

BEHAVIORAL HEALTH COURT
POLICIES AND PROCEDURES MANUAL

SUPERIOR COURT OF CALIFORNIA
COUNTY OF SAN FRANCISCO



July 2008

INTRODUCTION

In November 2002, the San Francisco Behavioral Health Court (BHC) was established to more effectively address the increasing number of mentally ill defendants cycling through the courts and jails. BHC is a collaboration of the Superior Court, Office of the Public Defender (PD), Office of the District Attorney (DA), Sheriff's Department, Jail Psychiatric Services (JPS), the San Francisco Department of Public Health's Community Behavioral Health Services (DPH/CBHS) and the Adult Probation Department (APD).

MISSION

The mission of the Behavioral Health Court of the Superior Court of California, County of San Francisco is to enhance public safety and reduce recidivism of criminal defendants who suffer from serious mental illness by connecting these defendants with community treatment services, and to find appropriate dispositions to the criminal charges by considering the defendant's mental illness and the seriousness of the offense.

GOALS

The primary goals of the Behavioral Health Court are to:

- Connect criminal defendants who suffer from serious mental illness to treatment services in the community.
- Find appropriate dispositions to criminal charges, taking into consideration the facts of each case and prior criminal history.
- Ensure public safety and reducing recidivism and violence on re-arrest through appropriate mental health treatment and intensive supervision.
- Increase collaboration between the court, counsel, city agencies, and community mental health treatment services.

ELIGIBILITY FOR BEHAVIORAL HEALTH COURT

The in-custody defendant must meet the criteria for a major Axis I mental disorder as defined by the current Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR). Individuals with co-occurring substance use disorders are also accepted where the mental health diagnosis is primary. BHC also accepts clients with an Axis II personality disorder where the mental illness is severely compromising that individual's ability to function in the community, and where we have the appropriate resources to treat that individual. Finally, we accept clients with developmental disabilities with the consensus of the Golden Gate Regional Center.

To be considered for BHC, a defendant must be charged with, convicted of, or on probation for a misdemeanor or felony offense where the behavior that led to the offense was connected to mental illness. The defendant's prior criminal history and treatment history in the community mental health system are considerations in determining eligibility.

Defendants charged with misdemeanor or felony domestic violence offenses, misdemeanor or felony elder abuse offenses, misdemeanor or felony weapons offenses, or serious offenses (as

defined by Penal Code section 1192.7(c)¹) are not eligible for BHC without the District Attorney's express consent.

Defendants who have suffered a prior conviction for any offense listed in Penal Code section 1192.7(c) are not eligible for BHC without the District Attorney's express consent.

Clients who are charged with murder or sex offenses are not eligible under any circumstances for BHC irrespective of their diagnosis. Defendants charged with Penal Code 314.1 or 290 may be considered on a case by case basis.

Participation in BHC is voluntary and the defendant must be willing to participate in community treatment. The client also must be willing to sign a release of information for details pertaining to his or her mental health treatment, substance use, legal status, and history to be shared with the BHC team.

Acceptance into BHC must be agreed upon by the BHC legal and treatment team, which includes the Judge, defense attorney, the Assistant District Attorney, the Probation Officer, community mental health provider,² and Jail Psychiatric Services (JPS).

REFERRALS TO BEHAVIORAL HEALTH COURT

If a defense attorney asks the Judge for a 4011.6³ for BHC eligibility, the Judge should order the screening. The DA has no standing to object. The only cases that should not be screened for BHC are homicides and sex offenses.

If the 4011.6 clinical assessment says the defendant is diagnostically appropriate, the case is sent to Department 7 (D7) on the date indicated by JPS. A case should not be sent to D7 without JPS approval. The Calendar entry should indicate "BHC eligibility." A decision about eligibility will be made in D7. The case should be sent to D7 if it is diagnostically appropriate even if the DA objects. These objections will be fully heard and discussed in D7.

¹ Penal Code section 1192.7(c) includes (other than sex offenses and homicide), but is not limited to: attempted murder; assault with a deadly weapon or instrument on a police officer; arson; any burglary in the first degree; robbery or bank robbery; kidnapping; any felony in which the defendant personally used a dangerous or deadly weapon; grand theft involving a firearm; carjacking; any felony offense which would also constitute a felony violation of Penal Code section 186.22; assault with a deadly weapon; discharge of a firearm at an inhabited dwelling, vehicle or aircraft; intimidation of victims or witnesses; criminal threats.

² BHC's primary treatment provider is Citywide Case Management Forensics (CWCMF), a program of the University of California, San Francisco. BHC clients are also served by other community treatment providers. Because CWCMF is the primary provider, it will be referenced throughout the text.

³ Penal Code section 4011.6: In any case in which it appears to the person in charge of a county jail, city jail, or juvenile detention facility, or to any judge of a court in the county in which the jail or juvenile detention facility is located, that a person in custody in that jail or juvenile detention facility may be mentally disordered, he or she may cause the prisoner to be taken to a facility for 72-hour treatment and evaluation pursuant to Section 5150 of the Welfare and Institutions Code and he or she shall inform the facility in writing, which shall be confidential, of the reasons that the person is being taken to the facility.

When the case comes to D7 for eligibility, the BHC team (DA, defense counsel, JPS, CWCMF, APD, and the Court) will discuss. A decision about eligibility will be made on a case-by-case basis considering the defendant's mental health diagnosis and history, facts of the incident, criminal history or lack thereof, possibility of placement and appropriate treatment, and other relevant factors.

If everyone agrees that the defendant should come to BHC but there is disagreement about the disposition, the case will be sent to D15 for further discussion about the disposition. Everyone on the team must agree for a case to enter BHC. In order to formally enter BHC, a disposition must be agreed upon and entered into the record.

Defendants may enter BHC upon a sentence of probation with BHC as a condition of probation, or upon a probation modification with BHC as a condition of probation.

BHC participation is usually at least one year. The BHC team will decide when a defendant graduates. Graduation is based on the nature of the charge, compliance while in BHC, re-arrests if any, and the likelihood of continuing in mental health treatment after leaving BHC.

BHC will not accept defendants charged with or on probation for sex offenses. This includes defendants charged with violating Penal Code section 290. Defendants with prior convictions for sex offenses facing new charges for a non-sex offense will be considered on a case by case basis. Factors to consider will be: is treatment possible (can defendant be placed in a program or will CWCMF take client); how old is the sex offense conviction; what is the conviction for; how serious is the mental illness, and; what is the result of a risk assessment regarding the likelihood of future sex offenses?

Clients who are charged with murder are not eligible under any circumstances for BHC irrespective of their diagnosis.

If a participant is re-arrested while in BHC, participation in the program will be re-assessed. The team may decide to allow the participant to continue in BHC after considering the new case and assessing the appropriateness of continued BHC participation. Continued participation in BHC is subject to the express consent of all team members.

THE TEAM

JUDGE

The BHC Judge heads the collaborative treatment team. In this capacity, the Judge regularly reviews case status reports detailing each participant's compliance with the treatment plan. During regular court appearances, the Judge administers graduated sanctions and incentives to increase each participant's accountability and to enhance the likelihood of long-term treatment compliance.

DISTRICT ATTORNEY

The role of the District Attorney in BHC differs from the traditional adjudication process. In BHC, all parties and counsel share the common goal of helping participants successfully comply with treatment in a community setting. The prosecutor reviews new cases concerning eligibility

pursuant to the guidelines herein. The eligibility assessment includes a review of the defendant's criminal history, consultation with victims, legal eligibility, and appropriate dispositions upon the defendant's entry into BHC.

As part of a collaborative team with the Judge, defense attorney, and clinical staff, the prosecutor monitors participant progress and can make recommendations regarding sanctions. If a participant is re-arrested, the prosecutor investigates the new case and assesses the appropriateness of continued participation.

PUBLIC DEFENDER/DEFENSE COUNSEL

The Public Defender/defense counsel represents and advises the defendant in all court proceedings and is mindful of the defendant's constitutional rights as a criminal defendant and the defendant's civil rights as a mental health consumer. The Public Defender/defense counsel uses a non-adversarial approach with a focus on protecting defendants' constitutional rights and their success in treatment to promote health and well-being. The Public Defender/defense counsel seeks to find treatment solutions for the defendant that minimize the defendant's exposure to incarceration, reduce the risk of re-arrest or new charges, and mitigate the consequence of a criminal conviction.

JAIL PSYCHIATRIC SERVICES

Jail Psychiatric Services (JPS) provides all of the mental health treatment in the San Francisco County Jail. JPS also focuses on transitioning inmates with mental illness back into the community by collaborating with treatment providers, family members, and the courts. JPS is responsible for screening inmates for BHC eligibility and presenting the case to the BHC legal team. JPS provides progress reports and clinical recommendations to the Court.

The Deputy Director of JPS, or his/her designee, represents JPS in BHC and presents new cases to the court team. In addition, the Deputy Director helps coordinate the Court's network of community-based treatment programs by maintaining contact with providers, coordinating community clinical presentations to the Court, and troubleshooting problems.

CITYWIDE CASE MANAGEMENT FORENSICS

Citywide Case Management Forensics (CWCMF), a project of Citywide Case Management, is a University of California, San Francisco/San Francisco General Hospital Department of Psychiatry outpatient program. CWCMF provides intensive case management services based on the Assertive Community Treatment (ACT) model for adult offenders who suffer from severe mental illness and co-occurring substance abuse disorders. BHC clients receive comprehensive mental health services (including assessment, individual, family and group therapy, crisis intervention, and medication management), assertive case management, vocational training, and supportive employment services, all of which are tailored to their individual needs. This approach is an evidence-based practice designed to assist clients to avoid criminal recidivism, reduce harm from substance abuse, and recover functioning while managing mental illness.

The CWCMF Program Director, or his/her designee, represents Citywide for BHC. The Program Director also manages daily clinical operations, including case flow, treatment planning, referrals to suitable treatment providers, and participant progress. The CWCMF Program Director provides reports and clinical recommendations to the Court.

COMMUNITY TREATMENT PROVIDERS

BHC maintains an extensive network of community-based mental health and substance abuse treatment providers. Services include locked-facilities, acute diversion units, dual diagnosis programs, residential facilities, hospital-based detoxification, short and long-term residential treatment, outpatient treatment, Psychiatric Emergency Services, Homeless Release Project, Supervised Pre-Trial Release, intensive outpatient case management services and others. The BHC team refers participants to specific programs based on their clinical need, the program's ability to comply with the Court's reporting requirements, and the program's capacity to provide culturally appropriate services (e.g. mental/ physical health, language, etc.). For outpatient services, the BHC clinical staff refers participants, when possible, to a provider located near their community. Treatment providers, with whom the BHC clinical staff maintains close communication, also appear in weekly staffings to provide input to the Court on participants' progress in treatment.

ADULT PROBATION DEPARTMENT

A specialized Probation Officer(s) oversees a predominantly or exclusively BHC caseload. The Officer works closely with defendants and provides updates to the team regarding compliance with terms and conditions of probation. The Officer focuses on community involvement, including meeting with clients in the field, interacting with community-based organizations, overseeing restitution, and networking with treatment providers.

OFFICE OF COLLABORATIVE COURT PROGRAMS, SUPERIOR COURT

The overall goal of the Office of Collaborative Court Programs is to enhance the efficiency and sustainability of collaborative justice programs as well as to increase public knowledge about problem-solving courts and to strengthen inter-organizational relations. Office staff assist with the day-to-day court operations of all collaborative court programs including BHC. They serve as liaisons with other team agencies and community programs, and are responsible for data collection and analysis, grant writing, resource development, and public outreach and information.

CASE PROCESSING

CASE IDENTIFICATION AND REFERRAL

Cases are generally identified in criminal court by Superior Court Judges, the Office of the District Attorney, community treatment providers, Jail Psychiatric Services clinicians, the San Francisco Police Department's psychiatric liaison, the Adult Probation Department, family members and other community members.

If defense counsel believes a defendant may be appropriate for BHC, counsel may request that the judge order an evaluation pursuant to Penal Code section 4011.6 to determine BHC eligibility. The court order is faxed to Jail Psychiatric Services (JPS) at 415-734-3216 and JPS assesses the client for motivation for treatment, compliance with treatment in-custody, insight into mental illness, amenability to treatment and diagnosis.

The 4011.6 report is returned to the original criminal court. If JPS determines the defendant is diagnostically appropriate for BHC, the case is transferred to BHC (Department 7) for a future court date as specified in the report. If the individual is found diagnostically ineligible, the case will remain in the court of origin.

SCREENING PROCESS

To ensure direct linkage with appropriate treatment services, the defendant must be in custody to be evaluated for BHC. Jail Psychiatric Services does a thorough mental status evaluation of BHC referrals to determine diagnostic eligibility. Information about the defendant's 'bio-psychosocial' history is also researched through friends and family, community mental health and medical treatment providers, San Francisco General Hospital's Lifetime Clinical Record, San Francisco County's community mental health database, court records, police reports and rap sheets, and Jail Health and Jail Psychiatric Services records.

The first time a defendant appears in BHC, the BHC legal team reviews the case and determines whether he or she is legally eligible to participate. JPS makes a clinical presentation about the defendant, including a recommended treatment plan. The District Attorney makes a presentation about the facts of the case, including victim input and impact, the strength of the case, restitution obligations, and the defendant's criminal history. If the defendant is on probation, APD makes a presentation about past compliance on probation. Assuming a defendant is eligible for BHC, a final decision on whether the defendant may enter is made by the entire BHC team, which includes the Judge, District Attorney, Public Defender, Adult Probation, Jail Psychiatric Services, and Citywide Case Management Forensics. The defendant's legal status may be an open misdemeanor or felony case, a probation sentence with BHC as a condition of probation, or upon a probation modification with BHC as a condition of probation.

EARLY INTERVENTION THROUGH JAIL PSYCHIATRIC SERVICES

After acceptance to BHC and the team's approval of a treatment plan, the Court signs a release order. JPS will then collaborate with the community provider to ensure continuity of care for the client. Defendants are released to the community with a treatment plan which includes housing and medication as necessary. For individuals in need of residential treatment, JPS completes the referral for an intake assessment to be completed by the San Francisco Department of Public Health, Community Behavioral Health Services Placement Committee, and helps the defendant obtain any necessary medications, identification, and entitlements.

PROGRAM REQUIREMENTS

BHC program requirements are developed on a case-by-case basis designed to best meet the needs and abilities of each participant. Each client is referred to a case manager specifically assigned to BHC for treatment planning, monitoring, accountability, and coordination. The case manager also provides information to the Court at weekly staffing and court reviews. General program requirements include the following:

- Adherence to mental health treatment and groups, as recommended.
- Adherence to psychotropic medication, if prescribed.
- Secure housing and residential treatment if necessary.
- Compliance with drug and alcohol testing and counseling if appropriate.

- Initiation of Social Security Disability/Insurance (SSDI/SSI) application or acquisition of public assistance if appropriate, including Medicaid.
- Compliance with terms of probation and reporting to Probation Officer.
- Attendance at regular court appearances.
- Evidence of productive use of time (obtain a job, volunteer community service, education, etc.) if appropriate.
- Community service work if appropriate.

OTHER PARTICIPATION ISSUES

- To graduate successfully, clients must demonstrate adherence to their treatment plan.
- BHC participation is usually at least one year. The duration of the program is determined by individual need and progress attained in meeting specific goals for treatment.
- Upon the graduation of a defendant, the case will be resolved pursuant to the negotiated agreement between the District Attorney, the defense attorney, and the Court.
- The defendant can opt out of BHC at any time and be returned to the original criminal court for case processing.
- A participant who commits a new offense is immediately reevaluated for continued participation in BHC.

TEAM DECISION MAKING

BHC has a clinical conference for all cases on the calendar that afternoon.⁴ The BHC team meets to review a clinical report from the service provider for each case. The meeting is also used to assess the status of difficult or complex cases in which current treatment and supervision do not appear to be working. Decisions are typically made by consensus. The general team approach is non-adversarial.

Additionally, the team addresses administrative matters pertaining to program planning and administration, treatment and service delivery, training, policies and procedures, data collection, grants and special projects, and issues that may have arisen since the last meeting. Team members may also meet periodically throughout the week to address treatment plans, community planning, funding and/or legislative processes, and to respond to problems that may arise.

⁴ Due to increased caseload, the team reviews new cases and gender-specific cases on an additional afternoon separate from court.

CONFIDENTIALITY

The BHC program is governed by Federal laws of confidentiality. Disclosure of information received in the course of treatment is strictly prohibited unless a court order “for good cause” is issued. Defendants must authorize the disclosure to the Court of information regarding their “diagnosis, attendance, scope of treatment, treatment progress and quality of participation, and termination or completion of treatment.” All parties and counsel attending the morning staffing must sign a pledge to maintain confidentiality of all client information and discussions.

Any confidential information obtained by the District Attorney BHC representative, including but not limited to 4011.6 and JPS Eligibility Reports, may not be shared. However, non-confidential information limited to a defendant’s BHC status and progress may be shared with the District Attorney Mental Health team lawyers. This information will remain confidential within that team and will not be shared. No court order is required for any party to disclose to the appropriate authorities any information revealed in BHC which is subject to mandatory reporting by any statute.

STATUS HEARINGS

Status hearings are a central feature of BHC. Participants appear regularly before the Judge who reviews progress. During the status hearing, the Court is provided with any additional treatment status reports and other information from a variety of sources. The client is expected to bring his treatment group check-in sheets or other proof of treatment compliance. Clients interact directly with the Judge during status hearings.

TREATMENT PLANS

Treatment plans are flexible and adjusted based on a client’s individual needs and goals. They take into account the client’s baseline functioning, individual capabilities, and holistic needs including physical, mental, and spiritual interests. Treatment plans are altered to reflect the client’s progress.

INCENTIVES AND SANCTIONS

Incentives and sanctions are used by the Court to motivate each client’s compliance with the recommended treatment plan. If treatment compliant, the client receives encouragement and incentives for continuing to do well. If the client is not compliant, sanctions may include a reprimand or increased intensity of treatment to enforce the importance of compliance with court orders. At the end of the hearing, the client receives a written reminder of the next court date on a pre-printed form.

INCENTIVES

Incentives are used to assist the defendant in achieving treatment goals. The Judge determines incentives based upon recommendations from the BHC team. Examples of incentives include:

- Verbal Reinforcement from the Court
- Tokens (e.g. movie tickets)
- Applause
- Certificates of Achievement
- Group Completion
- Less Restrictive Treatment
- Reduced Frequency of Court Appearances
- Graduation

SANCTIONS

Sanctions are used to assist the client in achieving treatment goals. At any time, with or without a sanction, a client may be assessed for a higher level of treatment, hospitalization, additional support meetings, or more intensive case management. The judge imposes sanctions after hearing from the client, counsel, and the BHC team.

Examples of sanctions include:

- Admonishment or Reprimand From the Court
- Volunteer Community Service Work
- Assignments/Written Essays
- Increased Intensity of Treatment
- Increased Frequency of Court Appearances
- Drug Testing
- Bench Warrant
- Termination of BHC and Return to Criminal Court for Adjudication

If the treatment plan is inadequate to meet the client's needs (e.g. the client exhibits symptoms of psychosis, suicidal ideation, self-injuring behavior, or continues to use drugs), the Court may order another assessment and the level of treatment will be intensified. The client may move from a community setting into a residential treatment program. The Court may order a psychiatric examination, money management, more AA/NA meetings, drug testing, or more intensive monitoring.

Incarceration is not typically used as a sanction in BHC. A client may be remanded into custody if the client is engaging in extremely high-risk behaviors and represents a threat to public safety.

TERMINATION

A client may be terminated from BHC. This usually occurs when the client re-offends, stops coming to court appearances, or has left a treatment program and refuses to return. In these circumstances, the case is returned to the original criminal department for adjudication. If a defendant re-offends or is re-arrested, his continued participation in the program is subject to the express consent of all members of the team both as to the new case and the pre-existing case.

If a defendant fails to appear in Court, the BHC judge may issue or stay a bench warrant for his arrest. The BHC team will determine suitability for continuation in the program once the defendant is back before the group. If a defendant is participating in BHC as a condition of probation and he stops coming to court, leaves a treatment program, or refuses to return to

treatment, he is in violation of probation and may have his probation revoked, and his jail or state prison sentence imposed. Upon a violation of the terms of probation, a defendant may only continue in BHC with the express consent of all team members.

GRADUATION

A ceremony and reception is held to commemorate participants who have met the minimum requirements as detailed above, maintained satisfactory progress, and remained engaged in treatment and services. Several months before graduation, the BHC team begins working with the client regarding his transition to graduate status and develops a plan to ensure that the client reintegrates safely into the community.

MANAGEMENT INFORMATION SYSTEM

The primary purpose of the data management system is to enhance the collaborative nature of BHC by shifting from paper data management to electronic tracking. Centralized data collection and data-sharing allow BHC team members to address the needs of clients more efficiently.

APPENDICES

- I. Behavioral Health Court Glossary
- II. Behavioral Health Court Eligibility Criteria
- III. Behavioral Health Court Flowchart
- IV. Behavioral Health Court Case Presentation
- V. Behavioral Health Court Authorization to Release/ Request Confidential Patient Information
- VI. Mental Health Resources
- VII. Private Defense Guide to Behavioral Health Court

APPENDIX I: BEHAVIORAL HEALTH COURT GLOSSARY

I. Diagnosis

A. The Diagnostic and Statistical Manual of Mental Disorders (DSM)

The DSM-IV organizes each psychiatric diagnosis into five levels (axes) relating to different aspects of disorder or disability.

5-Axis Diagnosis:

- **Axis I:** clinical disorders, including major mental disorders, as well as developmental and learning disorders. Common Axis I disorders include depression, anxiety disorders, bipolar disorder, ADHD, and schizophrenia.
- **Axis II:** underlying pervasive or personality conditions, as well as mental retardation. Common Axis II disorders include borderline personality disorder, schizotypal personality disorder, antisocial personality disorder, narcissistic personality disorder, paranoid personality disorder and mild mental retardation.
- **Axis III:** Acute medical conditions and physical disorders. Common Axis III disorders include brain injuries and other medical/physical disorders which may aggravate existing diseases or present symptoms similar to other disorders
- **Axis IV:** psychosocial and environmental factors contributing to the disorder
- **Axis V:** Global Assessment of Functioning or Children's Global Assessment Scale for children under the age of 18. (on a scale from 100 to 0)

Personality Disorder:

An enduring pattern of inner experience and behavior that differs markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment. Personality disorders are a long-standing and maladaptive pattern of perceiving and responding to other people and to stressful circumstances. Personality Disorders are characterized by the chronic use of mechanisms of coping in an inappropriate, stereotyped, and maladaptive manner.

Ten personality disorders, grouped into 3 clusters, are defined in the DSM-IV:

- **Cluster A**—Odd or eccentric behavior.
Includes:
 - Paranoid personality disorder
 - Schizoid personality disorder
- **Cluster B**—Dramatic, emotional or erratic behavior.
Includes:

- Antisocial personality disorder
- Borderline personality disorder
- Histrionic personality disorder
- Narcissistic personality disorder
- **Cluster C**—Anxious fearful behavior.
Includes:
 - Avoidant personality disorder
 - Dependent personality disorder
 - Obsessive-compulsive personality disorder

Developmental Disability (DD):

California defines a person with a developmental disability as anyone who has acquired mental retardation, autism, epilepsy or cerebral palsy before age 18 and is likely to need special services throughout life. The Federal definition uses age 22 and looks at a person’s range of abilities instead of diagnostic categories

Dual-Diagnosis: A diagnosis of both mental illness and substance abuse.

Triple-Diagnosis: A diagnosis of mental illness, substance abuse and HIV/AIDS

II. Mental Health Definitions

5150: Statute authorizing up to 72-hr mental health detention (in SFGH) if determined to be a danger to self or others.

1370: Incompetent to Stand Trial (IST) - The defendant lacks substantial mental capacity to understand the proceedings or assist in his or her own defense.

Behavior Modification - A way to help people acquire behaviors by structuring the person’s environment to reinforce or reward positive behaviors.

Decompensation: worsening psychiatric condition, the deterioration of existing psychological defenses in a patient already exhibiting pathological behavior.

Gravely Disabled: Inability to provide for food, clothing and/or shelter. This is the requirement that must be met to conserve someone and it is one of the three reasons for 5150’ing someone.

Lanterman-Petris-Short Act (LPS) - governs civil commitment and involuntary detention process in California. Begins with statute 5000 of the Welfare and Institutions Code. Sometimes used to simply mean ‘Conservatorship’ as in an ‘LPS Conservatorship’. This is distinguished from a Murphy Conservatorship, which is for defendants who have felony charges and are determined to be violent and a danger to the community.

SF First Team: An Intensive Case Management Agency

Supported Employment - Services and supports that are provided to individuals with disabilities to assist them to locate, perform, and retain a job.

Vocational Services - Services, including education and training that enable each individual to develop a capacity to work and progress as far as possible from vocational functions to affordable employment in the community. Such services include vocational evaluation, counseling, activity services, work adjustment, occupational skill training and job placement.

A. Jail Terminology

- **Psychiatric Sheltered Living Unit (PSLU):** Housing areas in the San Francisco County Jail for clients diagnosed with a mental illness. These housing areas are closely monitored by Jail Psychiatric Services and operate as a program that includes group and individual therapy as well as milieu activities.
- **C-Pod:** Housing unit in County Jail 8 for clients with more serious medical and psychiatric needs.
- **Psychiatric Housing:** Housing units in the jail for inmates with a mental illness who require a higher level of supervision and support than that which is provided in the general population.

III. Acronyms

ADL: Activities of Daily Living (hygiene, food, etc.)

CBHS: San Francisco Community Behavioral Health Services (a unit of DPH)

CWCMF: Citywide Case Management Forensics

DPH: San Francisco Department of Public Health

JAS: Jail Aftercare Services

JPS: Jail Psychiatric Services

SAMHSA: Substance Abuse and Mental Health Services Administration (part of the U.S. Department of Health and Human Services)

WISH: Women's Integrated Skills and Health

IV. Case Management Agencies

A. Intensive Case Management (ICM) Agencies

Intensive community services for individuals with severe and persistent mental illness that are designed to improve planning for client's service needs. ICM provides in-office and off-site crisis intervention, drop-in medication visits, general mental health and service linkage services to facilitate successful community integration. Service contact can be daily and on a 24-hour basis.

- **Citywide Case Management (CWCM):** Citywide Case Management clinicians work with clients who repeatedly require psychiatric emergency and/or acute inpatient treatment. The program has been in operation since 1981. The average yearly reduction of acute inpatient days by registered clients is 17%.
- **Citywide Forensic Case Management (CWC MF):** A subgroup of CWCM, the Forensic Case Management team, in collaboration with the Jail Psychiatric Services, began working with offenders with major psychiatric illnesses several years ago. In the first year of operation, with twenty clients, the team was able to obtain SSI and Medi-Cal coverage for 80 percent and housing for 100 percent of the clients. Eighty-one percent of the clients have been free of further incarceration, with the average jail bed days before the program being 13.9 and after the program, 1.7. The program expanded in 1999-2000 with a California Board of Correction grant. The Forensic Case Management team, made up of psychiatrists, social workers, psychiatric technicians, psychologists and peer case managers, offers case management services, pharmacological management, crisis intervention, individual, group, and family therapy.
- **Alternatives Program:** A program based at the Mission Mental Health Clinic that serves African American males with a severe and persistent mental illness. Alternatives Program clients receive intensive case management, on-site psychiatric care, medications, groups, outings, and individual counseling delivered through the model of African Centered treatment principles and strategies.
- **OMI ICM:** The OMI family center provides culturally relevant services to San Francisco residents with a severe and persistent metal illness. Services include psychiatric assessment, evaluation, individual and group counseling, medication, drop-in and outreach.
- **Family Service Agency Adult Care management:** The goal of Adult Care Management (ACM) is to support severely mentally ill individuals, enabling them to live in the community and to maintain the greatest possible independence, stability, and level of functioning possible. The program provides intensive case management to individuals in the community. Every attempt is made to ensure continuity of care and to develop a community support system. Individuals are connected to appropriate resources and

community health and mental health services, for the development and implementation of their plans to achieve their desired outcome.

- **Family Service Agency Geriatric Outpatient:** This outpatient program offers comprehensive services for seniors with mental health concerns, helping them to maintain independence and dignity while living in their own homes for as long as possible.
- **Family Service Agency Geri West:** This outpatient program offers comprehensive services for seniors with mental health concerns, helping them to maintain independence and dignity while living in their own homes for as long as possible.

B. Single Point of Responsibility (SPR) Programs

Single Point of Responsibility programs (SPRs), also known as Assertive Community Treatment (ACT), are intensive case management programs for clients who have a history of very high acute and/or long-term institutional care utilization. These case management agencies provide 24/7 care.

- **UC Community Focus:** Assertive community treatment program for 200 clients. Staff members speak 11 dialects and languages, serving a multicultural population.
- **Mission ACT:** Mission ACT is a neighborhood based assertive community treatment team. Mission ACT offers wrap around services to adults with persistent and severe mental illness, many with co-occurring alcohol and/or substance abuse disorders. Services are provided with special focused for the Latino and gay/lesbian community.
- **Westside ACT:** Westside ACT is a single point of responsibility (SPR) program serving 100 members who are frequent users of mental health services. Westside ACT is an integrated multidisciplinary treatment team providing intensive clinical case management to help clients live safely in their community. This is accomplished by providing a wide range of services including housing support, vocational rehabilitation, social integration, medication support, and clinical interventions where appropriate.

C. Full Service Partnership (FSP) Programs

Full Service Partnership programs (FSPs) were developed through money provided by the Mental Health Services Act (MHSA/Proposition 63). Mental Health providers work with an identified partner providing a full range of services. The term “partnership” is used consistently to refer broadly to shared responsibilities of the consumer and her/his family, care givers, providers, and community. The MHSA guiding principles describe the intent of full service partnerships in terms of the following goals:

- Significant increases in the level of participation and involvement of clients and families in all aspects of the public mental health system including but not limited to: planning, policy development, service delivery, and evaluation.

- Increases in consumer operated services such as drop-in centers, peer support centers, warm lines, crisis services, case management programs, self-help groups, family partnerships, parent/family education, and consumer provided training and advocacy services.
- Full implementation of an approach to services through which each client and her/his family, as appropriate, participates in the development of an individualized plan of services determined by the individual's goals, strengths, needs, race, culture, concerns, and motivations.

San Francisco FSPs include:

- Family Service Agency Transitional Age Youth
- CBHS Transitional Age Youth
- Family Service Agency Adult FSP
- Citywide FSP
- Hyde Street FSP
- Family Service Agency Older Adult FSP

V. Placements/Treatment Facilities

A. Acute Diversion Unit (ADU)

Acute Diversion Units (ADUs) are short-term unlocked social model crisis residential programs designed as an alternative to hospitalization for individuals experiencing an acute episode or crisis OR as a step-down from acute inpatient treatment. Services include assessment, general mental health services, medication prescription and administration, 24-hour monitoring and case management.

ADUs are 2 week programs where clients receive skills training and crisis intervention, while working on short term goals in their treatment plan. All ADUs have structured comprehensive in-house Day Treatment programs that include medication management by a Psychiatrist and primary health screening and ambulatory care by a Nurse Practitioner. The staff works with clients to resolve crises, improve interpersonal skills, and to help clients develop effective treatment plans that are goal-oriented and time-limited. Each day has a structured schedule with group and individual activities, including money management, medication education, symptom management and community outings.

Each Progress Foundation Crisis Residential Treatment Program has a Consultant Psychiatrist who both prescribes and monitors the effects of psychiatric medications for clients who voluntarily use them. In addition, many clients referred to the ADUs have physical health conditions that have gone undetected or untreated due to lack of access to primary health care. Nurse Practitioners are in each ADU weekly to provide health screenings, health education on topics such as nutrition, smoking cessation, and the

management of diabetes, and to treat general illnesses and injuries that do not require medical hospitalization.

- **Shrader House** est. 1973: A 10 bed psychiatric crisis residential treatment program, and specializes in Transitional Youth (TY) 18-25. It is located in San Francisco's Haight-Ashbury District.
- **La Posada** est. 1977: A 10 bed psychiatric crisis residential treatment program. This program emphasizes service to the Spanish-speaking community with bi-lingual Spanish-speaking staff on duty 24 hours a day. It is located in San Francisco's Mission District.
- **Cortland House** est. 1982: An 8 bed psychiatric crisis residential treatment program. This program emphasizes service to the African –American community. It is located in San Francisco's Bernal Heights District.
- **Avenues** est. 2000: A 12 bed psychiatric crisis residential treatment program. This program has staff with various Asian language capabilities. It is located in San Francisco's Sunset District.

B. Acute Residential

Acute Residential programs are for clients in crisis. Often these are clients coming out of hospitals and institutions. The stay tends to be shorter and there is typically a higher staff to client ratio.

- **Grove Street House:** An intensive crisis residential treatment program focusing on up to 10 adults who have been “dually diagnosed” with co-occurring mental health and substance use disorders. Grove Street House can offer up to 60 days for stabilization and future treatment planning.
- **Westside Lodge:** A large (36-bed) multi-service program including separate intensive residential and day treatment components as well as specialized programming for monolingual Asian clients. This program focuses on individuals with histories of long-term institutionalization and acute crises and provides a stay of between 60 and 180 days in a supportive environment.
- **4TH Avenue House:** An innovative model for residential detoxification in a small (10-bed) social setting with medical support and intensive stabilization of up to 3 weeks.
- **Fremont Place:** A medically managed detoxification residence, treatment and support program for up to 14 men, with a 7- to 21-day length of stay.
- **7TH Street Program:** A short term, post-detox, residential treatment program with 17 beds, providing evaluation, assessment, short-term treatment and discharge planning for multiply diagnosed adults.

C. Transitional Residential

Transitional Residential treatment programs are for clients whose primary issue is an Axis I mental illness. Clients may also be dually diagnosed (suffer from a co-occurring substance abuse issue). Programs are typically 90 days in duration. These programs are

for people who need counseling and intensive life skills development in preparation for community living and returning to work.

- **Conard House:** A licensed 16-bed 24-hour residential treatment program for adults. This Pacific Heights program includes a component for monolingual Asian clients. For more information about the referral process please call 415.346.6380.
- **Baker Street House:** A 16-bed transitional residential treatment facility serving individuals with serious and persistent mental health problems.
- **Robertson Place:** A 12-bed transitional residential treatment program with a day treatment component focusing on adults who have been “dually diagnosed” with co-occurring mental health and substance use disorders.
- **Acceptance Place:** A 12-bed transitional residential treatment program for gay men in the early stages of substance abuse recovery.
- **Ferguson Place:** A 12-bed transitional residential treatment program providing services to adults who have been “triply diagnosed” with mental health, substance abuse and HIV/AIDS related disorders.
- **Progress (Beulah) House est. 1969:** A 10-bed psychiatric transitional residential treatment program. This program has an in-house full Day Treatment program. Clients who have not yet established a schedule of outside activities such as school or work will work on individual treatment plans and activities of daily living during the day. There is a structured program during the evenings. Progress House offers DBT Skills Training (Dialectical Behavioral Therapy) and specializes in services to LGBT clients. The target length of stay is 3 months.
- **La Amistad est. 1978:** A 13-bed psychiatric transitional residential treatment program. La Amistad emphasizes service to the Spanish-speaking community, with bi-cultural, bi-lingual Spanish-speaking staff available. This program has an in-house full Day Treatment program. Clients who have not yet established a schedule of outside activities such as school or work will work on individual treatment plans and activities of daily living during the day. There is a structured program during the evenings and the program offers DBT Skills Training. The target length of stay is 3 months. It is located in San Francisco’s Mission District.
- **Carroll House est. 1979 and Rypins House, est. 1980:** Two 6-bed houses that make up the Seniors Program. The Seniors Program serves individuals who are 60 and older. The target length of stay is 4-6 months. Clients of both houses attend Day Treatment at the Rypins House site, unless they have other scheduled services outside the program. The Day Treatment program also serves former clients and seniors in the community, with a maximum capacity of 25. There is no time limit for day treatment attendance. Carroll House is located in the Mission District and Rypins House is located in the Bernal Heights District of San Francisco.
- **Ashbury House est.1995:** A psychiatric residential treatment program serving 8-10 mothers and their children with a maximum capacity of 20 individuals. The program is licensed to accept pregnant mothers and mothers

with children up to 12 years old. Ashbury House provides a structured in-house Day Treatment program, tailored specifically to the needs of mothers with mental illness. The program provides comprehensive parenting education as well as mental health services. Clients work on individual treatment plans to either maintain custody or re-unify with children that have been removed from their custody. The maximum length of stay is 1 year, with the opportunity to participate in after-care services. The program is located in the Haight-Ashbury District of San Francisco.

- **Clay House est. 1996:** A 16-bed psychiatric transitional program designed primarily for clients returning from long-term stays in locked institutions or other long-term care settings. The program has a comprehensive in-house Day Treatment program for the residents of the program. The maximum length of stay is one year. Clay House is located in the Pacific Heights neighborhood of San Francisco.
- **Dorine Loso House est. 2007:** A 14-bed psychiatric transitional program designed primarily for clients returning from long-term stays in locked institutions or other long-term care settings. The program has a comprehensive in-house Day Treatment program for the residents of the program. The maximum length of stay is 1 year. Loso House is located in the North of Panhandle neighborhood of San Francisco.

D. Board and Care

Board and Care Residential facilities are licensed by the State Department of Social Services, Community Care Licensing Division. These licensing categories include three types of facilities: 1) ADULT RESIDENTIAL FACILITY: serves adults with developmental or mentally disabled, ages 18-59 years; 2) GROUP HOME: serves individuals birth through 17 years old with a structured environment with services provided by staff employed by the licensee; 3) SMALL FAMILY HOME: serves persons with developmental disabilities, mental disorders or physical handicaps aged birth through 17 years old with care provided in the licensee's family residence.

- **Mar-Ric:** 2749 Lindbrook, Riverbank, CA 95367 (near Modesto)
- **Ruby's Board and Care in Fresno**
- **Ruby's Board and Care in San Francisco**

E. Locked Facilities (L-Facility)

- **Mental Health Rehabilitation Center (MHRC-pronounced "merk"):** a Locked facility located within SFGH
- **Crestwood Manor:** locations in Fremont, Stockton, and Modesto
- **Canyon Manor:** <http://www.canyonmanor.com/> Located in Marin. 89 beds available.

F. State Hospitals

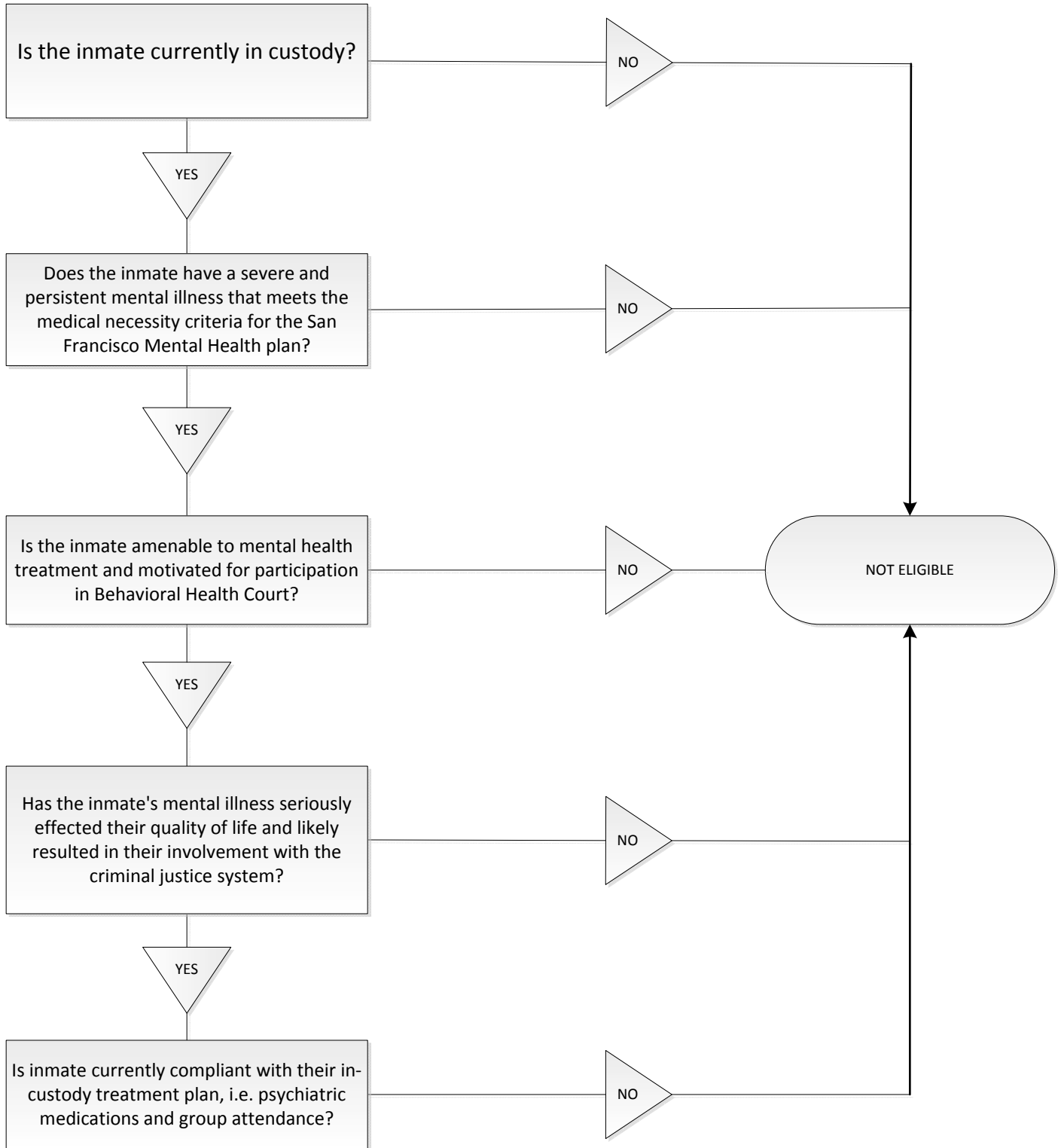
- **Patton State Hospital**
- **Napa State Hospital**
- **Atascadero State Hospital**

G. Other Facilities/Programs

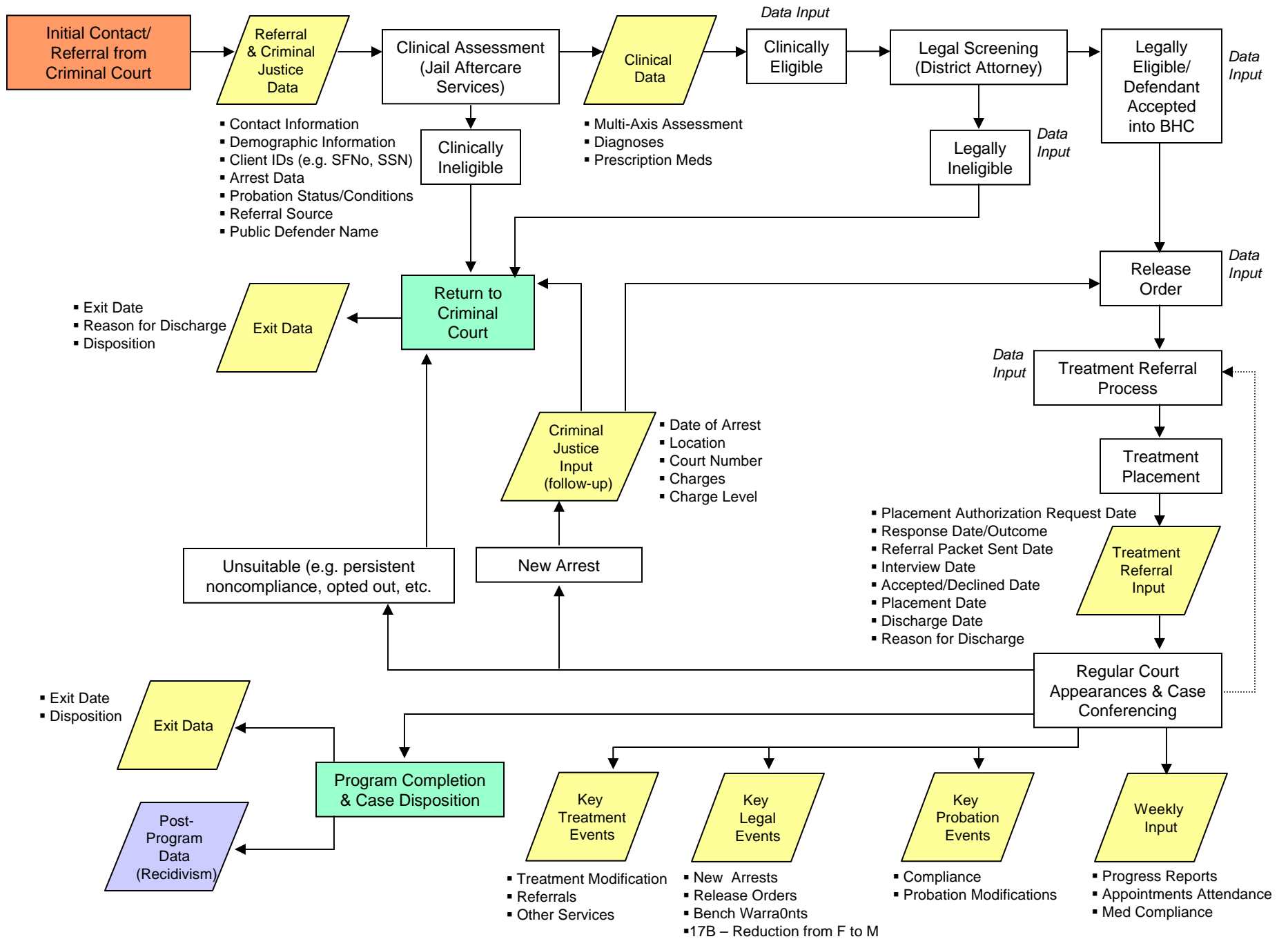
- **Psychiatric Emergency Services (PES/ San Francisco General Hospital):** PES at SFGH provides 24-hour, 7-day a week emergency assessment, stabilization and disposition for acutely ill adult psychiatric patients who are San Francisco residents. PES is the only designated evaluation facility for adult patients placed on psychiatric holds, known in public-safety parlance as “5150”. PES provides emergency assessment and hospital placement for San Francisco patients placed in sub-acute facilities that are experiencing an acute exacerbation. SFGH is the largest acute inpatient and rehabilitation hospital for psychiatric patients in San Francisco.
- **Single Room Occupancy Hotel (SRO):** The Kinney Hotel: Transitional Housing for clients getting out of jail. Jail Health Services has access to approximately 12 of these beds and many are used for clients in BHC.
- **Walden House:** Walden House offers residential and outpatient substance abuse treatment.
- **SAGE:** A program for women with a history of prostitution/trauma.

APPENDIX II: BEHAVIORAL HEALTH COURT ELIGIBILITY CRITERIA

Behavioral Health Court Eligibility Criteria



APPENDIX III: BEHAVIORAL HEALTH COURT FLOWCHART



Behavioral Health Court: Case Presentation

Date: _____

| | |
|--|--|
| Name | _____ |
| Date of Arrest | _____ |
| Referral Source | _____ |
| Attorney | _____ |
| SF# | _____ |
| DOB/Age | _____ |
| Gender | <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> MTF <input type="checkbox"/> FTM |
| Ethnicity/ Language | <input type="checkbox"/> White (non Latino) <input type="checkbox"/> English <input type="checkbox"/> Cantonese |
| | <input type="checkbox"/> Native American <input type="checkbox"/> Tagalog <input type="checkbox"/> Asian/Pacific Islander |
| | <input type="checkbox"/> African American (non Latino) <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____ |
| | <input type="checkbox"/> Latino/a <input type="checkbox"/> Russian |
| | _____ |
| Source of Income | <input type="checkbox"/> None <input type="checkbox"/> GA, CAAP, TANF <input type="checkbox"/> SSI/SSDI |
| | <input type="checkbox"/> Employed <input type="checkbox"/> Other _____ |
| Prior Housing Status | <input type="checkbox"/> Homeless/street/shelter <input type="checkbox"/> With Roommate |
| | <input type="checkbox"/> Independent apartment/house (shared expenses) |
| | <input type="checkbox"/> Hotel/SRO <input type="checkbox"/> With Roommate |
| | <input type="checkbox"/> With Parent/Guardian/Relative (no shared expenses) |
| | Will client have this same housing upon release? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Current Charge(s) | _____ |
| Diagnosis | _____ |
| Current Providers | _____ |
| History of Mental Illness (symptoms) and Treatment | _____ |
| History of Dangerous Behaviors (suicide attempts/violence) | _____ |
| Treatment Plan (how will BHC facilitate this) | _____ |
| Treatment Goals | _____ |
| Barriers to Treatment | _____ |
| Dependency court involvement? | <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many children: <input type="text"/> |

APPENDIX V: BEHAVIORAL HEALTH COURT AUTHORIZATION TO RELEASE/REQUEST CONFIDENTIAL PATIENT INFORMATION

**Behavioral Health Court
Authorization to Release/Request Confidential Patient Information**

I, _____, authorize **Jail Psychiatric Services and Community Mental Health Programs** to disclose records obtained in the course of my diagnosis and treatment for:

initial

MEDICAL

Any such disclosure shall be limited to the following specific types of information or dates of treatment: _____

initial

PSYCHIATRIC

Any such disclosure shall be limited to the following specific types of information or dates of treatment: I permit complete access to all of my Jail Psychiatric Services and Community Mental Health records.

I understand that psychiatric records are protected by the California Welfare and Institutions Code Section 5000 et. Seq. and are not subject to redisclosure.

initial

AIDS/ARC/HIV

Any such disclosure shall be limited to the following specific types of information or dates of treatment: _____

I understand that if my medical records contain results of any HIV blood test or other information about AIDS/ARC/HIV, this information will be disclosed as part of the medical record to the person authorized below to receive records. By initializing this box, I am providing written authorization, as defined in Health and Safety Code section 99.21G, to disclosure of that information.

initial

DRUG OR ALCOHOL ABUSE

Any such disclosure shall be limited to the following specific types of information and dates of treatment: _____

I understand that if my medical records contain ALCOHOL or DRUG RELATED information, this information is protected by federal laws and regulations and is not subject to redisclosure.

To: **Behavioral Health Court which includes the following parties: Superior Court Judges, the Public Defender's Office, Private Defense Attorneys, the District Attorney's Office, the Probation Department, Jail Psychiatric Services, Citywide Casemanagement, San Francisco Pretrial Diversion Project, Inc., Center on Juvenile and Criminal Justice, Community Mental Health representatives, and Community Mental Health program providers.**

This authorization shall become effective immediately and shall remain in effect for this one request only unless otherwise specified. This authorization will terminate on _____.

Date

DOB

Participant Signature

Witness

Print Participant Name

APPENDIX VI: MENTAL HEALTH RESOURCES

The Criminal Justice/Mental Health Consensus Project: The Criminal Justice/Mental Health Consensus Project, coordinated by the Council of State Governments Justice Center, is an unprecedented, national effort to help local, state and federal policymakers and criminal justice and mental health professionals improve the response to people with mental illnesses who come into contact with the criminal justice system.

<http://consensusproject.org>

GAINS Center: The National GAINS Center has operated since 1995 as a national focus for the collection and dissemination of information about effective mental health and substance abuse services for people with co-occurring disorders in contact with the justice system. The GAINS Center's primary focus is on expanding access to community based services for adults diagnosed with co-occurring mental illness and substance use disorders at all points of contact with the justice system. The Center emphasizes the provision of consultation and technical assistance to help communities achieve integrated systems of mental health and substance abuse services for individuals in contact with the justice system.

<http://gainscenter.samhsa.gov/html/>

PRIVATE DEFENSE GUIDE TO BEHAVIORAL HEALTH COURT¹
FEBRUARY 2009

WHAT IS BEHAVIORAL HEALTH COURT (BHC)?

BHC is a treatment court (similar to Drug Court) which seeks to provide mental health treatment to criminal defendants who have an *Axis I* mental health diagnosis, rather than have them follow the usual criminal prosecution path.

BHC is a collaborative court which is **non-adversarial**. Attorneys, both prosecutors and defense lawyers, play a different role than in traditional criminal court. When a BHC client is represented by a private defense attorney, that attorney is part of the BHC team for that particular client. The team for each client consists of the Judge, prosecutor, defense attorney, probation officer (when appropriate), Jail Psychiatric Services, and case manager from a community-based mental health service provider. While every team member is expected to bring the perspective of his or her traditional role to the table, team members are expected to listen to each other and work together under the guidance of the treatment providers for the benefit of the clients. Because this is a treatment court, the clinicians have the primary, and often, last say in presentations about the clients.

BHC's mission is to connect participating defendants with mental health services in the community. The legal goal of BHC is to obtain a favorable resolution/termination of the criminal prosecution and to place the client into a treatment situation that will both serve his or her needs and help to insure that he or she will not be rearrested. Each defendant has his or her own *treatment plan*, compliance with which is monitored by the BHC team on an ongoing basis. The treatment goal of BHC is to link mentally ill clients with appropriate community services so that they will remain engaged in treatment even after BHC-mandated plan has been completed.

Clients may enter BHC with open cases, with a pending probation violation, with a deferred entry of judgment (DEJ), or with a probationary sentence with BHC as a condition of probation. **The court accepts only persons who are in custody.**² The length of BHC participation varies considerably and is necessarily tied to the client's specific needs and response to treatment. Every client makes a **minimum commitment of one year**. The legal outcome for those who are successful in BHC is negotiated on a case by case basis.

¹ This guide was written by Betsy Wolkin and Jim Senal, both of whom have represented many BHC clients, and was edited by the BHC Team. It is intended specifically for private defense attorneys. Attorneys are urged to familiarize themselves with the official BHC Policies and Procedures (July 2008) available at www.sfgov.org/site/uploadedfiles/courts/divisions/Collaborative_Justice/BHCPoliciesandProceduresManual.pdf

² At the present time, there are no exceptions to the custody requirement due to limited resources and the fact that all evaluations are conducted by Jail Psychiatric Services.

I THINK MY CLIENT IS MENTALLY ILL. HOW DO I GET HIM OR HER INTO BHC?

Generally, your client must have an Axis I diagnosis to be **eligible** for BHC. However, on rare occasions, individuals with an Axis II diagnosis or a developmental disability diagnosis are admitted. Clients who are charged with murder or sex offenses are not eligible under any circumstances for BHC irrespective of their diagnosis. Defendants charged with misdemeanor or felony domestic violence offenses, misdemeanor or felony elder abuse offenses, misdemeanor or felony weapons offenses, or serious offenses (as defined by Penal Code section 1192.7(c)) are not eligible for BHC without the District Attorney's express consent. Defendants who have suffered a prior conviction for any offense listed in Penal Code section 1192.7(c) are not eligible for BHC without the District Attorney's express consent. Defendants charged with Penal Code 314.1 or 290 may be considered on a case by case basis.

BHC is not an alternative for defendants who are incompetent to stand trial within the meaning of Penal Code 1368.

Counsel should interview their clients thoroughly and discuss their prior psychiatric treatment history, their diagnoses, and medications that have previously been prescribed and/or are currently being administered by Jail Psychiatric Services. Counsel should also determine their clients' willingness to continue to take medication and participate in treatment. To be an informed advocate for a client in BHC, this information is essential.

If you think your client may be eligible³, you must request that the court order an evaluation by Jail Psychiatric Services pursuant to Penal Code 4011.6 **for purposes of BHC**. This type of 4011.6 evaluation usually takes two days. The report will be returned to the court that ordered the evaluation. If the client is found diagnostically **suitable** for BHC, then the case can be sent to Department 7 (BHC) on a subsequent Tuesday afternoon, on a date specified by JPS, for a case conference and eligibility determination. A case can be sent to Department 7 without the concurrence of the District Attorney in the court of origin, or over his or her objection, if the client is determined to be diagnostically **suitable**, except as mentioned above.

Counsel should carefully evaluate the timing of a referral to BHC. From a clinical point of view, the case should be referred to BHC as soon as possible after the client enters the criminal justice system. The sooner the client is in BHC, the sooner referrals can be made to community based treatment services and appropriate housing. These factors facilitate the clients ability to be released from custody at an earlier time. Approval for a case manager and residential treatment programs take time; waiting lists are often lengthy. On the other hand, there may be legal situations where the timing of a referral to BHC should be carefully considered. There are cases that are better served by a referral prior to preliminary hearing and others where a better strategy might be to make

³ See BHC Flowchart (Appendix III) in the Policies and Procedures Manual:
www.sfgov.org/site/uploadedfiles/courts/divisions/Collaborative_Justice/BHCPoliciesandProceduresManual.pdf

the referral after a preliminary hearing. For example, if counsel believes that the defendant's legal situation will improve after preliminary hearing because (1) the case might be reduced to a misdemeanor, or (2) counsel anticipates that the evidence adduced at preliminary hearing will be more favorable to the defendant than the evidence contained in the police report, or (3) evidence may be adduced at preliminary hearing that tends to mitigate the crime. Under these circumstances, even if the 4011.6 report indicates that the defendant is eligible, referral to BHC for suitability might be strategically delayed.

Sometimes referral to BHC, despite diagnostic eligibility, may be delayed so that counsel has an opportunity to collect psychiatric records, conduct an independent diagnostic evaluation and develop other appropriate case mitigation materials which may aid admission and facilitate a disposition consistent with participation in BHC.

IF JAIL PSYCHIATRIC SERVICES (JPS) FINDS THE CLIENT DIAGNOSTICALLY APPROPRIATE (OR ELIGIBLE) FOR BHC IN THE 4011.6, WHAT DO I DO NEXT?

If the client is diagnostically appropriate, the case goes to Department 7 (physically Department 15) for a Tuesday afternoon⁴ case conference to determine a client's **eligibility** for BHC. Case conferences are held in the law library on the second floor, beginning at 1:30 PM every Tuesday and 9:30 AM every Thursday. Present during the case conference will be the Judge, the prosecutor assigned to BHC, as well as representatives from various mental health treatment providers, including Jail Psychiatric Services, and the probation department.

Jail Psychiatric Services presents a mental health history and a proposed treatment plan which details how your client may best receive treatment in the community. If during the course of the representation of your client, you have obtained information that would further inform Jail Psychiatric Services about the client's mental health history and background or suitability, this information should be provided to JPS prior to the case conference so that it can be integrated into the suitability evaluation by JPS.⁵ JPS should be as familiar as possible with your client's treatment history prior to this conference. Case conferences are confidential and information provided by counsel during these conferences can only be used for treatment purposes.⁶

⁴ BHC is currently in session twice a week: Tuesday afternoon for persons in custody and all day Thursday for persons out of custody.

⁵ E-mail Tanya Weisheit, head of Jail Aftercare Services, at Tanya.weisheit@sfdph.org to alert her that you have supplemental materials that you are electronically forwarding or will drop off at the JPS office at 650 Fifth Street, Suite 309.

⁶ Every person who is present during case conferences is required to sign a confidentiality agreement. Counsel will be asked to do the same the first time they appear at BHC and it will remain on file and in effect thereafter. Confidential information shared at a case conference will not be used against your client in any fashion to further the criminal prosecution if your client is not accepted into BHC.

If the prosecutor agrees that the case is eligible for BHC, but requires a disposition, the case will be transferred to D15 for that purpose. If the prosecutor at the case conference does not think your client is legally eligible, because the offer to resolve the case is state prison or because the current charge or past criminal history makes him or her ineligible, the case may also be transferred to D15 in order to try to reach an appropriate disposition. The case conference is not the appropriate time to pre-try the case. The pretrial in D15 will be your opportunity to advocate for your client's **eligibility** for BHC and persuade the D.A. and/or the judge that your client should come into BHC. Defense counsel should be prepared to present any and all mitigating factors with respect to the criminal case. If the case cannot be resolved in D15 to enable the client to enter BHC, the case will be set for preliminary hearing or trial as soon as possible.

Acceptance requires that the client be **(1) suitable**, i.e. diagnostically appropriate for BHC and **(2) eligible**, i.e. can be treated in the community health system and be amenable to treatment, meaning that the client is interested in participating in treatment for their mental health, and related problems. Acceptance then requires a determination about the legal posture of the case for admission while in BHC and agreement to that posture by the client, counsel, prosecutor, and court. Acceptance is case specific and determined on a case by case basis.

Acceptance into BHC may be predicated on the entry of a plea and a probationary sentence, a plea and a DEJ, no plea, an admission of a probation violation or no admission. Acceptance can occur with the assent of the D.A. or may be over her objection (for instance with a plea open to the court) if the client is found otherwise diagnostically appropriate and motivated to participate in BHC.⁷ The client will not be sentenced or probation reinstated and modified until released from custody. There is usually an agreement at the time of the agreement on the disposition as to what might happen if the client does well in BHC, such as a shortened probationary period, a reduction of the charged offense to a misdemeanor, early withdrawal of the plea and dismissal of the criminal charge on a deferred entry of judgment, or outright dismissal.

MY CLIENT WAS ACCEPTED INTO BHC. WHAT HAPPENS NEXT?

If your client is accepted into BHC, he or she will begin to attend BHC regularly. At the first appearance following acceptance, the judge welcomes your client and gives the client a brief overview of the goals of BHC. Typically, while an individual is in-custody and awaiting placement in a treatment program, these appearances occur once or twice a month on Tuesday afternoon at 1:30. When you arrive, the team will discuss your client(s) status, his or her progress in in-custody treatment, and the expected wait-time for placement in a community program. If your client is out of custody, he or she will appear on Thursday afternoon. The case conference on Thursday is at 9:30 AM at which time there will be a progress report from the appropriate treatment provider

⁷ If the defendant is charged with a serious or violent felony as defined in the Penal Code, acceptance into BHC must be approved by the District Attorney and will not occur over their objection.

regarding the client's progress in treatment and a recommendation as to incentives or sanctions, including remand into custody. **Whenever your client is scheduled to appear in BHC, your appearance is mandatory at the case conference in the Law Library, as well as, in Court that afternoon.** You may wish to be in contact with your client's case manager at times other than the formal case conference.

Following case-conferencing, counsel is also required to appear in court later that day at approximately 3pm on Tuesday or 2pm on Thursday. You will need to be present with your client at each of these appearances and ask the Judge to call your client's case(s) by calendar line. If you have a conflict, please arrange for another attorney to stand in for you and advise substitute counsel of what has been discussed in the case conference, what progress your client has made and what your client can anticipate from the court. **Do not assume that the Public Defender can stand in for you.**

HOW QUICKLY WILL MY CLIENT BE RELEASED FROM CUSTODY ONCE THEY ARE ACCEPTED IN BHC?

As soon as a client is accepted into BHC, Jail Psychiatric Services starts the process of getting approval from the Department of Public Health for an intensive case manager and a residential treatment program if appropriate. As soon as a case manager is assigned, that person and the client will work together to develop a treatment plan that includes housing, medication management, therapy, school, employment and/or other appropriate services. Most often, clients are linked with Citywide Case Management Forensics, a mental health treatment center run by UCSF, and usually represented at BHC by Kathleen Connolly, Director. However, your client may be referred to any number of other treatment programs in San Francisco, depending on his or her needs. Treatment may be residential or out-patient in the community if other housing is available.

A client is not released from custody without a treatment plan and housing. It is a stated goal to get people out of custody and into treatment as soon as possible, but limited resources and limited beds in residential program often result in the client's spending many weeks in custody. **Clients should be advised of this possibility and urged to consider the long term benefits that will be derived from a positive placement in the community.** One benefit of referring a client to BHC as soon as possible in the criminal process is reduction of time in custody awaiting a community placement.

UNDER WHAT CIRCUMSTANCES WILL A CLIENT BE RETURNED TO CUSTODY?

A client is rarely remanded into custody as a sanction for not following his or her treatment plan. A remand, in the absence of a new criminal case, may occur if the client is engaging in high-risk behaviors or is a threat to public safety or is not engaged in treatment. If a client leaves a treatment program or has not been in treatment and whereabouts are unknown, a bench warrant will be issued.

UNDER WHAT CIRCUMSTANCES CAN MY CLIENT BE TERMINATED FROM BHC?

BHC is voluntary so a client can opt out of BHC at any time. His/her case will be returned to the criminal courts in the same posture that they came into BHC.

A new arrest may alter a client's status in BHC depending on the nature of the new offense. Usually, a new arrest requires a change in the treatment plan. The client may also be required to plead guilty to the new offense or admit a probation violation. This determination is made on a case by case basis.

The court may terminate a client from BHC for repeated new arrests, arrest for a serious violent crime, and or **prolonged non-compliance** with treatment

WHEN WILL MY CLIENT GRADUATE?

No client will graduate before completing a minimum of one year in BHC. Graduation for each client is determined on a case by case basis. **It is very important that counsel not mislead a client into thinking that one year of participation guarantees graduation.** The goal is to graduate from BHC within a reasonable period of time after the client has become stable in his or her treatment in the community. A major criterion for graduation is demonstration of consistent engagement in treatment and being arrest-free. This generally involves a determination that the client has stable housing, is compliant with prescription medication (if on medication), is involved with some type of activity in the community (school, work, volunteer activities etc) and is connected with community services so that mental health treatment can continue. The clinician is the primary person who makes the decision with regard to graduation with the concurrence of the BHC team. It is appropriate for counsel to inquire about the status of graduation after one year's participation in the program.