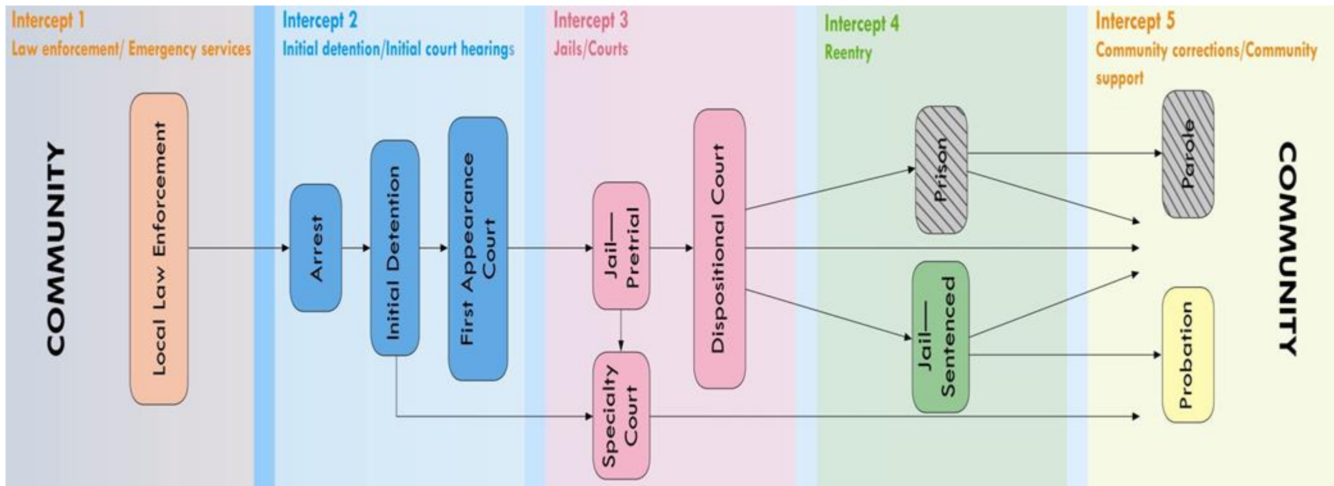
- Aurora Charter Oak and College Hospital-Cerritos have 6 law enforcement beds each, as well as 3 for youth.
- Psychiatric Emergency Departments offer some system decompression and serve as a valuable resource for law enforcement.
- County-wide resource management
- Department of Mental Health liaisons are available/working in inpatient units and Emergency Departments for linkage, as well as linkage/referrals for those without insurance.
- The Corporation for Supportive Housing and the Department of Health Services co-fund an emergency room diversion program.
    - CSH funds 15 hospitals
    - DHS funds 3 hospitals
- County hospital has DMH/DHS databases. A new Integrated Behavioral Health Information Systems data system is on the way.
- AB 1424- Family Form: "You shall take family information about mental illness"
- Street to Home (FUSE): housing voucher and mental health services
- The University of Southern California has an integrated urgent care facility.
- Santa Monica has mental health staff within the police precinct.
- West LA (Skid Row) has a clinician within the police precinct.

Gaps

- Long Beach PD patrol officers have limited training.
- Once the Long Beach MET has been activated, patrol officers are on their own if a psychiatric crisis arises in the meantime.
- The LAPD SMART Teams function 20 hours per day. During the remaining 4 hours each day, the triage of psychiatric crisis calls transitions to the command post.
- It is often more time efficient for law enforcement to book an individual into jail on a minor charge in order to get back into service more quickly, rather than spend many hours waiting in a psychiatric emergency department for the individual to be seen.
- While there are approximately 1,800 hospital beds throughout LA County for psychiatric purposes, only a small percentage of those beds can actually be accessed by individuals who are uninsured or who most frequently come into contact with law enforcement.
- 70-80% of law enforcement drop offs are at the Emergency Department.

- The police can wait up to 3-5 hours in psychiatric emergency departments due to capacity issues. Law enforcement cannot go back into service until the individual is seen by a psychiatrist. Long Beach does not have the resources for a 6-8 hour wait, as staff are working 10 hour shifts.
- Capacity issues at the emergency department cause delays/waits for law enforcement.
- The Volunteers of America Center had a detox program which lost funding.
- Long Beach does not have a practical and available detox facility.
- There are a lack of emergency department and inpatient hospital discharge planning options. Some are referred to urgent care, while others are referred to inpatient treatment or rehabilitation beds.
- There is not a service capacity priority given to persons who are discharging from emergency departments or hospitals for community based treatment.
- There is often a "communication gap" between social workers, community agencies and family members in assisting an individual during their transition from hospital-based to community-based care. If the individual does not sign a release of information form, the social worker will typically not speak with anyone, even in instances of care transitions, coordination, etc. This frequently causes stress and poor outcomes for individuals who already cycle in and out of the criminal justice system, as well as costly, more intense behavioral health treatment settings.
- There is a lack of state support for Crisis Intervention Teams (CIT).
- Private facilities have difficulty with discharge planning and poor family access.
- Law enforcement/crisis response is needed for Veterans.
- Long Beach Urgent Care is not designated to evaluate and treat persons involuntarily detained for mental health reasons under the Lanterman-Petris-Short (LPS) Act.
- Urgent care facilities are needed throughout LA County.
- Centralized drop off locations for law enforcement are needed throughout LA County in an effort to make early diversion a reality.
- Long Beach brings inebriates to jail instead of to a detox center/facility.

Intercepts 2 & 3



Resources

- Psychiatric Mobile Response Teams consist of Department of Mental Health licensed clinical staff assigned to a specific Service Area in Los Angeles County. These licensed clinical staff have the authority to initiate applications for evaluation of involuntary detention.
- The LAPD has access to 21 local lock up facilities throughout the county.
- The Long Beach- MET team can provide reach-in services when individuals are already in lockup and state that they feel like harming or killing themselves.
- Santa Monica- the individuals can be released from local lock-up to a known provider.
  - Ocean Pacific Community Center
  - St. Joseph Center
- LASD Inmate Reception Center (IRC)
  - A 15 question screen is utilized
  - 1,000 booked daily; 1/3 are referred
  - 342 mental health staff (of which 38 are psychiatrists)
  - 24/7 psychiatric coverage
- The Public Defender screens for mental health/veteran status.
- Veterans resources
  - Long Beach/LA for resources
- The LA County Jail has psychiatric coverage 24/7/365, either in person or over the telephone.

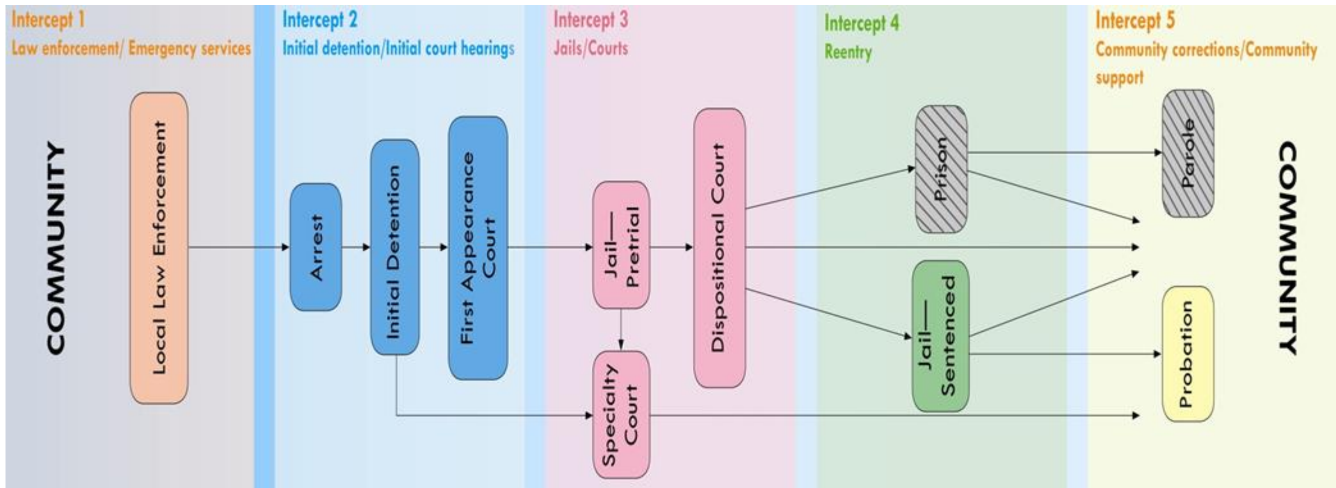
- Co-occurring disorders court diversion is available.
- Mental Health Court Linkage Program has 14 staff members serving 22 courts in LA County to assist with diversion and release to services.
- Sentenced offenders Drug Court- Homeless Community Court- Santa Monica; last created specialty court in 2006-2007 (felonies, generally nonviolent)
- Co-occurring Drug Court- Proposition 36- LA countywide post-conviction
- Specialty courts: Women's Reentry, Veteran's Court, Mental Health Court
    - All generally accept non-violent felonies.
- AB 109
- Revocation
- Department 95
- Mobile crisis with housing vouchers
- Integrated clinics
- Institutes of Mental Disease (IMD) step down programs- residential treatment and living situations
- Abandoned property could be used for housing.
- Shared/congregate housing
- Innovative locally-funded (non-HUD) housing models
- Funding is available to match with people who meet criteria.
- Co-located probation and treatment or peer support groups

Gaps

- There is no medication in lockup; this poses problems, particularly on weekends.
- At the LA County Jail, it can take up to 72 hours for an individual to be seen for needed psychiatric medications.
- Long Beach- no assessment or clinical presence
- Develop strategies for multi-disciplinary and collaborative approaches.
- No formalized Intercept 2 diversion exists at the current time.
- It is extremely rare for the Mental Health Court Linkage Program to get someone into services at the point of arraignment court.
- At the time of lockup, there is a heavy reliance primarily upon the individual to self-report key health information.
- No supervised Pretrial Release Program

- No pre-plea diversion
- Specialty courts have very limited capacity and only address a small fraction of cases which could go to specialty courts.
    - Funding is needed to expand capacity.
    - Very restrictive criteria to get into specialty courts
    - Lack of service providers to work with/be dedicated to specialty court participants
- Specialty courts are post-conviction courts; this allows the person to penetrate the criminal justice system even farther.
- Jail-based diversion via non-specialty courts is needed.
- Additional funding for court linkages is needed.
- The capacity of courts and treatment services has remained the same for the last 10-15 years.
- Small numbers of Supportive Housing slots
- Housing requirements are very restrictive for persons with mental health issues and criminal histories.
- The housing demand is much greater than the supply.
- “Not in my backyard” (NIMBY) housing issues throughout LA County

Intercepts 4 & 5



Resources

- 211 services hotline
- Patriot Hall Veterans
- 30-45 days of notice from jail release- can get on the medical list to make certain they leave the jail with a paper MediCal card
- Families are part of the solution.
- Track recidivism rates
- Jail and court linkages work together.
- The LA Sheriff's Department has a Community Reentry Center that has been open since July 2014.
  - Referrals to job centers, substance abuse treatment, assistance with benefits, mental health services and health insurance
- The LA County Jail can keep persons for up to 16 hours after their scheduled release date for further discharge planning/transitioning.
- Productive programs are now in place at the jail for mental health.
- Mental health clinicians are embedded within the Probation Department.
  - Receive information from the prison/jail; transfer information to providers

  - 35% are rearrested
- Area offices in multiple locations
- Probation has assumed parole functions with AB 109- Specialized probation- 10,000; 8 of 14 offices are covered with specialized probation; 20:1 caseloads
- Mental health is co-located at Probation Department hubs.
- AB 109 funds the services.
  - Not for the other 48,000 on supervision
  - Work with the Department of Mental Health to establish training on recognizing mental health
- Day Reporting Centers- the state allocated funding to counties for evidence-based practices for adults.
- Probation uses the Level of Service/Case Management Inventory to determine needs and risk assessment.
- Probation is exploring the utilization of SB 678 funds (which predates AB 109) to develop services for the probation population which has served time in state prison and is not AB 109 eligible.
- The National Alliance on Mental Illness could be better utilized to connect individuals discharging from incarceration with their families or other key supports who will be critical to their success and increased community tenure.

Gaps

- Lack of immediate/emergency housing
- Prison release: family connections need to be made sooner; a warm handoff to the families is needed at discharge.
- Little lead time for the jail navigator to put services in place
- Each Service Area has a jail navigator, but oftentimes they are overwhelmed. For example, San Fernando only has one jail navigator for the entire area.
- The LA Sheriff's Department Community Reentry Center is only able to be open 5 days per week.
- The jail has many services, but many inmates have not heard of reentry services.
- With so many inmates incarcerated at the LA County Jail, it is often difficult for good discharge planning and handoffs to occur.
- Probation is generally not available for misdemeanor offenders. Misdemeanor diversion is strongly needed.

- Dr. Frank Pratt (Medical Director for the LA County Fire Department) discussed how being on MediCal offers fewer physical and behavioral health treatment options than having no insurance coverage in some instances.
- There is a need for more Integrated Health Homes. Existing Integrated Health Homes are underdeveloped at this time.

Priorities for Change as Determined by Mapping Participants

- Training for all criminal justice professionals in the system- multi-disciplinary and holistic (17 votes)
- Expand capacity for treatment- continuum of care- for justice-involved persons (16 votes)
    - How much is needed?
    - What is the population?
- Data study to examine services needed, capacity needed, populations most in need, etc. (12 votes)
- Better communication/coordination between all system partners/data system/remove silos; develop policies and procedures to guide capacity utilization; develop resource database (10 votes)
- Crisis Alternative Centers/Crisis Stabilization Centers- law enforcement, families, individuals (9 votes)
- Expand housing for justice-involved persons (8 votes)
- Funding for initiatives and sustainability (4 votes)
- Define future configuration of Mental Health Court/Court Diversion (3 votes)
- Implement a pre-booking diversion program. Shorter drop-off times for law enforcement (3 votes)
- Creation/re-creation of an Intercept 2 diversion point (2 votes)
- Public education about behavioral health, homelessness, stigma, etc. (1 vote)
- Expand/enhance co-response models Psychiatric Mobile Response Teams, SMART, etc. (1 vote)

RECOMMENDATIONS:

Participants in the Summit and Sequential Intercept Mapping Workshop (SIMW) showed genuine interest and commitment to improve the continuum of resources available to justice involved persons with behavioral health disorders. Los Angeles County has many exemplary programs and strategies on which to build. As noted below, there are several on-going initiatives that currently address gaps identified in the report (e.g., SB 82) or can increase access to care for justice involved individuals with behavioral health disorders if awareness is raised and needs identified.

Rather than focusing on the development of new initiatives and resources, the focus of the 11 recommendations listed below is to "Adapt and Expand."

1. *Formalize a County Wide Planning Body to address the needs of justice involved persons with co-occurring mental health and substance use disorders.*

This recommendation is consistent with Recommendation 5 (p.19) of the Task Force for Criminal Justice Collaboration on Mental Health Issues: Final Report (April 2011).
http://www.courts.ca.gov/documents/Mental_Health_Task_Force_Report_042011.pdf

The first and fifth ranked priorities from the SIMW, as voted on by the participants, identified the need for improved cross system training, communication and planning. Workshop participants expressed the need for on-going dialogue, joint planning and increasing awareness regarding system resources. Implementation of initiatives to increase diversion opportunities will require involvement of a broad group of stakeholders with sufficient authority to impact state, county and municipal level change. An LA County planning body should coordinate activities with the Task Force for Criminal Justice Collaboration on Mental Health Issues, which is prepared to implement recommendations from its 2011 report.

Bexar County (Texas), Memphis (Tennessee), New Orleans Parish (Louisiana), and Pima County (Arizona) are examples of counties and municipalities that have developed Criminal Justice Mental Health Planning Committees.

Los Angeles County has 88 cities, 7 of which have over 100,000 residents. As a result, Criminal Justice/Mental Health resources, needs and strategies across the county vary widely. Development of additional localized planning structures to coincide with Department of Mental Health (DMH) Service Areas, judicial districts or municipal regions may facilitate planning, development and the implementation

of programs. Existing DMH Systems Flow Charts can also prove useful in supporting some of this work (Appendix 1).

2. Data Analysis/Matching; Add a County CJ/MH Technical Assistance/Resource Center.

The fourth highest priority identified during the SIMW was to utilize data to inform decisions. Across Intercepts there has been limited data collection and sharing of existing data regarding persons with mental illness in the justice system. Without adequate screening and data collection, it is difficult to identify and prioritize service needs, plan interventions, and target resources for the highest need and highest risk populations.

Participants acknowledged having data on existing programs, but data is not routinely analyzed to inform planning priorities, often due to a lack of resources and data not being strategically disseminated to interested stakeholders.

Resources to address data collection/analysis strategies include:

- The Urban Justice Institute published "Justice Reinvestment at the Local Level Planning and Implementation Guide"
  http://www.urban.org/publications/412233.html

  The guide offers an excellent overview of planning, data collection and justice reinvestment strategies across the criminal justice system.

- The "Mental Health Report Card" used by the King County, Washington Mental Health, Chemical Abuse and Dependency Services to document progress in meeting relevant client outcomes
  http://www.kingcounty.gov/healthservices/MentalHealth/Reports.aspx

- Data matching between jail admission data bases and community provider databases, as is done in Maricopa County, AZ as described in, *"Using Management Information Systems to Locate Persons with Serious Mental Illnesses and Co-occurring Disorders in the Criminal Justice System for Diversion"* http://gainscenter.samhsa.gov/pdfs/jail_diversion/using_mis.pdf and in the Illinois Jail Data Link Program, (Appendix 2).
- In 2013, the LA County DMH Jail Team developed a Pre-booking Diversion Proposal, "An Open Door to Recovery" which included a prevalence study of potentially divertible individuals

in Antelope Valley and Long Beach. The study's conclusion was that 72 individuals per day were potentially divertible from jail. This analysis is an excellent example of how data can confirm need and focus system resources. (Appendix 3)

The first and fifth ranked priorities by the participants identified the need for better cross system training, communication and planning. Recommendation 1 focuses on the need for a criminal justice/mental health planning structure.

With a county as large and complex as Los Angeles, there is a need for a resource center where criminal justice/mental health resources, events, and Initiatives can be centralized to:

- Disseminate information
- Track diversion activity
- Publish performance outcome measures
- Aid in planning
- Provide published resources
- Provide Technical Assistance and Training

Such a center can be modeled after technical assistance centers (Centers of Excellence - CoE) in the following states:

- Ohio Coordinating Center of Excellence (CCOE) http://www.neomed.edu/academics/criminal-justice-coordinating-center-of-excellence
- Illinois Center of Excellence for Behavioral Health and Justice
  University of Illinois Rockford
  http://www.illinoiscenterofexcellence.org/
- University of South Florida, Criminal Justice Mental Health Reinvestment Technical Assistance Center http://www.floridatac.com/
- Pennsylvania Mental Health and Justice CoE

http://www.pacenterofexcellence.pitt.edu/

3. Integrate Task Force Activities with system wide initiatives.

LA County has a number of mental health and criminal justice initiatives that can either directly support the work of the Task Force or that can be integrated with the work of the Task Force. Some of these initiatives already involve criminal justice partners. It will be critical for this Task Force to not only consider how it will relate to on-going planning efforts, but also how it will influence the planning and implementation of future efforts. Existing efforts include, but are not limited to:

- Healthy Way LA
- Integrated Behavioral Health Information Systems (IBHIS)
- Mental Health and Wellness Act of 2013
- AB 109 Funding
- Corporation for Supportive Housing (CSH) Mental Health, Jail Diversion and Supportive Housing Proposal (Appendix 4)
- CSH/DMH funded Emergency room diversion programs
- Policy Research Associates through its SAMHSA GAINS Technical Assistance Center recently provided a Train the Trainer event: *How Being Trauma-Informed Improves Criminal Justice System Responses*. The lead agency for the event was Tarzana Treatment Centers, which provides Seeking Safety Training as part of the Healthy Way LA initiative and provides outreach recruitment services into the jail for transitional housing programs. For a list of trainees at the recent event see Appendix 5.
- Program planning for LA County's new jail
- Advancing Safe and Healthy Homes Initiative/DMH Healthy Home Initiatives

4. Integrate Peer Programs and Peer Support Staff into planning and service delivery.

This recommendation is consistent with Recommendation 73 (p.42) of the Task Force for Criminal Justice Collaboration on Mental Health Issues: Final Report. The California Health Report recently published an article regarding Peer Respite Centers (Appendix 6). The programs described are excellent examples of utilization of peer models and an opportunity to adapt and expand existing programs.

Participants reported peer involvement in service delivery at various Intercept points.

Peer involvement in the Summit and Mapping Workshop was minimal. It is recommended that peers be formally involved in planning efforts moving forward. Depending on whether or not peers are currently employed, they may need stipends to travel to meetings, for meals and/or be paid for their time.

5. Expand screening for Veterans across Intercepts. Allow early diversion and misdemeanor alternatives for Veterans.

There is currently a felony, post-conviction Veterans Court in LA County. While this program is an important component of diversion alternatives for Veterans, providing diversion for misdemeanors, as well as lesser felony offenses earlier in the court process will allow for earlier intervention and likely better outcomes for Veterans. [It should be noted here, as well as throughout this document, “diversion” means diversion from jail or prison, as opposed to the more narrowly circumscribed statutory authorized diversion set forth in California Penal Code section 1000 et seq.]

Using the “Adapt and Expand” philosophy, LA County already has substantial resources for Veterans. Aside from the Department of Veterans Affairs services, the following programs, for example could be adapted, expanded or linked to diversion activities:

- Los Angeles City Attorney’s Office HALO program
- Los Angeles City Attorney’s Office VALOR program
- Patriotic Hall

In addition, the Department of Mental Health has Veteran specific mental health programs which could service Veterans who are not eligible for VA services or who do not wish to utilize VA services.

6. Consider broad approaches to improving accessible housing for justice involved individuals.

This recommendation is consistent with Housing Recommendations (pp.43 and 44) of the Task Force for Criminal Justice Collaboration on Mental Health Issues: Final Report.

Both Summit Participants and Mapping Workshop participants identified housing as a critical gap across Intercepts.

LA County is fortunate to have the Corporation for Supportive Housing as a stakeholder and they have already proposed housing strategies for justice involved individuals (Appendix 4).

INTERCEPT SPECIFIC RECOMMENDATIONS:

Intercept 1

7. Enhance/Expand Police Specialized Response and Mental Health Crisis Response, such as Systemwide Mental Assessment Response Teams (SMART), Mental Evaluation Teams (MET), and Crisis Intervention Teams (CIT).

This recommendation is consistent with Recommendations 7 and 8 (pp.19 and 20) of the Task Force for Criminal Justice Collaboration on Mental Health Issues: Final Report.

Expansion of specialized police response (e.g., SMART, MET, CIT) and improved crisis response was the third highest ranked priority identified in the SIM Mapping Workshop. In addition, participants in the Mental Health Summit, Intercept 1 Workgroup also identified insufficient resources for Psychiatric Mobile Mental Response Teams (PMRT) and crisis response options as gaps.

Participants in both the Summit Workshop and Mapping Workshop were satisfied with police specialized response teams, but noted that the LAPD SMART Team responds to approximately 35% of all calls. Elsewhere in the County, specialized police response is available in Long Beach and Santa Monica, as well as through the Los Angeles Sheriff's Department, which has 8 MET teams.

Participants in the Summit Workshop and the Mapping Workshop identified lack of crisis response options, especially crisis stabilization units as a significant gap. The Long Beach Police Department in particular identified long wait times (up to 6-8 hours) in area emergency departments as a significant issue. Participants noted that waiting for an available psychiatrist in the psychiatric emergency departments often accounted for delays. Lengthy delays for these types of important diversionary services often leave law enforcement with the difficult decision of whether to spend several hours "out of service" with a person while he or she waits to be seen in an emergency department or a psychiatric emergency department or, in the alternative, to take the person into custody, book him or her into a local jail, and return to service. The Psychiatric Mobile Mental Response Teams were also seen as valuable partners, but participants noted that there were insufficient resources to meet demands.

The Department of Mental Health has several initiatives underway to address this recommendation (Appendix 7).

Representatives from the City of Long Beach also identified a lack of a detoxification (sobering) facility, which has resulted in serial inebriates being incarcerated. San Diego has had a successful Serial Inebriate Program for several years and information about their program can be found at: http://www.sandiego.gov/sip/index.htm

Intercept 2

8. Expand diversion opportunities at arraignment and improve screening for diversion at later stages:

- *Bring the Department of Mental Health Court Liaison Teams to scale.*
- *Improve alignment regarding diversion at this intercept among stakeholders.*
- *Implement a Probation Pre-Trial Release Program*

This recommendation is consistent with Recommendations 12,15,16,17 and 18 (pp. 23-24) of the Task Force for Criminal Justice Collaboration on Mental Health Issues: Final Report.

Systemic screening for mental health issues and Veteran status is not present at the first court appearance or arraignment. Key mental health screening partners at this diversion point are defense counsel and the Probation Department. Resources may have to be added to these agencies to enhance screening and referral.

The DMH Mental Health Court Linkage Program is an innovative resource that LA County has operated for 10 years. Participants reported that the program's capacity to serve persons has not increased during that same period. Utilization of the DMH Court Liaison Program, a component of the Mental Health Court Linkage Program, was uneven across the county and there was a lack of alignment between the judiciary, prosecutors and Court Liaison Program regarding diversion philosophy.

Participants also expressed the opinion that housing was a barrier to diversion at this Intercept. While housing would likely improve successful diversion, diversion can be successful with individuals who are homeless, as demonstrated by the New York City CASES Transitional Case Management Program (Appendix 8). Reports from the Court Liaison Program also indicate that successful diversion can be accomplished with individuals who are homeless.

Diversion programs which emphasize engagement strategies, direct linkage, focus on immediate needs, and prompt access to community services can be successful even when there are not significant court sanctions available.

People with mental illness have more bail risk factors and are more likely to be remanded to jail. Pre-trial supervision programs allow for greater access to pre-trial release for persons with mental illness.

When additional court leverage is preferred, implementation of a Probation Department pre-trial supervision program can reassure the court that individuals are appropriately monitored and held accountable for adhering to release conditions.

Intercept 3

9. Expand post-arraignment diversion opportunities for defendants charged not only with misdemeanors but also felonies.

This recommendation is consistent with Recommendations 12,15,16,17 and 18 (pp. 23-24) of the Task Force for Criminal Justice Collaboration on Mental Health Issues: Final Report.

Strategies listed above in Intercept 2 also apply for this Intercept. Expanding capacity for the Court Liaison Teams, improving stakeholder alignment regarding diversion and implementing a pre-trial supervision program can increase diversion opportunities.

In addition, adding a jail diversion screening component at the jail can increase identification of potential diversion candidates. Jail diversion staff can work with the Court Liaison Team and defense counsel to present a diversion plan to the courts.

Diversion strategies at this Intercept should seek to minimize collateral sanctions, such as barriers to employment, housing, court fines, access to public benefits and voting rights. The Legal Action Center's ***After Prison: Roadblocks to Reentry*** (http://www.lac.org/roadblocks-to-reentry/) is an excellent review of sanctions which create employment and housing barriers and impede recovery.

Specialty Courts are not required for Intercept 3 diversion. Pre-trial supervision or periodic status updates by providers to the court for proscribed time frames can be effective. For more serious charges, persons can be sentenced to Probation with appropriate conditions.

Court Self-Help Centers could help address the unplanned releases from courts (see "Task Force for Criminal Justice Collaboration on Mental Health Issues: Final Report" Recommendation 39, p.30).

Intercept 4

10. Expand DMH Jail Navigator capacity and capacity of existing reentry programs.

Both the Summit and Mapping Workshop participants identified extensive resources devoted to reentry planning. Many of these programs reported being able to service additional individuals with additional funding. The DMH Jail Navigators in particular were identified as needing more resources to keep pace with the high volume of referrals and short time-frames with which to link individuals to services. Other providers include, but are not limited to:

- Just In Reach
- HALO Program
- Women's Reentry Court
- LASD Community Reentry Center

Intercept 5

11. Provide training on the Risk, Need, Responsivity (RNR) and Cognitive Behavioral Interventions.

This recommendation is consistent with Recommendations 57, 60, 62, 63 and 64 (pp. 36-37) of the Task Force for Criminal Justice Collaboration on Mental Health Issues: Final Report.

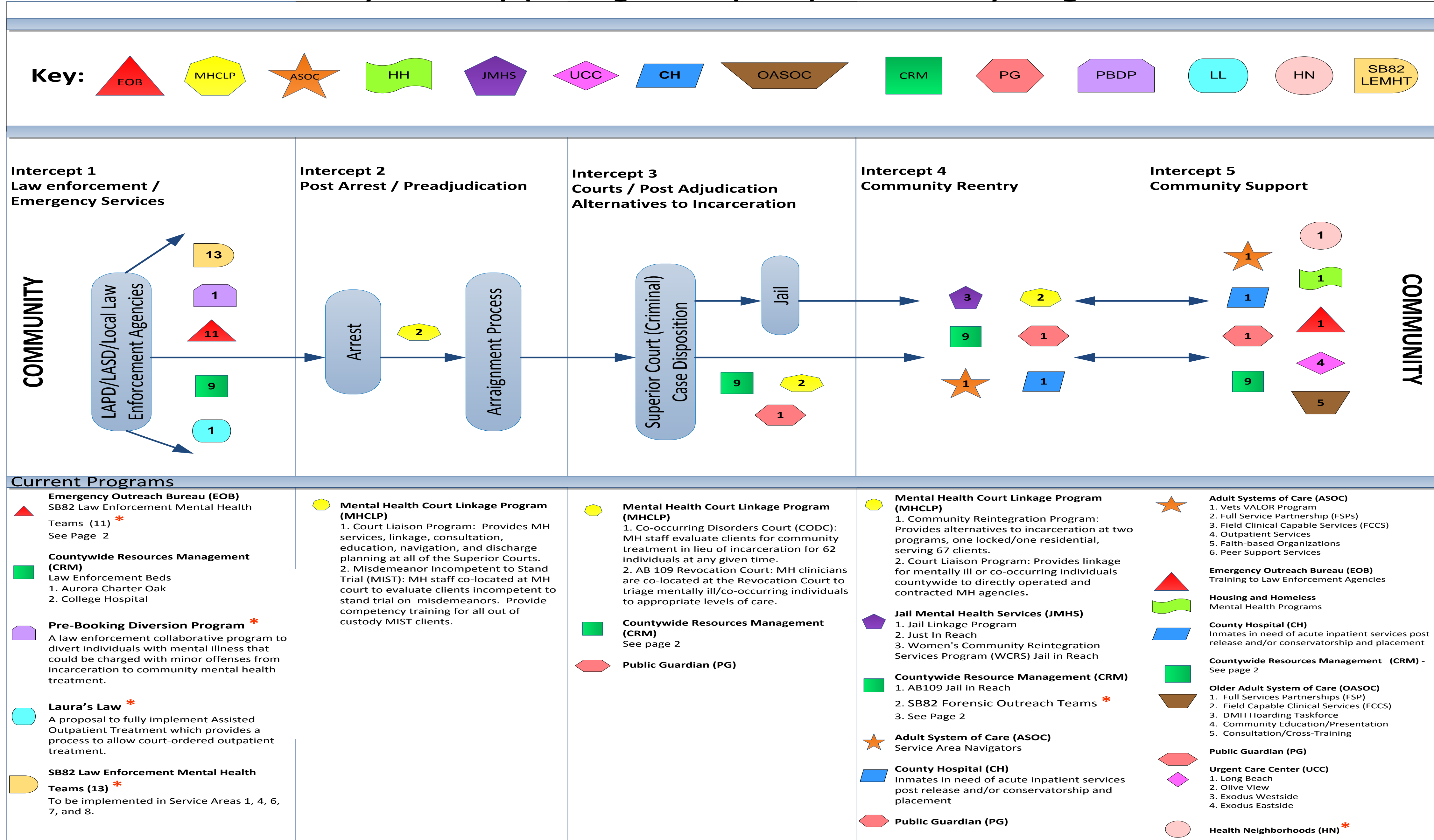
Other than housing, which was a gap across all Intercepts, there were no specific gaps or priorities identified for this Intercept. There are many best practices and innovative programs operating at this Intercept, including specialized mental health Probation caseloads, co-location of Department of Mental Health staff in Probation Department offices and peer-run programs for Probation clients.

The Probation Department performs risk assessments to determine supervision and program needs utilizing the Risk, Need, Responsivity (RNR) principle. This principle targets specific criminogenic risk factors to reduce recidivism and guide the intensity of supervision required. https://cpoc.memberclicks.net/assets/Realignment/risk_need_2007-06_e.pdf. It is important for the Probation Department to uniformly share risk assessment information with behavioral health providers and to expand RNR training and Cognitive Behavioral Treatment interventions which insure that criminogenic needs are addressed in behavioral health settings.

Appendix 1:

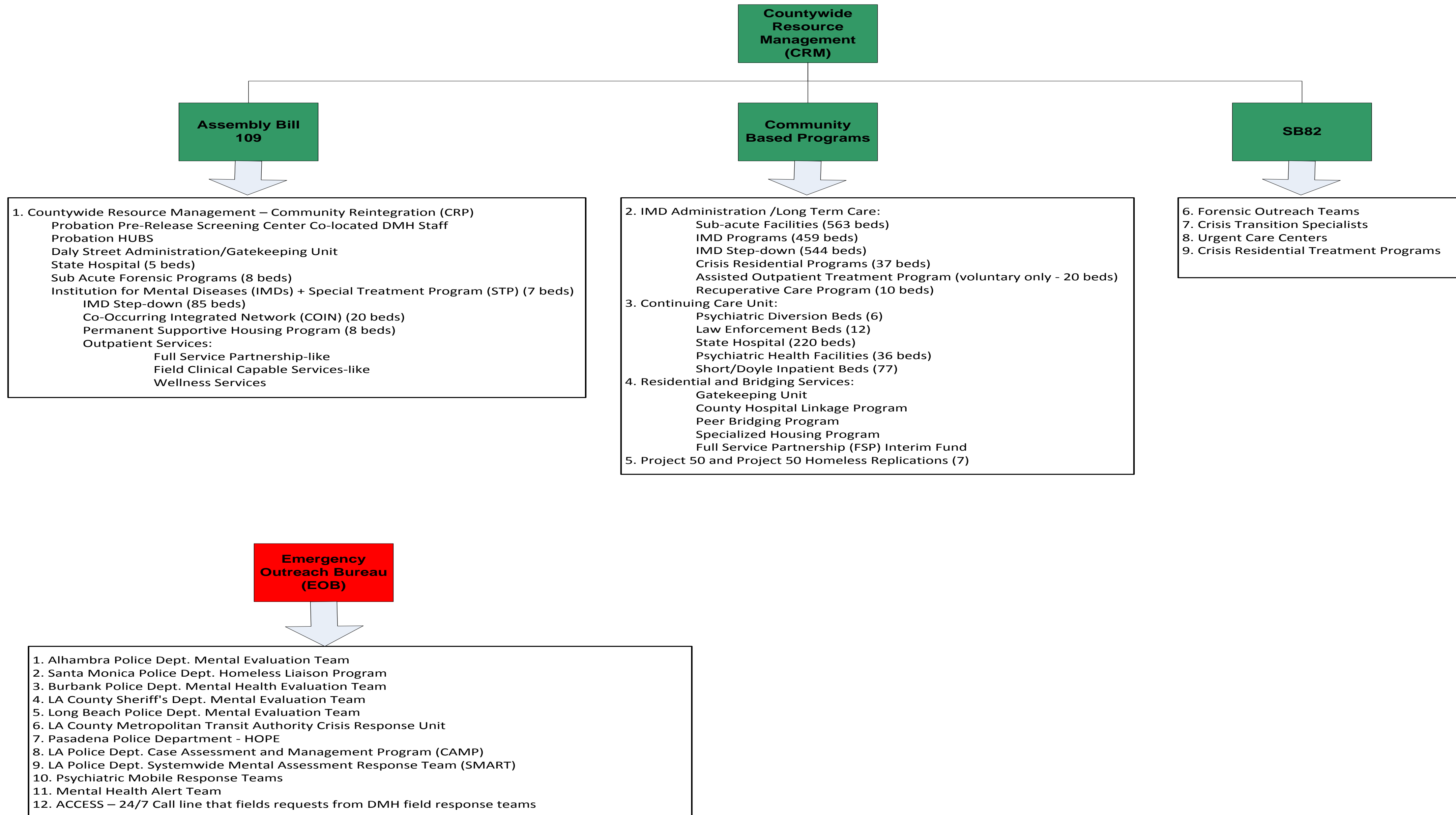
LA DMH Systems Map

County of Los Angeles – Department of Mental Health
Systems Map (Existing and Proposed) – Diversion by Design



* Proposed

County of Los Angeles – Department of Mental Health Systems Map (Current)



Appendix 2:

IL Jail Data Link

CSH supportive housing it works

Jail Data Link Frequent Users
A Data Matching Initiative in Illinois

Overview of the Initiative

The Corporation for Supportive Housing (CSH) has funded the expansion of a data matching initiative at Cook County Jail designed to identify users of both Cook County Jail and the State of Illinois Division of Mental Health (DMH).

This is a secure internet based database that assists communities in identifying frequent users of multiple systems to assist them in coordinating and leveraging scarce resources more effectively. Jail Data Link helps staff at a county jail to identify jail detainees who have had past contact with the state mental health system for purposes of discharge planning. This system allows both the jail staff and partnering case managers at community agencies to know when their current clients are in the jail. Jail Data Link, which began in Cook County in 1999, has expanded to four other counties as a result of funding provided by the Illinois Criminal Justice Information Authority and will expand to three additional counties in 2009. In 2008 the Proviso Mental Health Commission funded a dedicated case manager to work exclusively with the project and serve the residents of Proviso Township.

Target Population for Data Link Initiatives

This project targets people currently in a county jail who have had contact with the Illinois Division of Mental Heath.

- **Jail Data Link – Cook County:** Identifies on a daily basis detainees who have had documented inpatient/outpatient services with the Illinois Division of Mental Health. Participating agencies sign a data sharing agreement for this project.
- **Jail Data Link – Cook County Frequent Users:** Identifies those current detainees from the Cook County Jail census who have at least two previous State of Illinois psychiatric inpatient hospitalizations and at least two jail stays. This will assist the jail staff in targeting new housing resources as a part of a federally funded research project beginning in 2008.
- **Jail Data Link – Expansion:** The Illinois Criminal Justice Information Authority provided funding to expand the project to Will, Peoria, Jefferson and Marion Counties, and the Proviso Mental Health Commission for Proviso Township residents.

Legal Basis for the Data Matching Initiative

Effective January 1, 2000, the Illinois General Assembly adopted **Public Act 91-0536** which modified the Mental Health and Developmental Disabilities Administrative Act. This act allows the Division of Mental Health, community agencies funded by DMH, and any Illinois county jail to disclose a recipient's record or communications, without consent, to each other, for the purpose of admission, treatment, planning, or discharge. No records may be disclosed to a county jail unless the Department has entered into a written agreement with the specific county jail. Effective July 12, 2005, the Illinois General Assembly also adopted **Public Act 094-0182**, which further modifies the Mental Health and Developmental Disabilities Administrative Act to allow sharing between the Illinois Department of Corrections and DMH.

Using this exception, individual prisons or jails are able to send their entire roster electronically to DMH. Prison and jail information is publically available. DMH matches this information against their own roster and notifies the Department of Corrections Discharge Planning Unit of matches between the two systems along with information about past history and/or involvement with community agencies for purposes of locating appropriate aftercare services.

Sample Data at a Demo Web Site

DMH has designed a password protected web site to post the results of the match and make those results accessible to the Illinois Department of Corrections facility. Community agencies are also able to view the names of their own clients if they have entered into a departmental agreement to use the site.

In addition, DMH set up a demo web site using encrypted data to show how the data match web site works. Use the web site link below and enter the User ID, Password, and PIN number to see sample data for the Returning Home Initiative.

- https://sisonline.dhs.state.il.us/JailLink/demo.html
  - UserID: cshdemo
  - Password: cshdemo
  - PIN: 1234

Program Partners and Funding Sources

- **CSH's Returning Home Initiative:** Utilizing funding from the Robert Wood Johnson Foundation, provided $25,000 towards programming and support for the creation of the Jail Data Link Frequent Users application.
- **Illinois Department of Mental Health:** Administering and financing on-going mental health services and providing secure internet database resource and maintenance.
- **Cermak Health Services:** Providing mental health services and supervision inside the jail facility.
- **Cook County Sheriff's Office:** Assisting with data integration and coordination.
- **Community Mental Health Agencies:** Fourteen (14) agencies statewide are entering and receiving data.
- **Illinois Criminal Justice Authority:** Provided funding for the Jail Data Link Expansion of data technology to three additional counties, as well as initial funding for three additional case managers and the project's evaluation and research through the University of Illinois.
- **Proviso Township Mental Health Commission (708 Board):** Supported Cook County Jail Data Link Expansion into Proviso Township by funding a full-time case manager.
- **University of Illinois:** Performing ongoing evaluation and research

Partnership Between Criminal Justice and Other Public Systems

Cook County Jail and Cermak Health Service have a long history of partnerships with the Illinois Department of Mental Health Services. Pilot projects, including the Thresholds Justice Project and the Felony Mental Health Court of Cook County, have received recognition for developing alternatives to the criminal justice system. Examining the systematic and targeted use of housing as an intervention is a logical extension of this previous work.

Managing the Partnership

CSH is the primary coordinator of a large federal research project studying the effects of permanent supportive housing on reducing recidivism and emergency costs of frequent users of Cook County Jail and the Illinois Department of Mental Health System. In order to facilitate this project, CSH funded the development of a new version of Jail Data Link to find the most frequent users of the jail and mental health inpatient system to augment an earlier version of Data Link in targeting subsidized housing and supportive mental health services.

About CSH and the Returning Home Initiative

The Corporation for Supportive Housing (CSH) is a national non-profit organization and Community Development Financial Institution that helps communities create permanent housing with services to prevent and end homelessness. Founded in 1991, CSH advances its mission by providing advocacy, expertise, leadership, and financial resources to make it easier to create and operate supportive housing. CSH seeks to help create an expanded supply of supportive housing for people, including single adults, families with children, and young adults, who have extremely low-incomes, who have disabling conditions, and/or face other significant challenges that place them at on-going risk of homelessness. For information regarding CSH's current office locations, please see www.csh.org/contactus.

CSH's national *Returning Home Initiative* aims to end the cycle of incarceration and homelessness that thousands of people face by engaging the criminal justice systems and integrating the efforts of housing, human service, corrections, and other agencies. *Returning Home* focuses on better serving people with histories of homelessness and incarceration by placing them to supportive housing.

Corporation for Supportive Housing
Illinois Program
205 W. Randolph, 23rd Fl
Chicago, IL 60606
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Appendix 3:

Pre-Booking Diversion Proposal

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
PRE-BOOKING DIVERSION PROPOSAL
"AN OPEN DOOR TO RECOVERY"

September 2013

BACKGROUND

The Department of Mental Health (DMH) is a participant in a variety of collaborative criminal justice projects including law enforcement/mental health crisis intervention teams such as Mental Evaluation Teams (MET) and the Systemwide Mental Assessment Response Team (SMART), the Mental Health Court Linkage Program and most recently the Assembly Bill (AB) 109 Realignment Program. These interagency partnerships address the special needs of persons with mental illness who become involved with the criminal justice system. DMH is proposing to enhance its partnerships with law enforcement entities and the criminal justice system through the implementation of two pre-booking jail diversion programs, initially as pilot projects serving the Long Beach (LB) and Antelope Valley (AV) areas, and subsequently to be extended throughout Los Angeles County, utilizing the experience gained through the pilot projects.

The need for a pre-booking diversion program is significant. Police response to calls involving individuals with mental illness takes more time to complete than calls involving individuals who are not mentally ill. In the Los Angeles County jails, the cost to provide mental health treatment, as well as custodial care, to a daily census of over 2900 inmates with mental illness is substantial. Incarceration disrupts treatment in the community, impedes recovery, and may result in the exacerbation of symptoms. Defendants who are mentally ill and unable to afford bail have been found to spend longer times in custody than those that are not suffering from mental illness. Their court cases often take multiple court appearances to adjudicate, adding costs to the judicial system. A pre-booking interagency diversion program would provide a means of reducing the number of individuals entering the criminal justice system and a safety measure for individuals experiencing crisis.

Pre-booking diversion programs have been implemented in a number of jurisdictions throughout the country. Research indicates that these programs produce positive outcomes for persons with mental illness and for the community. The principal goal of the proposed project is to link individuals with mental illness to recovery services at the first point of contact with the criminal justice system as an alternative to repetitive incarcerations.

In August 2013 DMH Jail Mental Health Staff conducted a prevalence study to determine the number of potential mentally ill males incarcerated from the AV and LB areas that might benefit from a pre-booking diversion program. Findings indicate that 14% of those arrested for felonies and 33% of those arrested for misdemeanor charges may be more appropriately served by mental health treatment rather than incarceration (See Attachments 1 and 2).

PROJECT DESCRIPTION

The proposed LB and AV pilot projects would be housed in Urgent Care Centers (UCC) located in the AV and LB areas. The UCCs would serve as the entry point for the AV and LB Police Departments to link individuals to mental health services in lieu of their being charged with low level offenses. UCCs typically provide up to 24 hours of intensive crisis services and immediate care, including referrals to community based solutions, to individuals who otherwise would be brought to emergency rooms. The AV and LB UCCs would be expanded to allow specially trained law enforcement to divert individuals to mental health services whose low level offenses appear to be the result of or associated with their mental illness and who voluntarily agree to treatment. The diversion project would have the ability to link clients to needed services directly, including all levels of mental health care, health services, substance abuse treatment, housing, benefits (re)establishment, education and employment, and social services. The UCCs would be designated to receive or place individuals on 72-hour holds.

The goals of the Program are as follows:

- Enhanced coordination among law enforcement, mental health and other participating agencies
- Improved access to services for people with mental illness
- Diversion of people with mental illness from the criminal justice system
- Improved efficiency of police response to mental health related calls

DMH will use established partnerships to develop the proposed projects. As a first step, DMH plans to engage stakeholders such as the AV and LB Police Departments and law enforcement/mental health teams, the City Attorneys, the District Attorneys and Countywide Criminal Justice Coordination Committee to support the project. Once support is secured for the projects, a work group would be needed to coordinate tasks such as establishing agreements among participating agencies in each geographical area; identifying target populations and offenses; establishing program capacity and notification protocols when at capacity; developing training for police dispatchers and

specialized police officers; delineating the range of mental health and other services to which participants could be linked; establishing protocols, including information sharing; defining data tracking and outcome measures; and identifying funding sources.

This proposal would leverage existing County and local services - UCCs, other mental health providers and the mental health/law enforcement teams - to implement the programs. In addition to leveraging existing services, the projects will require additional funding including AB 109, Mental Health Services Act (MHSA) and Senate Bill (SB) 82. It is anticipated that both projects will require capital development and services funding including UCC staffing, recruitment, training, and development of enriched residential capacity to serve this population. Included in the UCC staffing will be a short-term case management team that can immediately house program participants if needed, provide treatment for mental health and co-occurring substance abuse disorders and follow participants for up to two months until connected to community services and supports. The timeline for the implementation of the AV pilot will be lengthier than LB pilot due to the need to develop a new UCC in the area.

Anticipated outcomes of the program include:

- Reduction in arrest for minor offenses of persons with mental illness
- Increased access to mental health services for individuals who come into contact with law enforcement
- Increased satisfaction of persons with mental illness with law enforcement services
- Increased training of police officers on recognizing mental health symptoms and resources.

Following successful implementation of these pilot projects, DMH envisions working with its partners to expand the programs in order to offer law enforcement personnel countywide a means to redirect people with mental illness away from the criminal justice system to recovery-based community treatment and services and to promote an end to the cycles of repeated incarcerations.

Attachment 1

Pilot: Identification of Potential Correctional Mental Health Clients for Pre-Booking Diversion

Method: A prevalence study was conducted on August 5, 2013. All incarcerated inmates from Service Area 1 and 8 (Antelope Valley and Long Beach) were surveyed.

Total	N = 169	
Felony	N = 133	77%
Misdemeanor	N = 36	21%

Recommended Diversion Exclusions

Arrest Charge

1. Murder, Attempt Murder
2. ADW with use of firearm and/or GBI
3. Robbery 1st and 2nd degree
4. Manslaughter, 1st or 2nd degree
5. Any sexual offense
6. Any child offense
7. Domestic violence
8. Arson
9. Battery GBI
10. Kidnapping, False Imprisonment, Car jack
11. Co Ret. (State Hosp. Returnees)
12. All other offenses with 4 or more previous arrest as determined by CII (Criminal Information Index)

Felony Charge

Excluded by criteria	N = 48	36%
County Returnees	N = 11	8%
CII 4 or more (criminal charge)	N = 38	29%
CII 4 or more (drug charge)	N = 17	13%
Acceptable for Diversion	N = 18	14%

Misdemeanor Charge

Same exclusion criteria as for felonies, but previous arrests by CII increased to 10 with no previous arrest constituting any of above exclusions (item 1 – 11).

Misdemeanor Results
N = 36

Excluded by criteria	N = 19	53%
County Returnees	N = 5	14%
Acceptable for Diversion	N = 12	33%

Total (Felony and Misdemeanor) acceptable for Diversion = 30 18% of whole sample (e.g. based on 400 bookings in a day 72 would be diverted from jail)

These diversion criteria are considered to be based on conservative criteria.

Discussion

Pilot study results regarding the possible diversion of mental health arrestees from incarceration are very promising, but these data must be viewed in context. First, subjects were selected from 2 Los Angeles County Service Areas (Antelope Valley and Long Beach). Due to possible variances in personal and demographic differences, these results may not be readily generalizable to different County Service Areas, (e.g. Downtown). Additionally, these data were collected via a "spot prevalence" count of mental health men incarcerated on a single date. Length of jail stay was not determined. Positive diversion factors tend to correlate with short jail tenure and vice versa. This factor needs further exploration and may well result in an increase in the percentage of potential diversion candidates.

The concept of diversion of the mentally ill from incarceration is clearly supported by these preliminary data and has very broad and promising ramifications for appropriate community based treatment of the mentally ill.

Appendix 4:

CSH Mental Health, Jail Diversion and Supportive Housing Proposal

Mental Health, Jail Diversion, and Supportive Housing:

A Model for Community Integration and Stabilization

July 2014

DRAFT

Introduction

Men and women experiencing homelessness and suffering from mental illness are substantially more likely be involved with the criminal justice system than those individuals who live with mental illness, but are stably housed. For these men and women access to supportive housing (stable, safe, affordable housing combined with supportive services, mental health treatment and healthcare) has the single greatest impact on their likelihood of recidivating. A stable home in the community not only provides safety, security and shelter, but allows a level of stability, dignity and community integration that cannot be provided by any other intervention.

Supportive Housing

Supportive housing is an evidence-based practice that reduces homelessness and improves health outcomes for individuals experiencing long term homelessness and disabling conditions. By definition supportive housing is affordable housing combined with a wide array of supportive services. The housing is not time-limited. Tenants rent apartments and sign a lease that grants them full protection under state and local tenant landlord laws. Tenants can stay in their apartments as long as they choose granted that they do not violate the conditions of their lease. The housing affordability is generally provided through rental assistance in the form of the Housing Choice Voucher program or other federal and local rental assistance programs that allow tenants to pay rent based on 30% of their income regardless of how low their income may be or in some cases lack of any income at all.

Supportive housing is linked to comprehensive voluntary and flexible supportive services, behavioral healthcare and primary healthcare that is based on the tenants' needs and preferences. While the housing and services are linked, tenants are not required to participate in services. Services are completely voluntary and tenants cannot be asked to leave their housing because of their lack of participation in services or adherence to treatment plans. Services are provided using a proactive approach, where service providers actively engage tenants and develop treatment plans based on tenants' preferences.

To understand what supportive housing is, it is instructive to also understand what supportive housing is not. Supportive housing starkly differs from transitional housing, shelters, sober living programs, group homes or board and care facilities, including the following:

Supportive Housing Tenants —versus—	Transitional Housing Residents
• Sign a lease (or sublease if master-leased) with landlord, have rights & responsibilities of tenancy under state & local law, are free to come & go or have guests	• Do not have leases, have no rights under landlord-tenant law, have restrictions on coming & going, as well as guests
• Have no restrictions on length of tenancy, can remain in apartment as long as complying with lease terms & desires to remain in apartment	• Do not determine their own length of stay (program decides length of stay)

Supportive Housing Tenants —versus—	Transitional Housing Residents
• May participate in accessible, usually comprehensive, flexible array of services tailored to needs of each tenant, with a case manager on call 24/7	• Service availability varies from program to program, without choice in services
• Are not required to participate in services as a condition of tenancy, of admission into housing, or of receipt of rental subsidies	• Are required to participate in services, or cannot remain in program or access subsidy
• Have rent based on income, in compliance with federal affordability guidelines (30-50% of income).	• May be asked to pay rent based on program's guidelines, not based on federal affordability guidelines
• Work closely with services staff who collaborate with (but are usually separate from) property management staff to resolve issues to prevent eviction	• Often have no advocate for resolving issues that may lead to eviction, as service providers usually the same as staff running home
• Live in housing that meets federal quality standards for safety & security	• May live in substandard conditions
• Usually occupy own bedroom, bathroom, and kitchen &, if sharing common areas, choose own roommates	• Have no choice over housemates, usually share bedroom with at least one (usually multiple) other tenants
• Are protected by Fair Housing law	• Are not protected by Fair Housing law

Supportive housing is community-based housing that can be provided in a single-site, or congregate, based model, mixed-population model, or a scattered-site model. Single-site supportive housing is a traditionally a single multi-family apartment building where all apartments are occupied by supportive housing residents. Single-site supportive housing is traditionally produced using community development or affordable housing financing and has the benefit of including on-site supportive services.

Mixed-population supportive housing is traditionally a single multi-family apartment building where a portion of the apartments are set-aside for supportive housing residents. Mixed-population models tend to combine traditional affordable housing dedicated to working families or individuals with a smaller or equal portion of apartments dedicated to supportive housing residents. Mixed-population developments are also traditionally produced using community development or affordable housing financing. Depending on the number of apartments dedicated to supportive housing residents these developments may or may not include on-site supportive services.

Scattered-site supportive housing is provided by dedicating tenant-based rental assistance to supportive housing residents who then secure rental housing from private landlords in the community. The most common program providing this form of supportive housing is the Housing Choice Voucher, or Section 8, program. In this model services are provided through mobile teams who provide services to tenants throughout the community.

Each of the models described above include unique opportunities and challenges. Some service providers prefer providing on-site services through a single-site model. While others prefer the community integration provided through scattered-site models. Similarly, some public agencies prefer the community development opportunities and increased housing supply produced by single-site models, while others prefer the speed of scattered-site approaches.

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Across the country we have learned that communities need all models. Programs to expand supportive housing should include multiple approaches.

Los Angeles County currently has no supportive housing dedicated to justice-involved individuals. Today justice-involved individuals access supportive housing through the homeless service delivery system and by independently applying for housing. As a result, justice-involved individuals face long wait lists and may be denied housing as a result of their history of incarceration. Any strategy to divert individuals experiencing mental illness from entering or returning to jail must include the provision of new supportive housing.

Financial Modeling

CSH has prepared a financial model based on providing 1,000 new units of supportive housing for justice involved individuals. Each model includes housing, as well as supportive services and program administration. 400 of these supportive housing units would be provided through new construction or rehabilitation of single-site or mixed population developments. This model assumes leveraging community development and affordable housing financing including project based rental assistance provided by public housing authorities.

600 of these supportive housing units would be provided through a scattered-site model. CSH recommends investing in an existing Department of Health Services program, the Flexible Housing Subsidy Pool. The Flexible Housing Subsidy Pool has infrastructure in place today, which would allow virtual immediate access to housing. The Flexible Housing Subsidy Pool is also designed for a similar population, frequent users of LA County health services who, by in large, also suffer from mental illness, substance use disorders and histories of trauma.

Each model assumes a 5-year operating cycle. It should be noted that supportive housing is not time limited. These models would need a new investment at the end of the 5-year operating cycle to continue. For the new construction/rehabilitation model this would require an investment in social services only because the rental assistance is provided by the federal government. The Flexible Housing Subsidy Pool would require an additional investment in both rental assistance and social services.

Permanent Supportive Housing New Construction/ Rehabilitation	400 Units	5-Year Cost
Capital Subsidy	$75K/unit*400	$30,000,000
Integrated Case Management Services	$400/mon*60 mon*400 people	$9,600,000
Program Administration	1 FTE/5 years	$500,000
Total		**$40,100,000**

*Assumes leverage of Project Based Section 8 or Shelter Plus Care and traditional affordable housing capital financing including Low Income Housing Tax Credits

Flexible Housing Subsidy Pool	600 Units	5-Year Cost
Move-in Assistance	$2,000*600 people	$1,200,000
Rental Assistance	$800/mon*60 mon*600 people	$28,800,000
Program Coordination	$125/mon*60 mon*600 people	$4,500,000
Integrated Case Management Services	$400/mon*60 mon*600 people	$14,400,000
Program Administration	1 FTE/5 years	$500,000

Total		$49,400,000

Funding Sources
There is no magic bullet to fund supportive housing. That said, funding sources do exist that could offset a portion of the cost of this model.

County-Owned Land
The County owns large parcels of land, such as medical centers, that may include properties that are being under-utilized. This land could be made available to supportive housing developers to help offset the cost of development.

Medi-Cal
The majority of justice-involved individuals in the County became eligible for Medi-Cal under the Affordable Care Act beginning January 1, 2014. Medi-Cal can reimburse providers for a portion of case management, mental health treatment, primary healthcare and even substance abuse treatment. While Medi-Cal reimbursement is limited, there is a new option in the Affordable Care Act called Health Homes that could provide more comprehensive coverage for services. The state passed a bill, AB 361, in 2013 to implement this option of the Affordable Care Act and will soon begin a planning process for implementation.

Mental Health Services Act
The Mental Health Services Act also includes funding that could be utilized to offset the cost of services. The Department of Mental Health currently has a program called Integrated Mobile Health Teams that combines Medi-Cal reimbursement with MHSA Innovations funding to fund a package of services that is similar to the integrated case management services included in the models above.

Linkages to Supportive Housing
Supportive housing works as diversion and discharge strategy when clients are effectively linked to supportive housing. Effective linkage is dependent on comprehensive programs that include the following components:

- Targeted and easily-implemented screening tools to identify clients
- Warm-hand off to Housing Navigators, who begin engagement in the court-room, jail, hospital or crisis stabilization unit
- Immediate access to low-barrier interim housing
- Immediate assistance with identification documents and housing application process
- Case management provided through a "whatever-it-takes" approach including transportation, food assistance, etc.
- Housing placement and ongoing intensive case management
- Linkage to primary healthcare, behavioral healthcare, and substance abuse treatment
- Connections to community, education, employment and family re-unification

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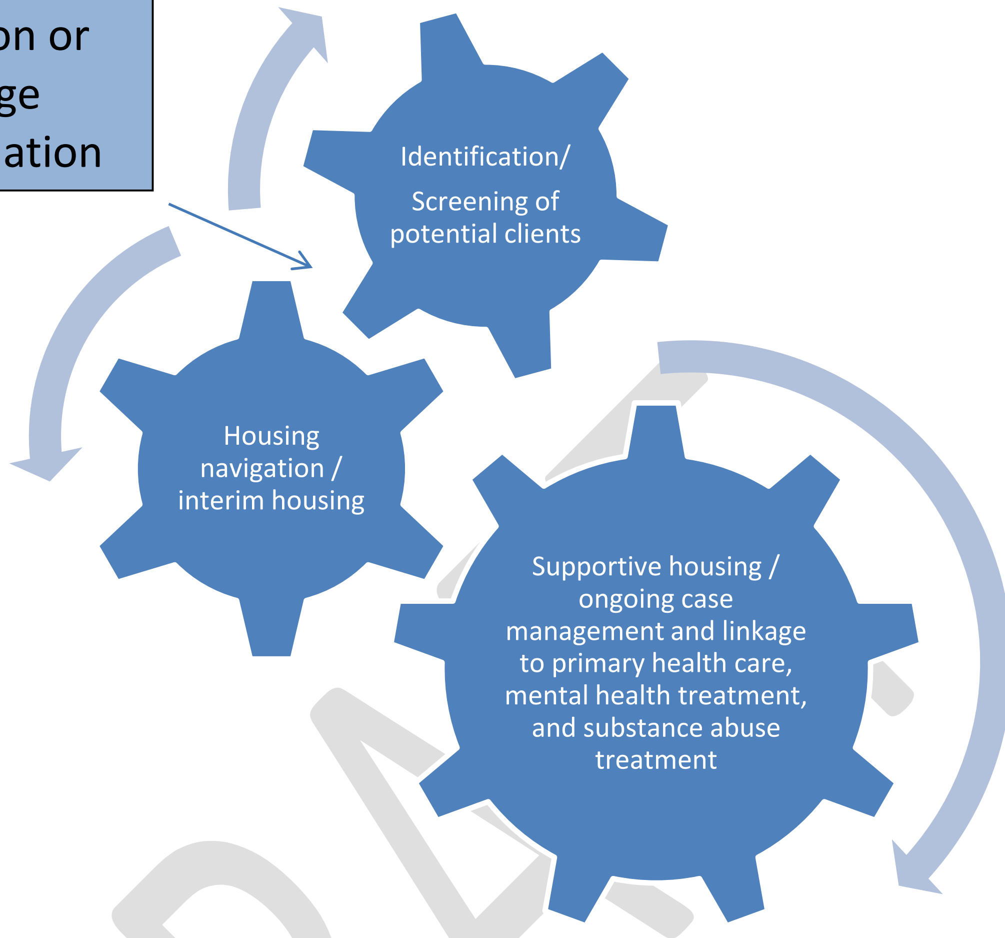
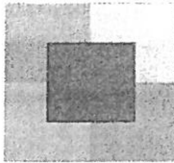


CSH has implemented two programs that utilize this model to connect individuals in institutions to supportive housing in Los Angeles County. The **Just in Reach 2.0 project** connects individuals experiencing long-term homelessness in LA County jails to supportive housing through the provision of in-reach, discharge coordination, housing navigation, interim housing, supportive housing placement and on-going case management. The **10th Decile project** (including the Frequent Users System Engagement program and the Social Innovation Fund program) connects individuals experiencing long-term homelessness who are frequent users of the healthcare system to supportive housing through the provision of discharge coordination, housing navigation, interim housing, supportive housing placement and on-going case management. Both of these programs are ideal models for future diversion and re-entry programs.

Appendix 5:

LA Trauma TTT Participants



SAMHSA'S GAINS Center for Behavioral Health and Justice Transformation

Substance Abuse and Mental Health Services Administration
SAMHSA
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www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)

SAMHSA's GAINS Center
How Being Trauma-Informed Improves Criminal Justice System Responses
Train-the-Trainer Event

Los Angeles County, CA • July 15-16, 2014

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Appendix 6:

Peer Respites

Peer respites for mental health consumers prevent hospitalizations

August 12, 2014

By Lynn Graebner

As people with mental health crises overwhelm California's hospitals, jails and homeless shelters, counties across the state are gradually embracing residential respite houses located in neighborhoods and staffed by peers — people who have been consumers of the mental health system.

For people on the verge of a crisis, staying at a peer-run respite, typically for a couple of days or up to two weeks, can help them recover with support from people who have had similar experiences.

That can prevent incarceration or forced hospitalization, which often damages family relationships and can cause the loss of housing or jobs, said Yana Jacobs, chief of outpatient adult services for Mental Health and Substance Abuse Services at the Santa Cruz County Health Services Agency.

California has three peer-run respites, two in Los Angeles County and one in Santa Cruz. San Francisco and Santa Barbara Counties are in the process of opening respites and Alameda County is considering one.

The latter three would likely be largely staffed by peers but not considered peer-run as peers probably won't be in administrative positions. That distinction makes a big difference, say advocates.

"If respites are run by the traditional system, even peer workers can start behaving like clinicians," said Oryx Cohen, Director of the Technical Assistance Center at the National Empowerment Center, a Massachusetts-based nonprofit peer-run mental health organization.

Without peers at the helm, hierarchical administrations can undermine shared decision making; the sense of clients and support staff being equals, each having something to offer and the dropping of clinical labels.

The peer-run model is growing throughout the country with 12 peer-run respites and two hybrid programs in 11 states. Six more are planned and funded, said Laysha Ostrow, a postdoctoral fellow at Johns Hopkins Bloomberg School of Public Health.

Growth is slow but steady. One barrier is the stigma that mental health consumers can't handle crisis situations, Cohen said.

"Departments of mental health and behavioral health just need to be educated and need to see that this is a viable alternative," he said.

It has been for Asha Mc Laughlin, who knows well the trauma of being hospitalized. She suffers post-traumatic stress disorder, major depression and anxiety due to being abducted, raped and threatened with murder when she was 16. Chronic back pain also plagues her mental health.

She's spent a lot of time in psychiatric hospitals in the past, but rarely uses them now since finding the Second Story peer respite in Santa Cruz three years ago.

Peer counselors there are trained in the Intentional Peer Support method and, unlike psychiatrists, can share their own experiences, alleviating some of the isolation people feel, and creating relationships that are mutually supportive.
"It seems there's just automatic healing in that," Mc Laughlin said. "And when my understanding supports them, it means a lot to me."
At Second Story guests talk conversationally with peer counselors, handle their own meds, cook meals and can join or lead group sessions ranging from art and meditation to dealing with conflict and alternatives to suicide.

"We've found that when we treat people like responsible adults they behave like responsible adults," said Adrian Bernard, one of the administrators and a peer counselor.

"We have had a huge amount of success getting people out of the [mental health] system," he said.

San Francisco is one of the latest cities experimenting with peer respites. Its Department of Public Health plans to launch a psychiatric respite next to San Francisco General Hospital and Trauma Center this fall, said Kelly Hiramoto, acting director of Transitions at the San Francisco Department of Public Health.

San Francisco desperately needs these types of alternatives to hospitalization, incarceration and homelessness. Last year the city had almost 800 jail inmates diagnosed with a psychotic, bipolar or major depressive disorder, reported San Francisco Mayor Edwin M. Lee's office.

The San Francisco respite is one of several remedies the city is trying. It will start with four beds with room to grow to 12 or 14, and five peer counselors as well as six entry-level mental health rehabilitation workers, Hiramoto said.

The city didn't go as far as some local mental health advocates had hoped, but they say it's a start.

"We're very supportive of the psychiatric respite. We think that's a great thing that will fill a gap," said Michael Gause, Deputy Director, Mental Health Association of San Francisco, a nonprofit advocacy organization. But they would also like to see a pure peer-run respite, he said.

Several other counties are also getting their feet wet. In the last year two peer-run respites have opened in Los Angeles County, Hacienda of Hope in Long Beach and SHARE! Recovery Retreat in Monterey Park. They're both funded by the Los Angeles County Department of Mental Health Innovations Program as three-year pilots.

Santa Barbara County has approved a largely peer-staffed respite and is seeking a site, said Eric Baizer, with the Santa Barbara County Department of Alcohol, Drug and Mental Health Services.

And Manuel Jimenez, director of Alameda County Behavioral Health Care Services, said a stakeholder group has proposed a peer-staffed respite for his county and he's supportive.

Statewide, California had less than half the national average of psychiatric beds per capita as of 2007, according to a 2010 report by the California Mental Health Planning Council, an advisory body to state and local government.

Respites could help fill that gap. Crisis residential programs, including peer respites, cost roughly 25 percent of hospital inpatient care and are often more effective, the report states.

Jacobs said one of the reasons these respites are successful in reaching people is they don't focus on diagnosis. She believes only about 25 percent of people being diagnosed schizophrenic actually are.

"The rest have trauma and are being labeled," she said. "You don't want to tell someone they have a serious mental illness and will be disabled the rest of their lives."

Bernard, for example, hears voices but hasn't been hospitalized since 2003.

"Now I have a community around me and three or four times they've kept me from going to the brink," he said.

Jason Davis, who first came to Second Story as a guest and is now a peer counselor, agreed that the enormous camaraderie there is what helped him overcome his paranoia.

"I support the house and the house supports me," he said.

The nonprofit Human Services Research Institute is doing a five-year evaluation of Second Story, required by the grant it received from the federal Substance Abuse and Mental Health Services Administration. Early analysis suggests a reduction in use of high-cost hospitalizations and other emergency services by those who use the respite, said Bevin Croft, Policy Analyst for the organization.

That's certainly true for Bernard, Mc Laughlin and Davis since joining the Second Story community.

"For the first time in my life I feel like people understand me and can support my growth," Bernard said.

http://www.healthycal.org/archives/16402

Appendix 7:

DMH Fact Sheet

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
Investment in Mental Health Wellness Act of 2013 Fact Sheet
December 2013

OVERVIEW

In June of 2013, Governor Jerry Brown signed the Investment in Mental Health Wellness Act of 2013 (MHWA) into law. MHWA establishes new grant opportunities that funds California counties or their nonprofit/public agency designates to develop mental health crisis support programs. The MHWA provides $142.5 million in capital funding and $6.8 million for mobile crisis support teams to increase the capacity for client services, crisis intervention and stabilization, crisis residential treatment, rehabilitative mental health services, and mobile crisis support teams. The California Health Facilities Financing Authority (CHFFA) will support capital improvement, expansion and limited start-up costs. The County of Los Angeles (County), along with Tri-City Mental Health Authority is eligible for $40 million of these funds including an additional $1.9 million for mobile crisis support teams.

PROPOSED PROGRAMS

Utilizing the capital funding from the MHWA, the County of Los Angeles Department of Mental Health (DMH) intends to develop five new Psychiatric Urgent Care Centers and establish 10-15 Crisis Residential programs in each of the eight Service Areas (SA). Additionally, there will be an expansion of our current mobile crisis support teams throughout the county.

Urgent Care Centers—*Provide short-term (23 hour), crisis intervention services to individuals 13 years and older who would otherwise be taken to or access care in emergency rooms.*

DMH currently utilizes four adult urgent care centers:

- Olive View—SA2
- Eastside Exodus Urgent Care Center—SA 4
- Westside Exodus Urgent Care Center—SA5
- La Casa Mental Health Urgent Care Center—SA8

The MHWA would fund an additional five urgent cares to be located on the campus of Harbor UCLA Medical Center, SA 7, the Antelope Valley, the greater Hollywood area, and SA 3. A UCC at Martin Luther King, Jr. Medical Center is also scheduled to open early 2014.

Crisis Residential Programs—*Each program serves 10-12 persons for an average of 10-14 days. This program provides immediate, structured housing and supportive mental health services, most frequently as an alternative to extended acute psychiatric hospitalizations.*

DMH currently funds three crisis residential programs:

- Hillview Crisis Residential Program—SA 2
- Didi Hirsch Excelsior House—SA 8
- Didi Hirsch Jump Street—SA5

DMH proposes to increase crisis residential bed capacity by 160 beds countywide through the development of approximately 10-15 new crisis residential programs

Mobile Crisis Support*—DMH operates a psychiatric mobile emergency response system twenty-four hours per day, seven days per week. The Emergency Outreach Bureau has several programs that provide field response services including Psychiatric Mobile Response Teams (PMRT), Law Enforcement Teams (LET), School Threat Assessment and Response Team (START), and Homeless Outreach Mobile Engagement (HOME).*

The $1.9 million for mobile crisis support teams will expand the field response operations personnel. In addition, there is a total of $500,000 that can be used for the purchases of vehicles for these teams.

EVALUATION CRITERIA

CHFFA will evaluate an applicant's ability to meet the following criteria:

1. Project* expands access to and capacity for community based mental health crisis services that offer relevant alternatives to hospitalization and incarceration.
2. Application demonstrates a clear plan for a continuum of care before, during, and after crisis mental health intervention or treatment and for collaboration and integration with other health systems, social services, and law enforcement.
3. Identifies key outcomes and a plan for measuring them.
4. Project is feasible, sustainable and ready or will be feasible, sustainable and ready within six months of the Final Allocation.

* Project means startup or expansion of Program(s) and acquisition, construction, renovation or financing of capital assets; or equipping and staffing a Mobile Crisis Support Team.

Appendix 8:

CASES TCM Program Brief

POLICY RESEARCH ASSOCIATES

Successfully Engaging Misdemeanor Defendants with Mental Illness in Jail Diversion: The CASES Transitional Case Management Program

Jacob & Valeria Langeloth Foundation | CASES | Policy Research Associates August 2012

Goals of this document:

- Provide a description of the development and operation of an alternative-to-incarceration program for repetitive misdemeanants
- Outline the strategy used by the program to promote engagement with behavioral health services through case management
- Review the program's effectiveness in reducing arrests, compliance with the court mandate, and linking participants to long-term treatment services
- Explain the role of positive court relations, standardized court screening, same-day engagement, and flexibility of service provision in the program's success.

Individuals convicted of misdemeanor offenses receive relatively modest punishment within the criminal justice system. As a result, programs that divert misdemeanants with mental disorders into treatment services lack judicial leverage to counter noncompliance. Yet misdemeanor cases constitute a huge burden for criminal courts. For example, in 2007, misdemeanor cases accounted for three-quarters of all arraignments in the Manhattan Criminal Court. The behavioral, medical, and public safety implications of noncompliance present courts and service providers with a need for more effective engagement strategies.

The Center for Alternative Sentencing and Employment Services (CASES) launched the Transitional Case Management (TCM) alternative-to-incarceration program in 2007 for misdemeanor defendants in Manhattan Criminal Court. TCM has received funding from the New York City Department of Correction, New York Mayor's Office of the Criminal Justice Coordinator, Bureau of Justice Assistance Justice and Mental Health Collaboration Program, Jacob and Valeria Langeloth Foundation, van Ameringen Foundation, Schnurmacher Foundation, and the Manhattan Borough President's Office. TCM provides screening, community case management, and coordinated support for individuals with mental disorders or co-occurring mental and substance use disorders at risk of jail sentences.

Background

CASES clinical staff identify participants in arraignment, before sentencing, and also while completing a day custody program court mandate after sentencing. The participants are individuals with mental disorders or co-occurring mental and substance use disorders who have completed three days in the day

custody program or are mandated by the court to participate in three or five community case management sessions as an alternative to incarceration.

Participants recruited from the day custody program voluntarily enter TCM after completing the court mandate. Defendants mandated to TCM directly from court can voluntarily continue in the program for up to three months after satisfying the court mandate. TCM is staffed by a psychologist responsible for court-based screening and project coordination, a licensed social work supervisor, a bachelor-level substance abuse case manager, and a part-time forensic peer specialist.

Participants

TCM enrolled 178 individuals from July 2007 through November 2010. Approximately three-quarters (78%) of participants were male. The mean age of participants was 40. About half (56%) were Black, 25% were Hispanic or Latino, 12% were White, 2% were Asian, and 5% were multi-ethnic.

The majority of participants had a psychiatric diagnosis of bipolar disorder (38%), depressive disorder (20%), or schizophrenia (19%). Most participants (85%) had a co-occurring substance use disorder. Ninety-five participants (53%) were homeless upon entry into TCM.

TCM participants had an extensive criminal history, with a mean of 27 lifetime arrests and a mean of 3.6 arrests in the past year. Every participant had at least one prior misdemeanor conviction and 53% had one or more prior felony convictions.

The conviction that preceded enrollment in TCM was for a property crime in about half of the cases (51%). One-quarter (25%) were convicted of possession of a controlled substance. Seventeen percent (17%) were convicted of a crime against a person.

Outcomes

Rearrest

In the year after program entry, the participants experienced 2.5 mean arrests. This figure, compared with 3.6 mean arrests in the year prior to program entry, represents a 32% reduction between the two periods. This reduction is statistically significant at the $p<.001$ level. Seventy-two percent (72%) of participants were arrested at least once in the year after program entry.

Pre-Entry and Post-Entry Mean Arrests for TCM Participants, by Lifetime Arrests (n=178)

Lifetime Arrests	No.	%	1 Year Pre	1 Year Post
0-3	15	8.4	1.3	0.3
4-10	32	18.0	2.4	0.7
11-20	33	18.5	3.5	2.2
21-40	62	34.8	4.2	3.1
≥41	36	20.2	5.1	4.2
Total	178	100.0	3.6	2.5

Participants with more lifetime arrests experienced an attenuated reduction in arrests between the two periods. Participants with the most lifetime arrests (41 or more) experienced only an 18% reduction in mean arrests prior to and after program entry. Yet participants with three or fewer lifetime arrests experienced a 75% reduction in mean arrests. Mean arrests fell 70% for participants with 4 to 10 lifetime arrests, 37% for participants with 11 to 20

lifetime arrests, and 25% for participants with 21 to 40 lifetime arrests.

Compliance and Service Linkage

The majority (82%) of the mandated participants successfully completed the court mandate, and 85% of those participants chose to continue to receive case management services beyond the mandated period. On average, participants took part in 16 voluntary case management sessions over the course of 156 days. Thirty-nine percent (39%) of the TCM participants were linked to long-term services prior to TCM program enrollment, and the program linked and transferred 25% of participants to long-term treatment services.

Keys to Program Success

Positive Court Relations

The TCM program benefits from having a professional clinician maintain a daily presence in the arraignment parts. This criminal justice–savvy individual is readily available to administer the screening protocol, engage with defense counsel, and provide pertinent information to judges to advocate for defendants who are eligible for the program. The clinician fine-tunes the program's court operations in response to feedback from defense counsel and the judges.

Standardized Court Screening

The clinician administers the structured screening protocol in the courtroom interview pens to all referred defendants. The 75-minute protocol reviews mental health (Mental Health Screening Form III) and substance use (Texas Christian University Drug Screen II), psychosocial domains, risk factors, court mandate conditions, and program expectations and goals. As a result, the clinician is able to determine whether a defendant is eligible for TCM during the period before the individual appears before the judge. The majority of defendants referred by defense counsel and judges are eligible for TCM.

Same Day Engagement

The TCM case management protocol calls for immediate engagement of new participants in a standardized orientation protocol. The objective of the protocol is to increase the likelihood a new participant will engage in the case management services. Participant engagement begins with an orientation session that takes place immediately after release from court (participants referred from the day custody program are oriented on the day of admission). The project coordinator introduces the participant to project community staff. An evaluation of the participant is provided to staff, with a focus on immediate needs, risk factors, and details about the court mandate.

Flexibility in Service Provision

The high engagement in services is attributed to TCM's flexibility in delivering services to participants. TCM has the capacity to provide the frequency and duration of service contacts to participants based on their immediate and ongoing needs. Program participants are seen by program staff as often as needed in any community setting convenient for the participant. They are seen if they arrive late or miss an appointment. The participants are welcomed by the program whenever they arrive or make contact with the staff to obtain services.

Conclusion

The TCM program points to the value of case management services to support reductions in the criminal recidivism of people with mental disorders or co-occurring mental and substance use disorders arrested for misdemeanor crimes. The program is now working to enhance the nature of its case management services with the use of a validated risk and need instrument. This will provide the staff with specific information regarding the criminogenic needs of their clients that should be addressed with services to achieve greater reductions in recidivism.

For More Information...

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Reference

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