Behavioral Health Court in Mendocino County, CA

A Multidisciplinary and Collaborative Effort Among Strange Bedfellows

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Mendocino County Statistics

- **3510 square miles of rugged terrain**
- **Very challenging to navigate**
- **Services sometimes up to 2.5 hours away**
- **Renegade mentality (Emerald Triangle)**
- **Injection drug use is higher than most other counties in California**
- **80 – 90% of PWID's have been exposed to Hepatitis C**
- **39.7% of county inhabitants living below self-sufficiency standard, compared to California's overall 31%**
- **20% of singles live below poverty level**
- **County jail beds = 301; sometimes as high as 335**
- **Rate of homelessness 2nd only to Detroit, MI (2007)**

Mendocino Stats (continued)

- **Rate of substantiated child abuse cases is double the California State average**
- **Shelter closed summer 2014**
- **Within City of Ukiah, there are ordinances against camping or parking (criminalization of homelessness)**
- **Change is law enforcement responsibility stems from Proposition 47 (release non-violent, lower level offenders) – crowded jail w/o appropriate bridging services available**

Who Do We Serve at MCAVHN?

Mendocino County AIDS/Viral Hepatitis Network (MCAVHN)

- Opened in 1987 as an all **volunteer agency** to assist persons who were struggling with an AIDS diagnosis
- Provided in-home support, **linkage to medical & behavioral health** supports
- Opened our own AIDS hospice residence in the early 90's – but closed by the mid-nineties

MCAVHN - (Continued)

- Focused on the mission to serve those **struggling to live with a devastating illness, and those dealing with stigma**; before medications began to change lives and the focus of interventions
- Necessary to **address the co-morbidities of HIV**, including HCV, mental illness, problematic substance use; more complex needs emerged
- Realized the need for **prevention services (harm reduction model);** adjunct to care management
- **Expanded vision** – wrote grants for outreach to the entire county, especially our indigenous Native populations

MCAVHN - (Continued)

- Outreach was delivered primarily through **Community Health Outreach Workers** (CHOW's) – very successful grant; helped us to understand the depth of the need, and amount of **persons who inject drugs (PWID's)** in our county i.e. N.A. disparity
- **Instituted syringe exchange** services, already knowing that 40% of HIV infections were from use of infectious equipment
- How would we accomplish this **public health intervention?**

MCAVHN - (Continued)

- Received small grants for harm reduction supplies; delivered completely by volunteers – as well as completely **"underground"** between 1998 to 2000
- Starting in 2000, we had to receive **"emergency"** actions through the County Board of Supervisors every two weeks
- **Outreach driven** – we hired 4 outreach staff in 2002 through the State Office of AIDS/Public Health to cover our far-reaching corners of the county due to the high-rate of PWID related hepatitis C (HCV)

Building/Adding Services

- While serving the initial HIV+ population; we understood the need to be able to deliver coordination of care and **centralized services** for multiple medical needs, behavioral health, substance use, legal, financial; reducing overall harm and increasing wellness within a **holistic paradigm** of service provision
- Over the next decade we began to serve populations with **multiple co-morbidities** as a natural expansion of our mission developed
- We were already in a **position to assist** people who were **Justice-Involved** clients

Why This Population?

1. **Problem defined**:

- **Complex co-occurring** conditions or disorders (e.g. those with at least a dual-diagnosis) and other co-morbidities
- Over-utilization of inefficient crisis-oriented, **high-cost** service provision – excessive emergency room **admissions**, psychiatric hospitalizations; incarcerations
- **Financial, medical, behavioral health, legal, psychosocial, housing, resource and transportation challenges**

Why? – (continued)

- High majority of our participants are **homeless** individuals **struggling** with basic **survival** issues
- Help to resolve basic human requirements for **food, shelter, income;** basic **stabilization** by providing assistance to meet these basic needs
- Make **positive connections** – assess **capabilities**; providing substantial assistance in the beginning of the partnership

Common Risks for Recidivism

Risk Factors

- ***Antisocial Attitudes***
- ***Antisocial Peers***
- ***Antisocial Personality***
- ***History of Antisocial Behavior***
- ***Family dynamics***
- ***Education/Employment challenges***
- ***Substance Abuse***

If the goal is reduce the risk, where do we start?

Specific Precipitating Event

A specific case that fired up the public in Mendocino County:

Aaron Bassler case: (example given)

What we had then -------

- **No psychiatric beds**
- **No Laura's Law**
- **Gutted mental health services**
- **Psychiatric first responders eliminated**
- **Psychiatrists seeing inmates reduced**

Overview & Introduction

- We needed a court dedicated to **defendants with Axis I mental illnesses** (schizophrenia, bipolar disorder, severe depression, anxiety disorders)
- The **majority** of referrals are for those with **co-occurring disorders**
- Referrals from jail, P.D. office , D.A., Judge, care managers, medical providers, etc.
- **Individualized** treatment/service plans
- **Incentives for defendants** to join and follow through

1. Reduced jail time or dismissal
2. Reduced supervision
3. Reduced fines

The "Seeds" of our "Mendocino Partners Against Recidivism" (MPAR) Collaboration/Group

- Met to **address issues of emergency room over-utilization and recidivism** – initiated by concerns for cost cutting measures by our largest local hospital. Initial partners were:

1. **Community hospital**
2. **Local FQHC**
3. **AOD treatment center**
4. **Sheriff's Dept. and jail medical services**
5. **Harm reduction case management agency serving persons with, and at risk for HIV and HCV**

Re-Building & Defining the BH Court

No Mental/Behavioral Health Court since early 2000's

1. No systematic way to address the level of **recidivism experienced** in Mendocino County (County-driven)
2. Due to MCAVHN's work with both the **CUSOC and ROSOC programs, we wedged our way into the County-driven steering committee** – soon the CBO's were developing the components for implementation
3. **High rates of PSMI and SUD** conditions in jail & etiology of arrest histories

Strengths in Systems Necessary to Accomplish Interventions/Goals

Strength

- ***Understanding that substance abuse and mental illness contribute dramatically to the prison population.***

Strength

- ***Recognizing that addiction to substances and mental illness is a treatment issue and need.***

Strength

- ***Knowing that treatment can work with the appropriate supports and bridges to life on the outside.***

Steps Towards Progress Building the Team
1. Develop Clear Goals

- Once core providers have made **commitments to improve the criminal justice and mental health systems**' response to persons with mental illnesses and co-occurring substance use disorders, they need to **set goals and identify shared objectives.**
- Doing so can help **reinforce buy-in** from partners and establish a clear direction. Identify individuals who have expertise in the criminal justice and behavioral health treatment systems. Working together, **establish common goals** that link the two systems and are specific and attainable (e.g., **reduced recidivism, increased access to integrated treatment,** increased retention in treatment).

Develop Clear Goals – (continued)

- **Identify** the unique goals of each system to clarify and resolve any differences or misunderstandings that may exist among group members.
- **Develop** objectives and a work plan to help identify roles and responsibilities within the group.
- **Ensure** that system leaders and change agents are involved, informed, and supportive of the collaborative efforts.

2. Get support from system leaders

- Criminal justice and treatment collaboration efforts should have the **endorsement from all systems' leaders** on the county or state level, as well as from policymakers such as the county executive, mayor, or commissioner, whose support may be valuable.
- Develop **mechanisms for communication** between the system leaders to cultivate and maintain their support. Develop mechanisms to integrate perspectives from relevant community members, elected officials, leaders of faith communities, victims, advocates and other stakeholders.

3. Identify and engage stakeholders

A wide range of individuals in the community have a **vested interest in reducing recidivism and increasing access to mental health and/or substance abuse treatment** for justice-involved individuals, and agencies should involve them as appropriate. Involve consumers and their family members as well.

4. Identify existing services and supports

- Those with behavioral health problems involved in the criminal justice system have **multiple and complex needs.**
- Understanding what services and resources are available, as well as those that are not, can help agencies **anticipate challenges** that may arise when trying to address the range of needs that individuals may have.

4. Identifying Existing Services and Supports – (continued)

- Conduct a "community audit" to **determine what services are offered** and delivered to clients involved in the criminal justice system.
- Develop a "map" of how individuals **access existing services**. Identify missing or insufficient services, practices, and programs.

Criminal Citation or Arrest Process

There are **six major points of contact** with the criminal system **after booking** has been completed:

1) **arraignment,**
2) **the pre-trial hearing,**
3) **the preliminary hearing,**
4) **trial,**
5) **sentencing, and**
6) **possible jail or prison time if convicted.**

At each of the stages of trial, the defendant may be represented by counsel. The issue then turns to whether the time, cost, punishment, and resources used by the criminal system at each of these stages are a useful investment for our society to make when **the root cause of the behavior has been determined to be a mental illness.**

Players in the Courtroom

Some unlikely Bedfellows working alongside a harm reduction agency:

- Superior Court Judges
- Public Defender's office
- District Attorney's Office
- Probation Department
- County Sheriff's Department
- Care Management Providers
- TAY service providers

Unlikely Bedfellows - continued

- Mendocino County's Contracted Mental Health **Specialty Case Management Provider (25+ yrs.)**
- Mendocino County's Contracted Children's Mental Health **Specialty Case Management Provider (children and youth through 24 yrs.)**
- Redwood Regional Services (Developmental Disabilities Provider) & **Supported Living Programs**
- Manzanita **(Peer mental health service provider)**
- **V.A.** (VASH) program staff

Possible Scenarios/Choices

- ***Scenario: You have determined, through assessment that two defendants are high risk/high need. They come into court and you ask them why they want to enter your behavioral health court program…***
- ***Defendant A: "I'm really looking forward to all of the services offered through this program. I have a lot of goals I want to accomplish like going to college, having better relationships with my family, getting a better job, etc."***
- ***Defendant B: "I don't need or want any help, but I REALLY want to get out of jail. I'm worried about going to prison and my attorney said if I go to this program, I can avoid that."***
- ***Question: Who should you admit to your program?***
- ***Answer: Both of them!***

Determining Barriers

***Barriers*- Issues that do not themselves affect risk, but create barriers for successful outcomes. These may be real issues, but they may also be indicators that more is needed:**

- ***"I don't have childcare."***
- ***"I couldn't find a ride there."***
- ***"I'm too self-conscious to share in group."***
- ***"My therapist doesn't understand my culture."***
- ***"I have a mental illness."***

Motivation & Lack Thereof

Motivation *for treatment at admission* ***DOES NOT*** *predict success or failure***.**

- *We* ***should determine motivation*** *in order to:* ***Assess for appropriate treatment interventions.***
- *We should* ***NOT*** *use level of motivation in order to: Assess for* ***program eligibility****. Especially when working in partnership with the criminal justice system.*

Compliance Concerns

Responding to Compliance Issues - *Setting Expectations (address these incrementally)*

- ***Proximal Goals-*** *Those goals I have the ability/capacity/resources to accomplish right now.*
- ***Distal Goals-*** *Those goals that I do not have the ability/capacity/resources to accomplish right now, but could in the future.*

Note:

- ***Abstinence is DISTAL***
- ***Treatment Attendance is PROXIMAL***

Assessing Medical Needs

i.e. High Risk for a Heart Attack – assess by variables including:

- ***Age***
- ***Sex***
- ***Family History***
- ***Smoking***
- ***High Cholesterol***
- ***High Blood Pressure***
- ***Inactive***
- ***Overweight***
- ***Diabetes***
- ***Medical History of Heart Problems***

Overview of Our Process

1. **Referral** from one of the sources – has the client signed an **ROI** in order to be presented
2. Meeting in court to **present case** during case conference
3. Client **comes into court** while in custody or post-release
4. Judge **explains process** to defendant; defendant accepts
5. If in custody, MCAVHN or other agency to pick up and take to the **care management** agency for intake
6. If out of custody, the client is directed by the Judge to go **directly for intake**
7. Referral and appointment scheduled for **psych evaluation** to be done within a week's time; and reported back by the following week
8. The client **begins services** with our agency unless already an existing client with another program

Overview (continued)

9. Service plan developed with client; if **"specialty" eligible**, wait for the TAR and Care Plan from the contractor to arrive in order to start Medi-Cal billing
10. **No waiting time** for services to begin – either "in-kind" work or bill to our JAG grant for time spent
11. **Weekly case conferencing** – update on developments; Judge requests ideas on interventions, sanctions, incentives, information from UA's, decides on next actions, etc. – participants come into court directly after case conference to **see the Judge –** outlines next steps for client and requests and receives the client's input

Different Funding Sources

- Medi-Cal (Medicaid) under "Specialty Mental Health Services" provision
- Board of State and Community Corrections "Justice Assistance Grant"
- Private foundation grants

Changes Taking Place as Others Come to the Table

- Players who have worked within a **different paradigm** – don't understand how this is different than Drug Court
- Use of **marijuana under some circumstances**, but this is also changing
- Strong **housing component for stability** – emergency bed purchased for the most fragile participants
- Our **local CoC** changing the paradigm to **"Housing First"**

Next Steps

- More **housing for PSMI** population
- More **housing for the most vulnerable**
- **De-criminalization** of homelessness
- **Multiple options** for homeless individuals
- Separate **grants to support** the bottom line needs for housing stability
- Spreading the use of **multi-disciplinary teams** into more far-reaching realms
- Involving city police & **reducing stigma**
- Funding for **Pre-booking Diversion Program**

Comments & Questions?

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