MENTAL HEALTH DIVERSION: PRACTICAL APPLICATIONS

By Morgan Shaw, PsyD
& Chris Garnica, PsyD

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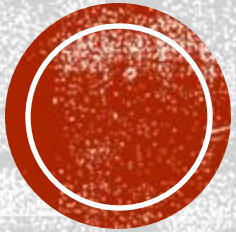


FACTS

- Estimated 60% of incarcerated individuals in CA have a substance use disorder & 1/4 are diagnosed with SMI
  - In 2019, 30% of female inmates & 20% of male inmates in CA received mental health (MH) treatment while incarcerated
- Nearly 1 in 7 CA adults have a mental illness
  - 1 in 26 have a Serious Mental Illness (SMI)
  - 1 in 14 children have an emotional disturbance that limits functioning
- As of December 2020, 18,000 people in CA jails were receiving mental health services for an identified MH disorder
  - 91% were receiving psychotropic medications
  - 26% were assigned beds for mental health conditions

MENTAL HEALTH NEEDS & CRIMINAL JUSTICE SYSTEM

Mental health disorders' role in influencing offending & recidivism

Punishment vs. rehabilitation

Jail- vs. community-based mental health treatment

Top-down vs. bottom-up treatment

TYPES OF DIVERSION PROGRAMS AVAILABLE TO CA DEFENDANTS

- **PC § 1000 Drug Diversion:**
  - Treatment & education for defendants with non-violent substance-related offenses with no prior disqualifying convictions
- **PC § 1001.80 Military or Veteran Diversion:**
  - Active military or veteran defendants are eligible if suffering from PTSD, TBI, substance dependence, or other MH conditions
- **PC § 1001.95 – 1001.97 Misdemeanor Diversion:**
  - Defendants with misdemeanors could have their case dismissed or erased upon successful completion of treatment or education courses
- ***PC § 1001.35 – 1001.36***
  - ***PC §1369/1370***

ASSEMBLY BILL (AB) 1810 & SENATE BILL (SB) 215 (2018)

Codified in PC § 1001.35 & 1001.36

Amended PC § 1369/1370 - Competency MHD

Pretrial diversion program for defendants with qualifying MH conditions

Appropriate treatment to address concerns must be available

2-year programs for Felonies

1 year program for Misdemeanors

Successful completion = charges dismissed

MHD AMENDMENTS TO PC § 1369/1370

- Became effective January 2025 to relieve burden on state hospital system
- If requested by the defense, competency evaluators must opine as to whether the defendant is eligible for MHD pursuant to PC § 1001.36
- All IST defendants who are eligible for MHD ***must*** be diverted, unless contrary to the **interest of justice** in the case
  - **Interest of justice** = restoring defendant to competency to reinstate the criminal proceedings in the future

INTEREST OF JUSTICE

Typically involves evaluating factors such as:

- **Nature and Severity of the Offense:** Understanding the seriousness of the charged crime.
- **Defendant's Mental Health History:** Considering the individual's mental health background and treatment needs.
- **Public Safety Considerations:** Assessing potential risks to the community.
- **Likelihood of Successful Restoration:** Evaluating the probability of the defendant attaining competence through treatment.

MHD AMENDMENTS TO PC § 1369/1370

- IST – MHD is limited to a period of 2 years from the MHD acceptance date or the maximum sentence for the offense, whichever is shorter
- **Successful IST – MHD completion** = dismissed charges
- **Unsuccessful IST – MHD completion** =
  - Order modified treatment plan
  - Refer to assisted outpatient treatment program (where successful completion means dismissed charges)
  - Refer to county conservatorship
  - Refer to CARE program
  - Reinstate competency proceedings with time in MHD counting towards maximum term of commitment

OBJECTIVES OF MH DIVERSION

Divert	Decriminalize	Deflect
Divert qualifying individuals from court & incarceration	Decriminalize mental health issues	Deflect revolving door of chronic mental health sufferers from jail/prison system

IMPLEMENTATION OF PC § 1001.35 & 1001.36

STEPS OF MH DIVERSION

Defense submits motion for MH Diversion

- Defendants will either be referred via competency or standard pretrial
- DA can stipulate to or oppose

Determination of eligibility, suitability, & qualified offense

- DSM Diagnosis by qualified mental health expert
- Causal factor
- No unreasonable risk

If accepted, treatment programing

Outcomes:

- Successful completion = Charges dismissed
- Unsuccessful completion/termination = Criminal proceedings reinstated

KEY ELEMENTS OF MH DIVERSION

Exclusionary diagnoses

- Antisocial Personality Disorder
- Pedophilia

Exclusionary offense

- Murder or voluntary manslaughter
- Any offense requiring registration as a sexual offender
  - Sexual battery, assault, trafficking, kidnapping, indecent exposure,
  - Rape, spousal rape, aiding rape
  - Lewd/Lascivious/Oral copulation on child < 14 yro
  - Continuous sexual abuse of a child
- Weapons of Mass Destruction

KEY ELEMENTS OF MH DIVERSION

Diagnoses not necessary causal, but must have played significant role in the offense

- Clear & convincing evidence

Waive 6th amendment right

Must agree to consent-to & comply-with treatment

Shall Find

SHALL FIND: PC § 1001.36(B)(2)

(2) The defendant's mental disorder was a significant factor in the commission of the charged offense. If the defendant has been diagnosed with a mental disorder, the court shall find that the defendant's mental disorder was a significant factor in the commission of the offense unless there is clear and convincing evidence that it was not a motivating factor, causal factor, or contributing factor to the defendant's involvement in the alleged offense. A court may consider any relevant and credible evidence, including, but not limited to, police reports, preliminary hearing transcripts, witness statements, statements by the defendant's mental health treatment provider, medical records, records or reports by qualified medical experts, or evidence that the defendant displayed symptoms consistent with the relevant mental disorder at or near the time of the offense.

RECENT CASES

MH Diversion can be denied for failure to comply with treatment:

Sarmiento v. Superior Court (2024)

Voluntary substance abuse & untreated MH sequelae

- Unreasonable risk of danger to public
- Super Strike offenses

People v. Hall (2024)

Expulsion from residential treatment facility

- Demonstrable actions of failure to comply & consent to treatment obligations

MHD PRACTICAL APPLICATIONS

STEP 1: EVALUATION

EVALUATION

- **Diagnosis**
  - Defendants **must** be ***diagnosed*** with a MH disorder
    - Who can diagnose?
    - What qualifies?: Provisional vs. Unspecified vs. Other Specified vs. Rule Outs
    - Differential Diagnoses
    - Primary Diagnosis: Substance Use Disorders?

DIAGNOSES

Most commonly qualifying diagnoses:

- Bipolar Disorder
- Schizophrenia
- Schizoaffective Disorder
- Posttraumatic Stress Disorder

Previously excluded, but now acceptable diagnosis:

- Borderline Personality Disorder (AB 1412)

EVALUATION

- **Evaluating the function of the offending behavior**
  - Diagnosis must have played a role in offense
    - Can consider relevant evidence, including:
      - Police Reports
      - Medical Records
      - Evaluation Reports

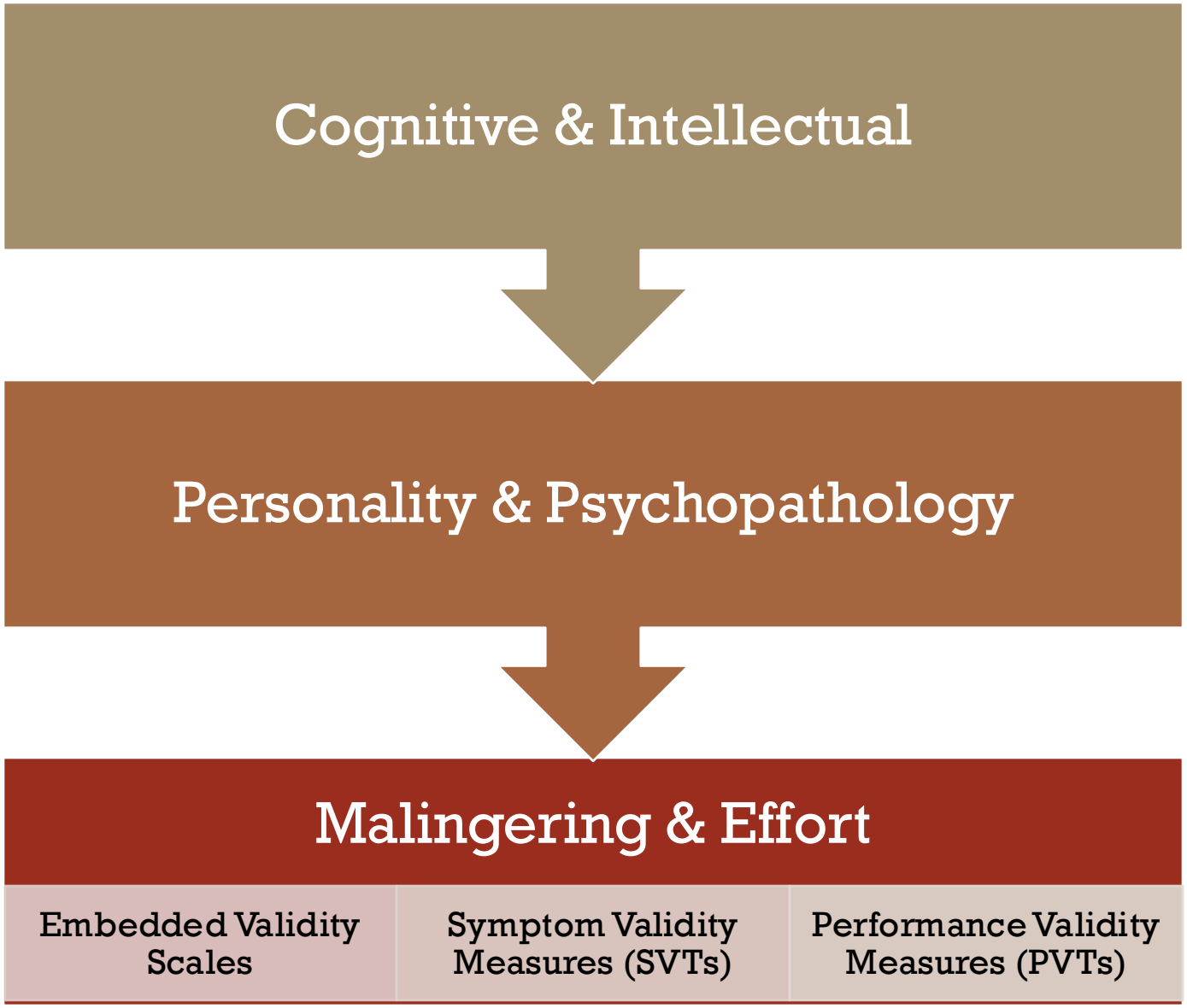
EVALUATION

- **Prognosis**
  - Will the diagnosis respond well to treatment?
    - Does the appropriate treatment program exist?
  - Will the defendant consent-to and comply-with treatment?

ASSESSMENT

- **Daubert Standard**
  - Expert testimony/opinions must be based on:
    - Reliable principles and methods
    - Sufficient facts or data
    - Peer reviewed & published
    - AND general acceptance by the scientific community
- **How might this apply to psychological assessment of MH conditions?**

ASSESSMENT


Cognitive & Intellectual
Personality & Psychopathology
Malingering & Effort
Embedded Validity Scales
Symptom Validity Measures (SVTs)
Performance Validity Measures (PVTs)

WHAT ABOUT VIOLENCE & RISK ASSESSMENTS?

- Issue of Super Strike Offenses
  - Super Strike Offenses = serious or violent Felony offense that could result in life imprisonment (or death penalty*)
  - Derived from PC § 1170.18, which outlines what constitutes an unreasonable risk, narrowing it down to the likelihood of committing these severe offenses
- Issues of Public Safety:
  - Likelihood of recidivism
  - Level of oversight/supervision
  - Medication compliance
  - Any relevant protective factors
- **How might a Violence/Risk measure aid or hinder these determinations, with respect to MHD evaluation constraints?**

ASSESSMENT LIMITATIONS

- **Telehealth vs. In-Person**
  - Telehealth technical limitations
    - Rapport
    - Bx/testing observations
    - Assessment administration
  - In-Person environmental limitations
    - Private office vs. Jails
      - Can waste a whole day waiting around at jails
    - Practically limited on time
    - Limited on funding

STEP 2: REPORT WRITING

REPORT WRITING

Includes all relevant identifying personal data & information pertinent to the criminal proceedings

- Age, education level, etc.
- Referral question clearly defined

Well rounded background history

- Starts with a thorough clinical interview
- Does the history support your diagnoses and conclusions?

Assessments:

- Assessments administered are ***clearly defined & current***
- Scores are clearly indicated
- Interpretations are appropriate & accessible for the target audience

Diagnostic Impressions & Conclusions:

- Typically combined to answer the following referral questions, taken directly from the statute:

REPORT WRITING: CLINICAL OPINIONS USING PC § 1001.36 CRITERIA

1. **Is there a DSM-5-TR Diagnos(es)?**
   - Flushing out diagnoses
   - Justifying & qualifying any:
     - Provisional
     - Unspecified
     - Other Specified
     - Rule Out

2. **Did the specific symptoms significantly contribute to the crime?**
   - Tie the diagnosis into the offending behavior
     - Does not need to be causal, must be significant
   - Facets to consider:
     - Understanding
     - Judgment
     - Impulsivity
     - Disinhibition
     - Others?

REPORT WRITING: CLINICAL OPINIONS USING PC § 1001.36 CRITERIA

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3. **Would the defendant's symptoms motivating the criminal behavior respond to mental health treatment? What is the recommended treatment to meet the specialized needs of the defendant?**
   - Should be specific
   - Caveat:
     - Does the treatment program exist and do they have access to it?
     - Symptoms must be amenable to treatment

4. **Does the defendant present an unreasonable risk of danger to public safety if treated in the community?**
   - Likelihood of recidivism
   - Level of oversight and supervision
   - Medication compliance
   - Structure/supports necessary to improve compliance
   - Protective factors
     - Willingness/Eagerness to seek treatment
     - Support system
     - History of treatment efficacy/compliance
     - Others?

REPORT WRITING: CLINICAL OPINIONS USING PC § 1001.36 CRITERIA

WHAT HAPPENS AFTER OUR REPORTS ARE SUBMITTED?

(e) At any stage of the proceedings, the court may require the defendant to make a prima facie showing that the defendant will meet the minimum requirements of eligibility for diversion and that the defendant and the offense are suitable for diversion. The hearing on the prima facie showing shall be informal and may proceed on offers of proof, reliable hearsay, and argument of counsel. If a prima facie showing is not made, the court may summarily deny the request for diversion or grant any other relief as may be deemed appropriate.

WHAT HAPPENS AFTER OUR REPORTS ARE SUBMITTED?

- **If the court is satisfied and orders MHD:**
  - The court will seek the appropriate treatment with public or private funds, and determine if the identified program is willing to accept responsibility for the defendant's treatment
  - Treatment providers provide regular progress reports to the court
  - Charges dismissed or criminal proceedings reinstated

REBUTTALS

- Prosecution can ask an opposing expert to examine the original MH Diversion motion/psychological report to offer professional opinion on the efficacy and accuracy of their:
  - Procedures
  - Diagnoses
  - Diversion-specific conclusions
- Rebuttals may be used to determine if suitability is met

REBUTTALS

AUTHORING REBUTTALS

1. **Review the Expert Report:** Carefully read the expert report to understand the conclusions and the basis for the expert's opinions.
2. **Identify Strengths/Weaknesses:** Look for any inconsistencies, lack of evidence, or flawed reasoning in the report.
3. **Gather Supporting Evidence:** Collect any additional evidence that contradicts the expert's findings or supports your position.
4. **Draft the Rebuttal:** Write a clear and concise rebuttal that addresses the points made in the expert report. Focus on factual inaccuracies, methodological flaws, and alternative interpretations of the evidence.
5. **Include Ethical, Legal, Diagnostic, & Procedural Arguments:** Incorporate relevant standards and case law to support your arguments.
6. **Review and Revise:** Ensure that your rebuttal is well-organized, free of errors, and persuasive.

REBUTTAL VIGNETTE 1:

- The MHD evaluating psychologist is a School Psychologist (i.e., EdS with PPS credentials) who only received formal education in psychoeducational assessments. An attorney asked the School Psychologist to evaluate a defendant for MHD. The School Psychologist administered a full psychoeducational battery (i.e., WAIS-IV, WIAT-III, VMI, ABAS-3). Despite having variable intellectual & achievement scores, some within the *Low Average* range of functioning, the School Psychologist diagnosed the defendant with Intellectual Developmental Disorder (IDD) primarily based on inconsistent collateral reports regarding his adaptive functioning concerns and referred him for MHD.

REBUTTAL VIGNETTE 2:

- A defendant who is actively engaged in treatment for PTSD acquires battery charges. The defendant seeks out expensive, private neuroimaging to demonstrate the cognitive impact of his PTSD diagnosis. Further, the clinician treating his PTSD conducts a MHD evaluation, stating that they will remain a neutral evaluator in the context of the MHD evaluation and not allow their therapeutic relationship to bias the findings. The treatment provider includes the neuroimaging as part of the evaluation and refers the defendant for MHD.

REBUTTAL VIGNETTE 3:

- The evaluating psychologist met with the client for 1.5 hours total, virtually. Although the interview was not extensive and collected little personal historical data, the client advised of an extensive family history of Autism, as well as a personal history of ADHD and Substance use proclivities. Review of records was not mentioned in their report. The psychologist did not administer assessments but conducted 2 brief telephonic collateral interviews: 1 with a family member and 1 with a substance abuse mentor, both of whom mentioned the family history of Autism. The psychologist diagnosed the client with an Unspecified Substance Use Disorder, Autism, and ADHD Unspecified Type, on which they based their recommendation for MHD.

REBUTTAL VIGNETTE 4:

- A psychologist evaluates a defendant with a well documented diagnosis of Schizophrenia; however, the defense attorney advises that the DA is concerned the defendant is exaggerating his psychotic symptoms due to his legal circumstances. The psychologist evaluates the defendant in person and administers an RBANS, SASSI-4, and MoCA. The psychologist diagnoses Schizophrenia, drew a nexus between Schizophrenia and the instant offense, lays out a treatment plan, and recommends MHD.

REBUTTAL VIGNETTE 5:

- A psychologist evaluated a defendant telephonically. The psychologist completes a telephonic evaluation, administers self-report assessments verbally over the phone, and asks the client to describe themselves to include in an MMSE. The psychologist writes a report including a full behavioral observation section, assessment interpretation, and MHD-specific conclusions, but does not include that the evaluation was telephonic. The psychologist diagnoses PTSD and refers the defendant for MHD.

REBUTTAL VIGNETTE 6:

- A psychologist performs a MHD evaluation on a defendant that clearly and thoroughly assesses and describes a diagnosis of Major Depressive Disorder with Psychotic Features. Although the psychologist writes sparingly on other topics and only briefly mentions the instant offense with a vague, single sentence referencing the police reports, they thoroughly layout a treatment plan and recommend MHD.

REBUTTAL VIGNETTE 7:

- A psychologist evaluates a client with a decades long history of methamphetamine abuse who reports sobriety since being incarcerated the last two months. The client reports that he has a past diagnosis of Bipolar Disorder and was prescribed Wellbutrin and Vistaril. Client reports symptoms of rapid speech, problems with sleep, and impulsivity. Psychologist diagnoses client with Bipolar Disorder and SUD and recommends residential treatment.

WHAT HAPPENS IF AN EXPERT REBUTS YOU?

- Court may hold a hearing to evaluate the conflicting evidence & arguments presented by both experts
  - You may be called to testify & be cross examined
  - A determination regarding the client's diversion suitability will be made
- In some cases, further proceedings are needed before the court makes a final ruling

QUESTIONS?