MENTAL HEALTH COMMISSION
MHSA-FINANCE COMMITTEE MEETING MINUTES
FEBRURAY 17th, 2022 - FINAL

Agenda Item / Discussion	Action /Follow-Up
I. Call to Order / Introductions Chair, Cmsr. Douglas Dunn, District III called the meeting to order at 1:40 pm. <u>Members Present:</u> Chair, Cmsr. Douglas Dunn, District III Cmsr. Leslie May, District V Cmsr. Rhiannon Shires, District II <u>Members Absent:</u> Cmsr. Graham Wiseman, District II <u>Other Attendees:</u> Cmsr. Barbara Serwin, District II Cmsr. Laura Griffin, District V Angela Beck Jennifer Bruggeman Dawn Morrow, Supv. Diane Burgis' office Teresa Pasquini Jen Quallick, Supv. Candace Andersen's office Lauren Rettagliata Baylee Weschler, Social Justice Advocate, NAMI CC	Meeting was held via Zoom platform
II. PUBLIC COMMENTS: None	
III. COMMISSIONERS COMMENTS: • (L. May) I would like to make a suggestion that any motions we are to vote on be moved up to just after the approval of last month's meeting minutes, from this month forward, in order to complete committee/commission business before speakers and other topics. This is due to the motions that were not able to be voted on in the past two (commission) meetings. I'd like to suggest this for all meetings to 'take care of commission business' before moving on to speaker and topics. (B. Serwin) I'm fine with that suggestion, there are just a couple caveats. Sometimes the discussion that is schedule for the meeting pertains to the motion and is a lead in and people are able to hear/debate and it leads up to the motion. The second circumstance is when we have guests that can only attend at a certain time and we need to schedule around them. • (D. Dunn) That is what I was building up to for this meeting. The discussion will be tied into the motion and vote on it directly afterward. (L. May) Let me be clear. We had two different motion to be voted on. There were changes suggested to a motion in December and we did, to vote on	

in January but it was tabled for February due to time constraints. Hopefully the meeting in March it will be moved up to the top of the agenda so we can vote on all these motions.	
IV. COMMITTEE CHAIR ANNOUNCEMENTS/COMMENTS: We are going to be moving in different areas after this meeting. The state of California is granting counties a lot of one-time infrastructure type funds (Bricks and Mortar). There is approximately $800mil in one-time funds to expand the BHS work force. However, it will go away after a couple of years. The brick and mortar, once done, it's done. For example, there is a 'shovel ready' project (around the $200mil) for all over the state that must be in by March 31; there is a children and adolescent piece, which is another $200mil and then, finally, Round 5&6 ($80mil each) where the funds (for what we have been speaking about at the recent meetings) will come up later this year around the August/September time frame. I'm unsure but I am bringing this up that we will be moving in a much different, broader areas of concern moving forward.	
V. APPROVE minutes from January 20th, 2022, meeting: • Cmsr. Douglas Dunn moved to approve the minutes with one correction (Cmsr. Shires is District II). • Seconded by Cmsr. Leslie May **Vote:** 3-0-0 **Ayes:** D. Dunn, L. May, R. Shires Abstain: none	**Agendas and minutes can be found at:** http://cchealth.org/mentalhealth/mhc/agendas-minutes.php
VI. UPDATE on discussions with Patrick Godley, CCBHS COO & CFO, regarding the 2021-2022 and 2022-2023 Behavioral Health Services budget Referring to the correspondence to Mr. Godley as background on what I would like for him to do. The information he provided us, knowing some is six years old now, it was very helpful then and gives a very (quick) high level overview of where funding comes from to fund the programs in behavioral health. That was the purpose in providing those attachments. Mr. Godley indicated he could not be available for the committee meeting but will likely be able to attend the MHC meeting. I reached out to him per the request of the MHC Chair (Cmsr. Serwin), but have not yet received response back yet. However, the information provided will serve some purpose as we go into Agenda Item VII. Are there any questions on the letter I put together to Mr. Godley? (Teresa Pasquini) Are you going over the budget? (Cmsr. Dunn) there are some persons new to the committee and I will go through some of the attachments as we get to the motion so they understand where certain funding comes from and why.	**Meeting handouts can be found at:** http://cchealth.org/mentalhealth/mhc/agendas-minutes.php

(Teresa Pasquini) I was just looking at your letter and the list of items seemed like it was all related to capital facilities. (Cmsr. Dunn) Well, the $2.2bil (of the $15bil) will be funneled to the counties and how that is going to get distributed, I have not been able to see it. (Teresa Pasquini) It is only getting funneled to the counties if they have a grant that is accepted. If they have a shovel-ready project. (Cmsr. Dunn) Yes, and that is going to be the issue for this upcoming grant to see if they have a community partner. (Teresa Pasquini) Okay, just trying to track where you were going. Just to go back to commissioner comment, when you spoke to 'reframing the focus of the meetings', what will that look like and, I'm curious, did you have a workplan for this year? Did you adopt an action plan this year? (Cmsr. Dunn) That is something we need to do moving forward and something we are working on for the March meeting. We have not done so and need to do so. (Teresa Pasquini) So the commission has not adopted an annual work plan for the year. (Cmsr. Serwin) We set goals for the year and there was a finance goal, do you remember what that was, Doug? (Cmsr. Dunn) I don't recall at the moment, but yes, each committee had a goal. (Cmsr. Serwin) The idea, Teresa, is that we set three goals for the year and assigned them to the various committees and each committee takes it from there, in terms of developing their format for how they will go about it. (Teresa Pasquini) I am asking because I don't see anything more important than this, so I am just curious why you are shifting gears from your focus Doug? (Cmsr. Dunn) This is a very important issue, but there are several other issues that are starting to bubble up and this committee needs to be aware of them and be ready to follow them. We are just thinking of a broader approach, more than just the IST issue, of which we have been concentrating on very intensely for the last several months and when round five and six of funding comes up, that is when some of these things are going to get into that funding package. There's a focus on this that'll be (at least) partially at this time. It's likely several more months down the line.	
VII. DISCUSS the following information requested for incompetent to stand trial (IST) and LPS Murphy Conservatees: ➢ Facts, assumptions and missing information regarding the IST and LPS Murphy Conservatee budgeting needs. ➢ Size of population in county now and projected size in 2022; Budgeted amount this year and requested for 2022. ➢ Housing Treatment, and Services needed. ➢ If possible, a breakdown of costs for supporting this population; and Identification of which government (county or state) and/or agency is responsible for paying for these costs. ➢ If possible, update on funding possibilities in the Dept, of State Hospitals (DSH) Incompetent to Stand Trial (IST) Workgroup Final Report	**Meeting handouts for this agenda item are attached after the minutes and can be found at:** http://cchealth.org/mentalhealth/mhc/agendas-minutes.php

(Cmsr. Dunn) Dr. Scannell and/or Stephanie Regular were supposed to be here but could not make it. What I can tell you regarding this information is that we know there are 22 misdemeanor incompetent to stand trial (MIST) persons that have not gone to state hospitals this year that are in this county. We know they are not getting services that they should be getting; stopped as of January first. We know there are Murphy Conservatees that are subject to being returned to the county over the next several years and we do have motions we will be voting on at the commission meeting in March, on a total of approximately $13mil ($3mil for the MIST population and $10mil for the felony IST population). (Screenshare attachments) Following what is showing on screen are the funding sources that Behavioral Health receives funding from. The patient revenue is basically MediCAL (the dollar for dollar federal match). In 2016-2017 it was $66mil and is approximately $70mil presently. The other major funding sources are Realignment and MHSA funding, as well as the county general fund. (Lauren Rettagliata) Thank you for sharing that. Realignment shows a deficit in 2016. That did not stay a deficit, there was actually a recalculation done and more funds were given to the county the following year. Some years may look to be a deficit, but you have to track for a number of years to see that our county, many times has undercalculated the amount actually received from MHSA. (Cmsr. Dunn) Correct, the next attachment specifies the sources or revenue: MediCAL (which includes the federal match), realignment (broken into 1991 and 2011), MHSA and the county general fund. We see the expenditures of those services broken down between child and adolescent services, adult services and the MHSA funds that cover both, the Contra Costa Regional Medical Center (CCRMC), managed care and administrative and support services. The information I have received for 2021/22 indicates the current BHS budget is approximately $252mil. The Welfare and Institutions Code 4147(a) referring to penalties assessed to counties within the next three years if certain short-, medium-, and long-term goals are not reached between now and 2025. Those penalties could be a stop on admissions to the state hospitals, especially for LPS conserved persons and for persons that are, could go up 150% per day. For Contra Costa County (CCC), that cost would go up from $754/day to over $1330/day. If none of these plans work out, that is what the counties could be facing. (Cmsr. May) My concerns are: What, if any, preparation CCC is making in case this happens? If we don't and the cost goes up? Have they planned for this? (Cmsr. Dunn) BHS has not communicated that so far. I strongly surmise that when we get to these motions at the top of the March meeting, particularly the one dealing with $10mil for the FIST, they are going to say "Whoa, wait a minute here" and that is where we (the	

commission) need to press BHS for their plan to avoid this 150% per day penalty, plus the state hospital refusing to admit anymore persons. (Cmsr. May) Why wouldn't they know this is on the table? It's a bit alarming for them to wait until the last minute. We need to find out if they know what is on the table and if so, they need to give some answers and not give the commission the runaround. What is the plan? How are you going to handle this? This is serious. (Cmsr. Dunn) I agree. The next report describes the problem and the 65 page explanation of suggestions to solve the problem, but the state legislature must act on this. I have had this attached to previous meetings (both this committee and the main MHC Meeting). The final report from the State Hospitals is the last attachment and this report is much more digestible than the IST solutions document. The DSH put this out due to the feedback from counties regarding the populations being returned with lack of funding. The only place for this most vulnerable population is the jail or the street and they want to know what the state is going to do to help the counties. This document should be more specific, but at least it is a start. It offers $571mil annually if the legislature will agree, to be broken out in three main areas: early stabilization and community care, expanding FIST community programming with community-based restoration and diversion, and then increased placements to conditional release program (CONREP) and transition to county services. This report describes the problem and then describes the lawsuit, which originated here in CCC Detention centers. The report breaks down between stabilization and early access to treatment, waitlist management. There is a set aside of $75mil this year and $66.8mil ongoing. The speak to jail-based competency treatment and community-based programs patient management, approximately $5mil per year. Expanding community programs via community based restoration and diversion. They are talking about expanding 5000 beds to the counties to do this, and broken out housing augmentation and IST housing infrastructure. The report states providing $125k per FIST client. (Teresa Pasquini) I wanted the committee to be aware, there was a three-hour hearing last week, Stephanie Regular did testify at this hearing. It was a budget hearing. I found out after the fact and asked for the video and watched it. It is informative and I will send it in. It gives you a feel for what the committee is thinking and going over this budget. It was specifically on the DSH and the IST population. You can see the testimony and hear the comments from Senator Eggman and Senator Pan. NOTE: The video and packet for the Senate Sub Committee Hearing on DSH held 2-10-22 was received via email and forwarded to all meeting participants on 2/17/22@3:03pm.	

(URL: https://www.senate.ca.gov/media/senate-budget-subcommittee-3-20220210/video)

(Cmsr. Dunn) The last two major items, is a plan to do 'something' with CONREP ($433k this year with $1.2mil ongoing) to get more persons into CONREP. The DSH proposes to cap the IST growth at the number of persons from FIST from each county this year. The number cannot go up, as it states if they exceed their baseline referral rate, they will be responsible for a portion of the treatment costs.

(Teresa Pasquini) This is something Stephanie Regular specifically disagreed with and called for sobering centers, respite centers and divert all gravely disabled redirect at the beginning, not at the end and she stated she believes they need to disband CONREP. Since you are mentioning CONREP, I just wanted you to know. She wasn't speaking on behalf of CCC that day, she was speaking on behalf of the Public Defender's Association.

(Jennifer Bruggeman) I have a question related to the motion (last month) regarding the $13mil for the MIST/FIST population. MHC was going to ask BHS for $3mil specifically earmarked to provide appropriate levels of housing and treatment and services for those coming back to the county and then it went to $13mil. I think I had to leave the meeting early but missed the conversation on how it got to that number. Is there a specific detailed ask of what that covers and if that request is specifically from MHSA or elsewhere in the BHS budget, or non-specified? (RESPONSE: Cmsr. Dunn) That remains to be worked out. The $10mil includes both the FIST and the LPS / Murphy conservatees. That is treatment, excluding the building or refurbishing of projects and that would come out of the $2.2bil the state provided in its 2021/22 budget for infrastructure projects. The RFP for that will come out between May/June and September (it has not been published yet).

(Lauren Rettagliata) I know Pat Godley has been hard to get a hold of, but may hold the answers. It may be someone else. We must have some idea (as a county), exactly how many people are going to come back into our county and who these people are and what the cost is. Someone is paying for their housing at this point and there is a cost associated with that housing. Where is the BHS proposed budget regarding what it is going to cost. We have had a number for months to know this possibility. I feel we are flying blind. $3mil isn't going to be enough. It might just be enough to cover assisted outpatient treatment (AOT) but not housing. We have had some preliminary costs presented but there are more people that will be coming back. Who has the answer to exactly how much money we are looking at, as a county, that we are going to be held responsible for to meet the needs of some very ill people?

(Cmsr. Dunn) Dr. Scannell has said she would be available for this committee meeting in March and would at least have the numbers on people. I will follow up with Mr. Godley and if you

can get me the phone contact, I can follow up with him to see what he knows. Stephanie Regular has been asking for this information (both numbers and dollars) and she keeps saying that BHS leadership doesn't seem to be telling her anything. With funding deadlines starting with infrastructure grants rolling out, the train is moving down the tracks and we need to know what we are doing to meet this. (Cmsr. May) I am trying to figure this out because there is a facility I am aware of that has patients coming in that are pre-IST / prior to jail and it is approximately $12,000 per week. I know this because I was working there. They haven't reached the IST level and how are they coming up with these numbers? What do they think… I just understand, are they reaching up in the sky and pull a number 'this is what it's going to cost'. I just don't understand where they are coming up with these budget numbers. This population is going to cost much more than any others, it is exorbitant. (Cmsr. Dunn) Exactly. There is no way they can come back immediately into the community from the state hospital or the state prison. They have to go to a multi-level, locked mental health rehabilitation center (MHRC). (Cmsr. Serwin) I just want to make a statement. I don't know who is in this meeting with me, but we were asking Dr. Tavano questions about this population, the numbers. She said multiple times that she didn't know how many were here already and didn't know how many were coming. Then she stated the state was changing its mind about its responsibilities in terms of payment for clients. I find it exceedingly frustrating to hear that. I have a hard time buying it if there are numbers budgeted. These numbers need to based on something. (RESPONSE: Cmsr. Dunn) I don't know if BHS department leadership has yet seen this latest state hospital final proposal. Jennifer, if you want to forward on to Dr. Tavano, or I can do so. We need answers. (Cmsr. Dunn) NAMI CC IST priorities paper. This opposes any efforts to expand the use of jail-based competency restoration for non-violent individuals with serious mental illness. (Cmsr. May) There is a facility (not in this county), this campus was built for (I believe) the veterans. Something happened but it is a brand-new state-of-the-art campus that has never been used. If there is any way we can find out exactly where it is and see what we can do to get a hold of that campus. It is already completed. The county waited until the last minute and now we are in crisis mode. We need to look at other solutions. We need a facility to house and treat this population that is not jail. (RESPONSE: Cmsr. Dunn) This is something Kennisha Johnson needs to be aware of and should be able to follow up on. (Cmsr. May) Well she never comes to the meetings and I understand there are serious health problems with her family but when you don't see or hear a person for in 4-6 months, it's hard. I don't have much faith in communicating with a person when they are a no-show. It is almost as if the commission and	

NAMI – we are being bounced around. It's a shell game and it is at the point of ridiculousness now.	
VIII. MOTION: Advise Behavioral Health Services to actively pursue all state budget approved funding opportunities laid out in the Dept. of State Hospitals (DSH) Incompetent to Stand Trial (IST) Solutions Workgroup Report and Final Report Executive Assistant read motion: ***"Advise** Behavioral Health to actively pursue all state budget approved funding opportunities laid out in the Dept. of State Hospitals (DSH) Incompetent to Stand Trial (IST) Solutions Workgroup Report and Final Report"* (no discussion, moved to vote) **Vote on Motion:** ***Advise** Behavioral Health to actively pursue all state budget approved funding opportunities laid out in the Dept. of State Hospitals (DSH) Incompetent to Stand Trial (IST) Solutions Workgroup Report and Final Report* Cmsr. Douglas Dunn moved to vote on Motion as written. Seconded by Cmsr. Leslie May. **Vote: 3-0-0** **Ayes:** D. Dunn, L. May, R. Shires. Abstain: None	
IX. Adjourned meeting at 2:47 pm	

Contra Costa County
Health Services Department
Mental Health Division Summary
FY 2016 - 17 Projection

Prepared on 1/12/2017

	16/17 Adopted Budget	16/17 November Projection	16/17 (Over) Under Budget
Salaries	$ 36,475,685	$ 35,060,520	$ 1,415,165
Benefits	21,491,895	20,763,629	728,266
Services & Supplies	131,051,217	130,453,409	597,808
Other Charges	5,257,325	5,564,778	(307,453)
Fixed Assets	28,700	25,000	3,700
Gross Expenditures	$ 194,304,822	$ 191,867,336	$ 2,437,486
Expenditure Transfers	(3,268,205)	(3,611,647)	343,442
Total Expenditures	**$ 191,036,617**	**$ 188,255,689**	**$ 2,780,928**
Revenue:			
Patient Revenue	$ 66,115,751	$ 65,587,553	$ 528,198
State Aid & Grant	3,132,172	3,196,968	(64,796)
Federal Aid & Grant	2,813,547	2,884,651	(71,104)
Realignment	57,701,103	58,639,666	(938,563)
MHSA	43,114,746	40,368,116	2,746,630
Other income	886,124	927,410	(41,286)
Total Revenue	**173,763,443**	**171,604,364**	**2,159,079**
County Contribution	**$ 17,273,174**	**$ 16,651,325**	**$ 621,849**

Patient Revenue : Medi-Cal, Medicare, Contra Costa Health Plan (CCHP) & Private Insurance.

State Aid & Grant : Medi-Cal Administrative Activities Claims (MAA), Supplemental Security Income (SSI), Assembly Bill (SB) 109,
Grant from Office of Statewide Health Planning & Development,
& Grant from CA Department of Health Care Services.

Federal Aid & Grant : Funding from Department of Rehabiliation, Mental Health Block Grant,
Dual Diagnosis Grant, Path Grant & Court Collabrative Grant.

Realignment : Sales Tax, Vehicle License Fee, EPSDT, Managed Care, Katie A & Health Families.

MHSA : Mental Health Service Act

Other Income : Rent on Real Estate, Occupancy Fees, School District Billing & Miscellaneous Revenue & Misc revenues.

Prepared by: Kathleen Tong
Reviewed by: Faye Ny

2. What are the expenditures of major services-(i.e.: children, children and families, adult services and caregivers, mental health clinics, mental health crisis services, etc.)?

Major Sources of Revenues

	In Million FY 2017/18 Budgeted Amount
Medi-Cal	$ 67.7
1991 Realignment	$ 29.0
2011 Realignment	$ 33.4
MHSA	$ 51.6
Others*	$ 12.7
County General Fund	$ 17.3
Total	$ 211.7

*Others consisted of Medicare, HMO, Private pay/Insurance, Medi-Cal Administrative Activities Claims, Grant from Dept of Rehabilitation, Other State Aids, Mental Health Block Grant, PATH Grant, AB109, SSI, and School District Billings.

Expenditures of Major Services

	In Million FY 2017/18 Budgeted Amount
Child & Adolescent Svcs	$ 58.7
Adult Svcs	$ 55.5
MHSA	$ 51.5
Contra Costa Medical Center	$ 24.7
Managed Care	$ 8.6
Admin & Support Svcs	$ 12.7
Total	$ 211.7

a. Which areas of services have been growing?
Response: Children, Adult, and MHSA

b. Are the expenditures of growth sustainable?
Response: Challenges exist.

9.) In 2017, there may be a shortage in MHSA funding, approximately $8.5 million less, from $51.5 million to $42 million. The MHSA Program Manager informed on 11/1/17, that spending is under the budgeted amount, but if there is a shortfall, we are need to slow down spending the MHSA surplus or cutback on programming.

a. What happens when our revenue, either General Fund, State or Federal forecast/expected dollars are less than expected?

Contra Costa Health Services
Mental Health Division
1991 and 2011 Realignment Spending Information
Projected Fiscal Year 2017-2018

	FY17/18 Projected Realignment Revenue based on most recent State Allocation in FY16/17
1991 Realignment:	$ 31,164,765
2011 Realignment:	29,647,017
Estimated FY16/17 Growth to be received in FY17/18	1,966,672
Total Mental Health	31,613,689
Sub Total Mental Health Allocation	**62,778,454**
2011 Realignment:	
Substance Abuse Disorder	4,483,225
Grand Total Realignment	**67,261,679**

	FY17/18 Projected Expenditures by Program
1991 Realignment	
State Hospital	$ 5,563,766
Managed Care Inpatients	1,166,500
Institutions for Mental Disease (IMD)	4,490,553
Adult Contracts	11,078,095
Board & Care	1,526,825
County Adult Clinics	7,339,025
1991 Realignment Expenditures	$ 31,164,765
2011 Realignment	
Managed Care Outpatients	$ 2,647,541
Children's Contracts	24,803,125
County Children's Clinics	4,163,024
Total Mental Health	31,613,689
Substance Abuse Disorder	4,483,225
2011 Realignment Expenditures	$ 36,096,914
Total Realignment Expenditures	**$ 67,261,679**

Attachment D

4147. (a) To confront the crisis of individuals found incompetent to stand trial (IST) and in recognition of the importance of these defendants who are committed to the State Department of State Hospitals to begin receiving competency treatment as soon as practicable, the California Health and Human Services Agency along with the State Department of State Hospitals shall convene an Incompetent to Stand Trial Solutions Workgroup to identify short, medium, and long-term solutions to advance alternatives to placement at the State Department of State Hospitals.

(b) Workgroup members shall be appointed by the Secretary of California Health and Human Services and the workgroup shall be chaired by the Director of the State Department of State Hospitals. Members of the workgroup shall serve without compensation. Members may include, but are not limited to, representatives from the following entities and interested parties:

(1) California Health and Human Services Agency.

(2) State Department of Health Care Services.

(3) State Department of Developmental Services.

(4) Department of Corrections and Rehabilitation.

(5) Department of Finance.

(6) Other state agencies, as needed.

(7) Judicial Council.

(8) Other partners, including local government and justice system representatives of entities involved in the commitment of IST defendants to the State Department of State Hospitals and representatives of patients and their family members, as needed.

(c) The workgroup shall submit recommendations to the California Health and Human Services Agency and the Department of Finance no later than November 30, 2021, outlining short-term solutions that can be accomplished by April 1, 2022, medium-term solutions that can be accomplished by January 10, 2023, and long-term solutions that can be accomplished by January 10, 2024, and January 10, 2025, to support the State Department of State Hospitals in serving individuals with the most intensive behavioral health treatment needs and providing timely access to treatment for individuals found IST on felony charges.

(d) The workgroup may meet as often as bi-weekly until the workgroup is disbanded by the Secretary of California Health and Human Services.

(e) The workgroup may consider, but is not limited to, recommendations that accomplish any of the following:

(1) Reduce the total number of felony defendants determined to be IST.

(2) Reduce the lengths of stay for felony IST patients.

(3) Support felony IST defendants to receive early access to treatment before transfer to a restoration of competency treatment program to achieve stabilization and restoration of competency sooner.

(4) Support increased access to felony IST diversion options.

(5) Expand treatment options for felony IST individuals, such as community-based restoration programs, jail-based competency treatment programs, and state hospital beds.

(6) Create new options for treatment of felony IST defendants including community based, locked and unlocked facilities.

(7) Establish partnerships to facilitate admissions and discharges to reduce recidivism and ensure that the most acute, high-risk, and at need patients receive access to State Department of State Hospitals beds, while patients with lower risk or acuity are treated in appropriate community settings.

(f) (1) Until December 31, 2024, if the Secretary of California Health and Human Services determines that either of the conditions stated in subparagraphs (A) or all of the conditions stated in subparagraph (B) have occurred, the State Department of State Hospitals may take the actions described in paragraph (2), if authorized by the Secretary of California Health and Human Services and the Department of Finance, and after Department of Finance has provided no less than a 30-day notification to the Joint Legislative Budget Committee and the State Department of State Hospitals has provided notification to the county public guardian and county behavioral agencies.

(A) The recommendations required to be completed by subdivision (c) cannot be completed due to reasons outside of the control of the California Health and Human Services Agency or the State Department of State Hospitals.

(B)(i) Insufficient progress has been made in implementing the recommendations in a timely manner to provide timely access to competency treatment for IST defendants committed to the State Department of State Hospitals.

(ii) IST commitments to the State Department of State Hospitals continues to exceed the capacity available, in facilities the department has jurisdiction over pursuant to Section 4100, to provide restoration of competency treatment.

(iii) The State Department of State Hospitals continues to maintain an IST admission waitlist that exceeds the capacity of the facilities within its jurisdiction pursuant to Section 4100 to admit IST commitments.

(iv) As a result of the conditions described in clauses (i) through (iii), inclusive, IST defendants committed to the State Department of State Hospitals are not able to receive timely access to restoration of competency treatment and no reasonable state solutions are available, including timely solutions to increase capacity within the facilities within its jurisdiction pursuant to Section 4100 that may admit IST commitments.

(2) If the requirements of paragraph (1) are met, the State Department of State Hospitals may take the following actions:

(A) The State Department of State Hospitals may discontinue admissions for new patients committed to a state hospital pursuant to Section 5358.

(B) The State Department of State Hospitals may, following the determination by the Secretary of California Health and Human Services pursuant to paragraph (1), impose patient reduction targets over the next three fiscal years for patients committed to a state hospital pursuant to Section 5358. Reduction targets shall only be to the minimum level necessary to achieve timely access to treatment for IST commitments, as determined by the State Department of State Hospitals and the Secretary of California Health and Human Services and will allow no less than a minimum of six months for the first reduction target to be achieved.

(C) The State Department of State Hospitals may charge 150 percent of the daily bed rate for counties, pursuant to Section 4330, that exceed the bed usage for patients admitted pursuant to

Section 5358 and that are above the specified patient reduction targets made pursuant to subparagraph (B).

(g) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the State Department of State Hospitals may implement, interpret, or make specific this section by means of a departmental letter or other similar instruction, as necessary.

(h) Contracts awarded pursuant to this section, including contracts to implement solutions developed by the Incompetent to Stand Trial Solutions Workgroup, shall be exempt from the requirements contained in the Public Contract Code, Section 19130 of the Government Code, Section 4101.5, and the State Administrative Manual and shall not be subject to approval by the Department of General Services.

INCOMPETENT TO STAND TRIAL
SOLUTIONS WORKGROUP
Report of Recommended Solutions

A report of recommended solutions presented to the California Health and Human Services Agency and the California Department of Finance in Accordance with Section 4147 of the Welfare and Institutions Code

November 2021

TABLE OF CONTENTS

I. Purpose of Workgroup and Report

The Legislature enacted Welfare & Institutions Code (WIC) section 4147 through the passage of Assembly Bill 133 (Chapter 143, Statutes of 2021) and the Budget Act of 2021 (Chapter 69, Statutes of 2021), which charged the California Health & Human Services Agency (CalHHS) and the Department of State Hospitals (DSH) to convene an Incompetent to Stand Trial Solutions (IST) Workgroup (Workgroup) to identify actionable solutions that address the increasing number of individuals with serious mental illness who become justice-involved and deemed Incompetent to Stand Trial (IST) on felony charges.

The purpose of the Workgroup is to identify solutions to advance alternatives to placement in DSH restoration of competency programs and includes strategies for reducing the number of individuals found incompetent to stand trial; reducing lengths of stay for felony IST patients; providing early access to treatment prior to transfer to a DSH program; and increasing diversion opportunities and treatment options, among other solutions. Per WIC Section 4147, the Workgroup must submit recommendations to CalHHS and the Department of Finance on or before November 30, 2021, for short-term, medium-term, and long-term solutions that provide timely access to treatment for individuals found IST on felony charges. The IST Workgroup convened between August 2021 and November 2021 and held five meetings and nine topic-focused sub-working group meetings with a number of representatives and stakeholders from several state agencies, the Judicial Council, local government and criminal justice system representatives, and representatives of IST patients and their family members.

This report describes: 1) the background of the increasing numbers of referrals of individuals committed as IST in California and across the nation, 2) an overview of the IST Workgroup and the process utilized to develop the recommended solutions, and 3) a census of recommendations provided by the members of IST Workgroup and stakeholders to the CalHHS and Department of Finance.

The census of recommendations provided in Section V represents the gathering of the collective discussion and recommendations from members of the IST Solutions Workgroup and sub-working groups and input from public participation in the meetings of these groups. Consistent with the direction provided by statute, any recommendations that did not represent actionable short, medium, or long-term solutions are not included. These recommendations do not represent the viewpoints or opinions of any one entity or the State, nor do they represent consensus of the members of IST Solutions Workgroup. Some IST Solutions Workgroup members may support or oppose specific recommendations. All recommendations received by the Workgroup, meeting minutes and specific support, opposition, and feedback by individual IST Solutions Workgroup members and the public may be found at the IST Solutions Workgroup website**:**

- https://www.chhs.ca.gov/home/committees/ist-solutions-workgroup/

IST Solutions Workgroup Members and their affiliations:

- **Chair: Stephanie Clendenin**, Director, California Department of State Hospitals (DSH)
- **Stephanie Welch**, Deputy Secretary of Behavioral Health, California Health and Human Services Agency
- **Nancy Bargmann**, Director, California Department of Developmental Services
    - On occasion Director Bargmann was represented by Carla Castaneda, Chief Deputy Director of Operations, California Department of Developmental Services; and Dawn Percy, Deputy Director, Department of Developmental Services
- **Adam Dorsey**, Program Budget Manager, California Department of Finance
- **Brenda Grealish**, Executive Officer, Council on Criminal Justice and Behavioral Health, California Department of Corrections and Rehabilitation, Office of the Secretary
    - On occasion, Executive Officer Grealish was represented by Monica Campos, Council on Criminal Justice and Behavioral Health, California Department of Corrections and Rehabilitation, Office of the Secretary
- **Tyler Sadwith**, Assistant Deputy Director, Behavioral Health, California Department of Health Care Services
    - On occasion Assistant Deputy Director Sadwith was represented by Jim Kooler, Deputy Assistant Director, California Department of Health Care Services; and Elise Devecchio-Cavagnaro, Consulting Psychologist, California Department of Health Care Services
- **Brandon Barnes**, Sheriff, Sutter County Sheriff's Office
    - On occasion Sheriff Barnes was represented by Cory Salzillo, Legislative Director, California State Sherriff's Association
- **John Keene**, Chief Probation Officer, San Mateo County & President-Elect, Chief Probation Officers of California
- **Stephanie Regular**, Assistant Public Defender, Contra Costa County Public Defender Office & Co-Chair of the Mental Health Committee of the California Public Defender Association
- **Veronica Kelley**, Director, San Bernardino County Department of Behavioral Health & Board President, California Behavioral Health Directors Association
    - On occasion, Director Kelley was represented by Michelle Cabrera, Executive Director, California Behavioral Health Directors Association (CBHDA)
- **Farrah McDaid Ting**, Senior Legislative Representative, Administration of Justice, California State Association of Counties (CSAC)
    - On occasion Josh Gauger, Legislative Representative, California State Association of Counties (CSAC) also represented CSAC

- **Scarlet Hughes**, Executive Director, California Association of Public Administrators, Public Guardians and Public Conservators
- **Jessica Cruz**, Executive Director, National Alliance of Mental Illness – California
- **Pamila Lew**, Senior Attorney, Disability Rights California
    - On occasion, Kim Pederson, Senior Attorney, represented Disability Rights California
- **Francine Byrne**, Judicial Council of California
- **Jonathan Raven**, Chief Deputy District Attorney, Yolo County

II. Incompetent to Stand Trial Crisis – a History

Overview

Over the last decade, the State of California has seen significant year-over-year growth in the number of individuals charged with a felony offense who are found Incompetent to Stand Trial (IST) and committed to the State Department of State Hospitals (DSH) for competency restoration services. The State of California has responded to the substantial growth in the felony IST population through multiple investments to increase DSH's capacity to serve these individuals with serious mental illness. However, the growth in the felony IST patients has exceeded the capacity and outpaced other efforts to respond to the growth in the felony IST population, resulting in growing waitlist and wait times to admission. In 2015, the American Civil Liberties Union sued DSH (Stiavetti v. Ahlin[1]) regarding the amount of time IST defendants were waiting for admission into a DSH treatment program alleging violations of individuals' due process rights. The Alameda Superior Court ultimately ruled that DSH must commence substantive treatment services in 28 days for felony IST patients. DSH appealed this ruling and ultimately in the summer of 2021, the Superior Court's order was affirmed. Meanwhile, the worldwide COVID-19 pandemic has significantly exacerbated DSH's ability to meet the IST demands and as of November 2021 over 1,700 individuals are awaiting restoration of competency treatment.

The IST Process

IST defendants are determined by a court to be unable to participate in their trial because they are not able to understand the nature of the criminal proceedings or assist counsel in the conduct of their defense. When the court finds a felony defendant incompetent to stand trial in California, they can be committed to DSH to provide clinical and medical services with the goal of restoring their competency and enabling them to return to court to resume their criminal proceedings.

As court proceedings in a defendant's trial are beginning, the defense attorney may raise a doubt with the court that the defendant may be incompetent (doubt can also be

[1] As of 12/01/2021 this case will be renamed *Stiavetti v. Clendenin*

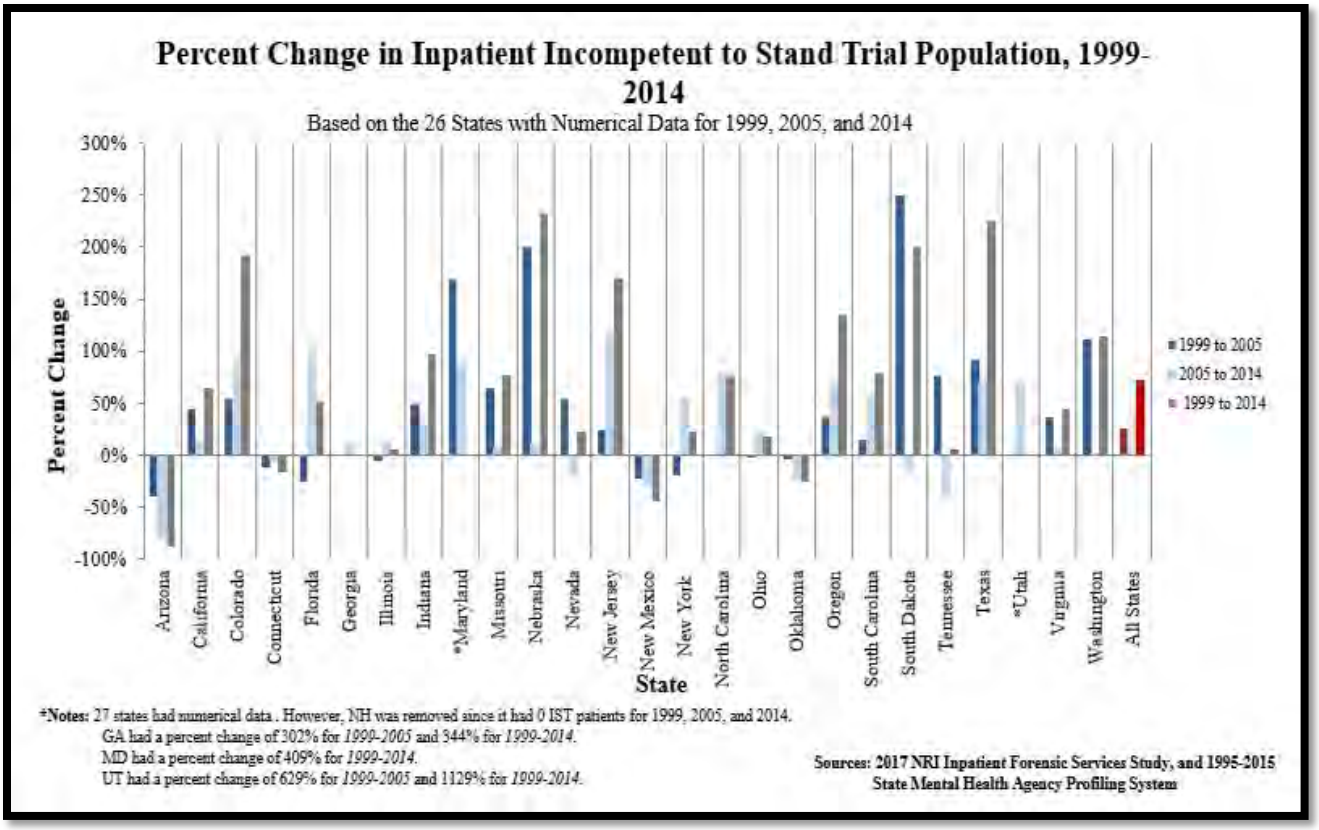
raised by the prosecution and by the court itself). Once a doubt is declared, the court will order an independent evaluation of the defendant by a court-appointed psychiatrist or psychologist (also known as an Alienist). If the alienist finds that the individual is incompetent, the court defers the current legal proceedings and orders a placement evaluation by the CONREP Community Program Director to determine if the felony IST should be treated in a DSH inpatient facility or an outpatient program.

The focus of treatment for the IST population is on restoration of trial competency in the most expeditious manner so that the deferred legal proceedings can resume, not to establish long-term mental health treatment for an individual. To this end, the training of criminal procedures is continuously the focus of the treatment milieu for IST patients. Once specific mental health issues and medication needs are addressed, patients are immersed in groups or individualized sessions that train them in various aspects of court proceedings. Each patient receives instruction as to what they are charged with, the pleas available, the elements of a plea bargain, the roles of the officers of the court, the role of evidence in a trial, and their constitutional protections. Knowledge of these areas is assessed using a competency assessment instrument. Additionally, an IST patient may participate in a mock trial where staff members act as judge, jury, district attorney, and defense attorney to assess the patient's ability to work with counsel. At any point during the treatment program, the patient may be evaluated to confirm they are competent to stand trial. After evaluation, if there is concurrence that the patient is competent, a forensic report is sent to the court, identifying that the patient is competent and ready to stand trial. Because the focus of IST treatment programs is the rapid restoration of competency for the purposes of criminal proceedings, individualized, comprehensive treatment of patients' mental health disorders is not provided by this treatment pathway.

National Data and California Data

The exponential increase in individuals found IST across the country has left State-run mental health systems, including the California Department of State Hospitals (DSH), challenged to meet the demands of year-over-year increases in the number of IST referrals to their systems. A 2017 study conducted by the National Association of State Mental Health Program Directors Research Institute (NRI)[2] found that from 1999 to 2014, the overall number of forensic patients in state hospitals increased by 74% while the number of IST patients increased by 72% during that same period. The following chart displays the percentage change overtime for 26 states:

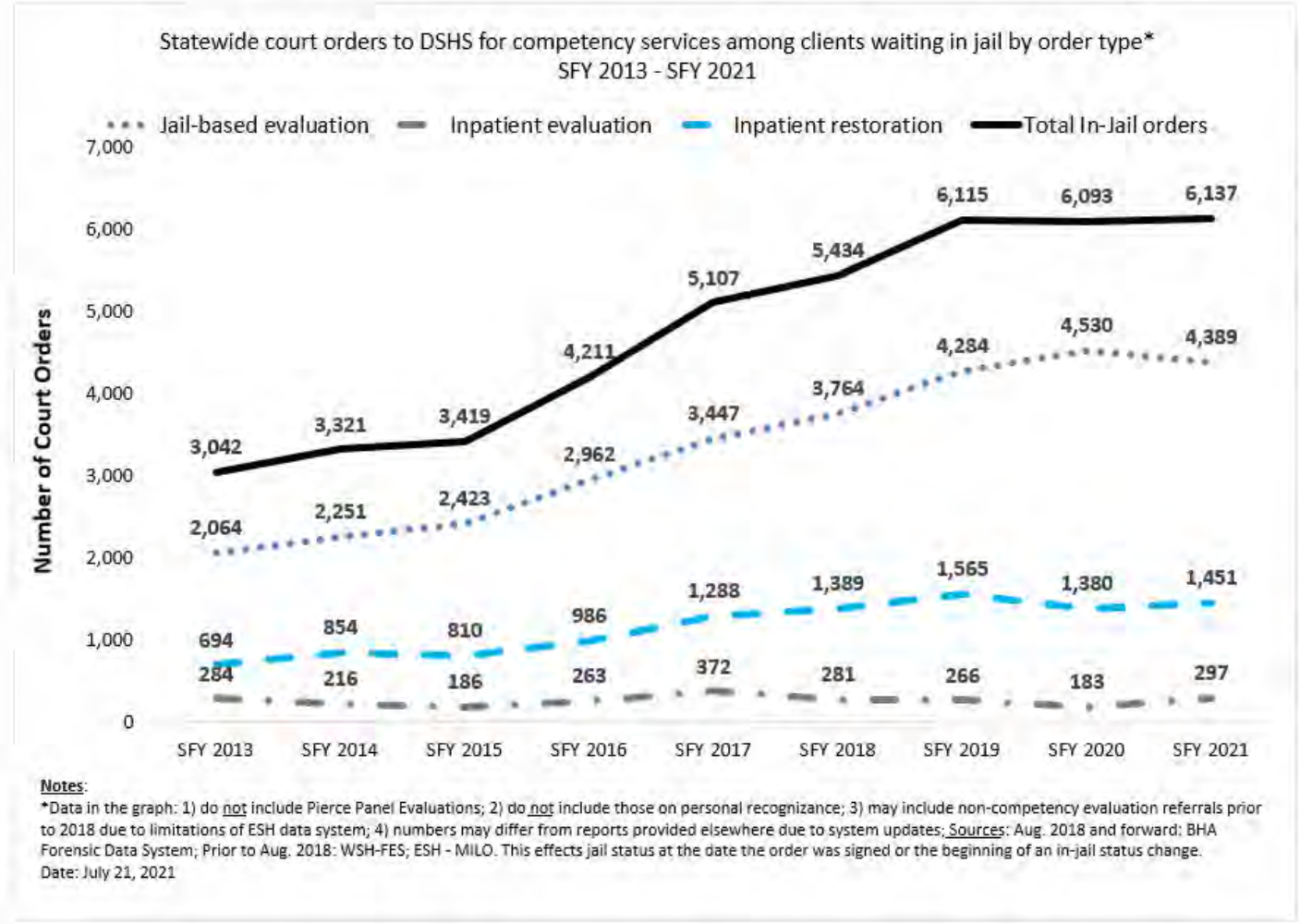
[2] Wik, A., Hollen, V., Fisher, W.H. (2017) Forensic Patients in State Psychiatric Hospitals: 1999-2016. https://www.nasmhpd.org/sites/default/files/TACPaper.10.Forensic-Patients-in-State-Hospitals_508C_v2.pdf.



Multiple state hospital systems across the country are facing lawsuits because of their inability to continuously increase the number of forensic inpatient beds available to admit and treat IST patients within court mandated timeframes, including here in California (*Stiavetti v. Ahlin*) which has set a 28-day post commitment deadline for DSH to begin substantive treatment of an IST ordered to DSH. Most notably, in the State of Washington (Trueblood v. Washington (2015)), the State has paid over $100,000,000 in contempt fines because of its inability to meet court ordered timeframes for admission into treatment programs largely because the demand for IST services has outpaced the state's efforts to develop capacity[3]. Under a recent change to the settlement agreement, the fines are being redirected to support improved access to appropriate behavioral health services that are designed to dramatically reduce the number of people entering the criminal court system. However, as the following chart shows, as Washington State has built out its forensic system in response to this suit, the referrals

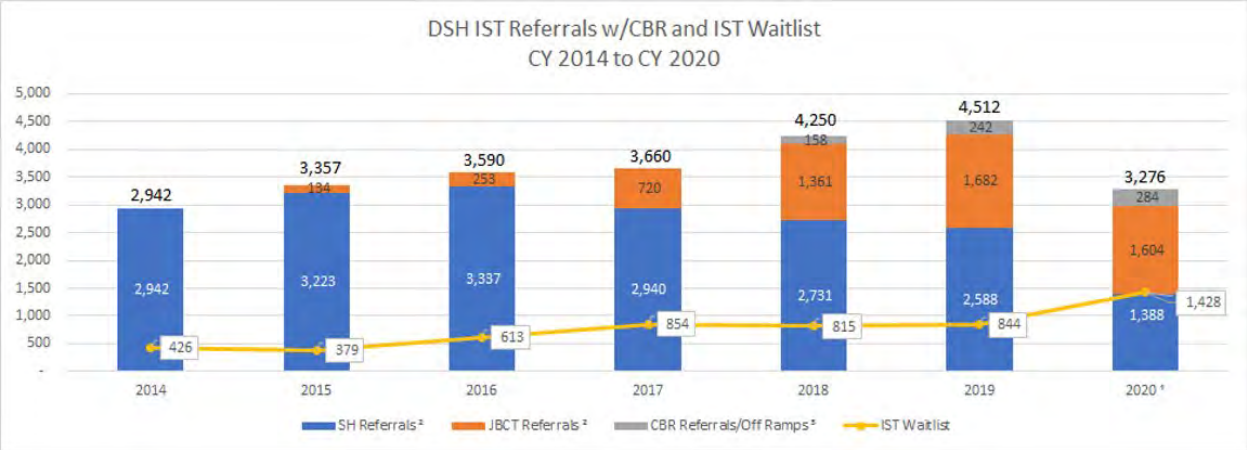
[3] From "Trueblood et al v. Washington State DSHS," by Washington State Department of Social and Health Services, https://www/dsjs/wa/gov/bha/trueblood-et-al-v-washington-state-dshs. Retrieved November 22, 2021.

of IST patients have only continued to increase and, regardless of the funding made available to the state system, capacity cannot keep up with demand[4]:



Unfortunately, the IST crisis in California has mirrored the crisis experienced across the country. However, the size of California's population has magnified the IST crisis in this state. DSH first noted a substantial increase in IST referrals around 2013. Each year since then, DSH has experienced growth in the number of IST referrals to the department's felony IST programs that has outpaced DSH's efforts to increase capacity to meet the demand for services resulting in a growing waitlist as displayed in the following graph:

[4] Chart displays growth in competency referral rates received by the Washington State Department of Social and Health Services. From "Trueblood et al v. Washington State DSHS," by Washington State Department of Social and Health Services, https://www/dsjs/wa/gov/bha/trueblood-et-al-v-washington-state-dshs. Retrieved November 22, 2021.



In 2020, while IST referrals decreased due to the global COVID-19 pandemic and statewide Stay-in-Place orders, the IST treatment programs' ability to admit new IST patients were also significantly impacted by COVID-19 outbreaks and the necessary infection control procedures implemented to protect patients and staff. In 2021-22, DSH is again experiencing a high number of referrals from the courts that exceeds the pre-pandemic referral rates, however, DSH must still maintain its implementation of COVID-19 infection control practices as required by the California Department of Public Health. These infection control measures as well as intermittent COVID-19 outbreaks continue to limit the efficiency and the rate of admissions to its programs. As such, the waitlist has grown to over 1700 individuals as of November 2021.

Individual Patient Characteristics

To better understand what was potentially driving the sustained increase in felony IST referrals, DSH partnered with the University of California, Davis to study the IST patients being admitted to Napa State Hospital. This review of DSH IST admissions found the following:

- Between calendar years 2009 and 2016, the percent of IST patients admitted to Napa State Hospital diagnosed with a psychotic disorder, psychosis NOS, or mood disorder ranged from 72.5% to 84.1%. A small percentage of IST patients were found to have a primary substance use disorder, cognitive disorder, or were malingering.
- In 2009, 17.7% of IST patients admitted to Napa State Hospital had 16 or more prior arrests. By 2016, the percentage of IST patients admitted to Napa State Hospital with 16 or more prior arrests had increased to 46.4%.
- In 2016, approximately 47% of IST patients admitted to Napa State Hospital were unsheltered homeless prior to their arrest. Between 2018 and 2020, 65.5% of IST patients admitted to Napa State Hospital were homeless (sheltered or unsheltered) prior to arrest.

- On average, 47% of IST patients admitted to Napa State Hospital had received no Medi-Cal billable mental health services in the six months prior to arrest; 23% had received one to two mental health services in emergency departments (EDs); 20% had received three or more mental health ED services; and 10% received no mental health ED services.

To provide some context to these findings, DSH and UC Davis conducted a national survey asking state mental health officials about their states' crisis. The responses received were another indicator of the scale of the problem facing the nation: 68.8% of survey respondents indicated the rate of referrals for competency restoration for misdemeanor offenses was increasing in their state, 65.3% of respondents indicated that the rate of referrals for competency restoration for felony offenses was increasing in their state, and 78% of respondents indicated the rate of referrals for competency restoration for felony and misdemeanor offenses were both increasing in their state. In addition, 70.8% of respondents shared that their state hospital system has a waitlist for admitting IST patients and 38.8% of respondents indicated that their state is currently facing litigation related to the admission of IST patients into their system of care. Finally, the survey asked respondents to rank what, in their experience, were the leading causes of this crisis. Here are the top four responses ranked in order of impact to the crisis:

- Inadequate general mental health services
- Inadequate crisis services in community
- Inadequate number of inpatient psychiatric beds in community
- Inadequate ACT services in community

The results of this national survey and the clinical review of the IST patients admitted to DSH has led DSH to hypothesize that the drivers of this crisis are as follows:

- Individuals with Schizophrenia Spectrum Disorders are drifting into an untreated, unsheltered condition.
- These conditions are leading to increased contact with police and criminal charges.
- This increased contact is leading to a surge in IST referrals to state hospitals.
- Building more state hospital beds will only exacerbate the problem long term.
- IST restoration of competency treatment is not an adequate long-term treatment plan.

Finally, DSH wanted to know if currently designed IST treatments impact or change the trajectory of IST patients' lives subsequent to discharge from DSH. DSH worked with the California Department of Justice (DOJ) to obtain criminal offender record information

for IST patients discharged from DSH. The offender record information was then matched with DSH discharge data and used to determine disposition outcomes for the original IST commitment as well as to determine the rates of recidivism of individuals post competency restoration at DSH. The analysis of DOJ and DSH data reflects how the treatment provided by law to IST patients to restore competency does not have a long-term positive impact for the individual and the community. Under existing law, competency treatment is focused on the stabilization of an individual's psychiatric symptoms and basic legal education which together are intended to allow the defendant to work with their attorney, understand the charges against them, and effectively participate in their own defense.

DSH looked at the 3-year post discharge recidivism rates utilizing DOJ criminal offender record information data and found a:

- 69% recidivism rate[5] for IST patients discharged from DSH in FY 2014-15
- 72.3% recidivism rate for IST patients discharged from DSH in FY 2015-16
- 71% recidivism rate for IST patients discharged from DSH in FY 2016-17

In examining the legal pathways of IST patients post competency restoration treatment at DSH state hospitals and jail-based competency treatment programs, the data shows that from FY 2016-17 through FY 2018-19 (6,048 IST discharges in total), 15% of felony IST patients had a single offense and post discharge from DSH 35% had their charges dropped (includes case dismissed, proceedings suspended, not guilty, acquitted). Over the same period, 85% of felony IST patients had multiple offenses and post discharge from DSH 24% had some or all their charges dropped. The full range of disposition outcomes for the felony IST patients discharged over this period include the following: 27.8% were sentenced to jail/probation (served either concurrently or consecutively), 25.9% had their cases dismissed, 24.3% were sentenced to prison, 14.2% were sentenced only to jail and 0.2% were found guilty of some or all of their charges but found not guilty by reason of insanity (NGI) and committed to DSH for treatment rather than prison.

In summary, what this analysis shows is that most individuals committed to DSH as an IST are not sentenced to state prison or committed to DSH for longer-term treatment. Most IST patients restored by DSH return to their county of commitment and serve time in jail, are released on probation, or are simply released. The rate of arrests of discharged IST patients shows that whatever circumstances led to an individual's prior arrest have likely not changed and most IST patients are stuck looping through the criminal justice system and DSH.

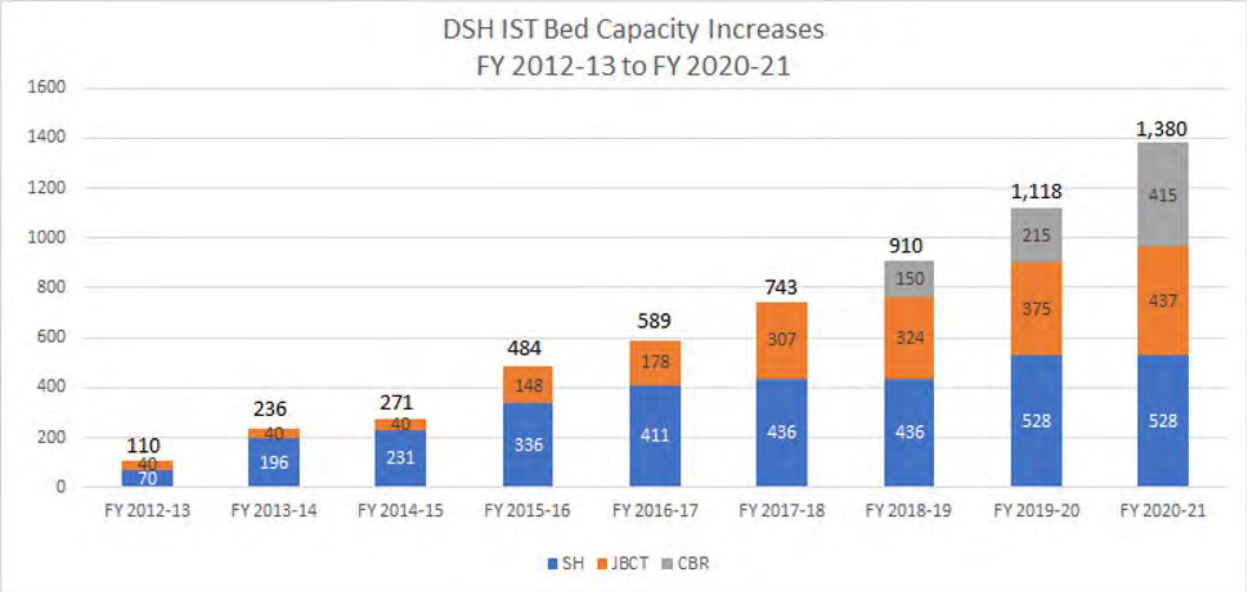
[5] Recidivism rate reflects percentage of individuals with new arrests after discharge from DSH. DSH focuses on arrests instead of convictions because defendants are committed to DSH post-arrest but pre-conviction.

III. Department of State Hospitals' Efforts to Date

Since FY 2012-13, DSH has made multiple efforts to mitigate the effects of increasing IST referrals through capacity expansion, system improvements, and legislative changes.

Increased Capacity at DSH

Since the beginning of the IST crisis, DSH has established new IST capacity through the activation of 528 new state hospital beds, 445 jail-based treatment beds, 415 community-based restoration (CBR) beds, and a 78-bed Conditional Release Program (CONREP) step down program (currently in progress). DSH is also in the process of establishing 352 additional CBR beds and a CONREP Mobile Forensic Assertive Community Treatment (FACT) Team to further expand DSH's capacity to serve IST patients. As the following table shows, in the first year of the crisis DSH added 110 beds for IST treatment and by FY 2020-21 DSH had added a total of 1,380 beds between State Hospitals (SH), Jail Based Competency Treatment (JBCT) programs, and the Community Based Restoration (CBR) program:



In the 2021-22 budget, DSH was appropriated $255 million to create new sub-acute capacity across the state to serve felony IST patients; $32.8 million to expand the CBR program by 552 beds (300 in LA, of which 200 activated in spring 2021, and 252 across the rest of the state); $47.6 million to expand the DSH Felony Mental Health Diversion (Diversion) program (see pp. 17-18 for a detailed description of this program); $13.1 million to expand the department's Jail Based Competency Treatment program expansion and; $9.7 million to establish a Forensic Assertive Community Treatment

(FACT) program in CONREP to serve higher acuity patients, such as ISTs, in the community.

In this budget, DSH also received $12.7 million to establish a four year, limited-term IST Re-evaluation Program. This program establishes a temporary team of forensic evaluators who will re-evaluate IST patients for competency who have been committed to DSH and have been in jail for over 60 days. If an IST is evaluated and found to have regained competency while in jail the IST Re-evaluation team will submit the appropriate reports to the courts. Additionally, if the IST Re-evaluation identifies an IST who has not restored to competency may be appropriate for the DSH Felony Mental Health Diversion program or community-based restoration, the IST Re-evaluation team can make a referral to these programs. The goal of this program is to address the current waitlist of over 1,700 IST patients by bridging the gap between DSH's current capacity, the current rate of IST referrals, and the ongoing impacts of COVID-19 to admissions and discharges to the State Hospitals while the department's new investments in community-based treatment are implemented.

As part of its efforts to increase the number of felony IST patients that receive treatment each year, the Department contracts with 21 California counties to provide restoration of competency services to IST patients in county jail facilities. Jail-Based Competency Treatment (JBCT) programs are designed to treat IST patients with lower acuity and to quickly restore them to trial competency, generally within 90 days. If a JBCT program is unable to restore an IST patient to trial competency quickly, the patient can be referred to a state hospital for longer-term IST treatment. DSH currently operates three JBCT program models:

1. Dedicated bed model – serves IST patients from one specific county with an established number of dedicated program beds.
2. Regional model - serves IST patients from multiple counties statewide with an established number of dedicated program beds.
3. Small county model – serves 12 to 15 IST patients annually and does not have dedicated program beds.

Funding for these programs includes patients' rights advocacy services. The funding for the patients' rights advocacy services complies with Assembly Bill (AB) 103 (Statutes of 2017). AB 103 requires that all DSH patients have equal access to patients' rights advocacy resources, including IST patients who are admitted to JBCT programs.

Over the last few fiscal years, the Department has also focused efforts on expanding the capacity of its CONREP program with the goal of stepping down more patients committed to DSH as NGI or as Offenders with Mental Health Disorders (OMDs) to free up additional beds within the State Hospitals for IST patients. CONREP is DSH's statewide system of community-based services for specified court-ordered forensic individuals. Mandated as a State responsibility by the Governor's Mental Health

Initiative of 1984, the program began operations on January 1, 1986 and operates pursuant to statutes in Welfare and Institutions Code (WIC) 4360 (a) and (b). The goal of CONREP is to promote greater public protection in California's communities via an effective and standardized community outpatient treatment system. The CONREP Non-Sexually Violent Predator (Non-SVP) population includes:

- Not Guilty by Reason of Insanity (NGI) (Penal Code (PC) 1026)
- Offender with a Mental Health Disorder (OMD) (both PC 2964 parolees who have served a prison sentence and PC 2972 parolees who are civilly committed for at least one year after their parole period ends). This category also includes the Mentally Disordered Sex Offender (MDSO) commitment under WIC 6316 (repealed).
- Felony Incompetent to Stand Trial (IST) (PC 1370 patients who have been court-approved for outpatient placement in lieu of state hospital placement)

Individuals suitable for CONREP may be recommended by the state hospital Medical Director to the courts for outpatient treatment. Currently, DSH contracts with seven county-operated and eight private organizations to provide outpatient treatment services to non-Sexually Violent Predator clients in all 58 counties of the state.

DSH is partnering with several community-based providers to build out the continuum of care and increase the availability of placement options dedicated to CONREP clients. This expands the number of community beds available for patients who are ready for outpatient treatment but still need a higher level of care within CONREP. These facilities allow patients to step down into a lower restrictive environment and focus on the skills necessary for independent living when transitioning to CONREP. The expansion of CONREP capacity and patient placement allows DSH to backfill vacated state hospital beds with pending IST placements who are not eligible for outpatient treatment. Expanding the availability of beds to treat DSH patients is critical to providing timely access to those requiring and awaiting treatment in higher acuity state hospital settings.

Current efforts in expanding residential placement options include:

- Authority to establish a dedicated 78-bed step-down program intended to address higher-level needs and patient acuity and operated in a secured Institute for Mental Disease (IMD) facility. The program was designed for state hospital patients ready for CONREP in 18-24 months. This setting allows for OMD and NGI patients to step down into a lower restrictive environment and provide the skills necessary for a more independent living setting when transitioning to CONREP, thereby allowing for the vacated state hospital beds to be backfilled by IST patients. This program is pending official regulatory approval and necessary modifications to the facility but is expected to be activated in late summer 2022.
- Recognizing the need for more step-down CONREP beds in northern California, DSH received authority to partner with a new provider to establish a 10-bed IMD

program. Activation began in July 2020 and was expanded by an additional 10 beds in July 2021.

- Authorized in 2021 Budget Act, DSH received authority to partner with a provider to establish a 180-bed Forensic Assertive Community Treatment (FACT) model of care in CONREP that will provide 60 beds each in Northern California, Southern California, and the Bay Area. This new level of care for CONREP will establish residential beds where services will be delivered onsite allowing for placement of individuals with higher needs. The program is designed to provide 24/7 services to clients as needed to support client success and reduce the likelihood of rehospitalization through de-escalation and crisis intervention practices. Additionally, a FACT model of care can be used to place IST patients ordered to CONREP where a community-based restoration program is not available. DSH estimates program activation of the 60 Northern CA beds to occur in January 2022, the 60 Southern CA beds to activate in early spring 2022, and the 60 Bay Area beds to activate in early winter 2022.

- An augmentation of $1 million in the 2019 Budget Act to support general housing costs being absorbed by CONREP providers.

Systems Improvements

The second strategy DSH has employed in its attempt to manage the escalating IST crisis has been the implementation of multiple systems improvements that increase DSH's efficiency in admitting, treating, and discharging IST patients. Through these efforts, the department has reduced the average length of stay (ALOS) for IST patients to 148.7 days in a state hospital bed and 69.7 days in a jail-based competency bed. The decrease in the ALOS for IST patients is the result of improved utilization management at the state hospitals (a process by which treatment is matched to a patient's specific clinical needs), the creation of the Patient Management Unit, and multiple legislative changes that supported each of these efforts.

The Patient Management Unit (PMU) was established in June 2017 in the Welfare and Institutions Code 7234 through Assembly Bill 103 (Chapter 17, Statutes of 2017) to provide centralized management, oversight, and coordination of the referral and patient pre-admission processes to ensure placement of patients in the most appropriate setting based on clinical and safety needs. Prior to the establishment of the PMU, the court system was able to order commitments to any DSH hospital of its choosing, creating admission backlogs and inefficiencies. Now, PMU receives all court commitments to the department and utilizes DSH's Patient Reservation Tracking System (PaRTS) to manage the admissions of all DSH patients.

Finally, multiple legislative changes have been made to support the department's efforts to maximize the use of each DSH-funded bed:

- AB 2186 (Chapter 733, Statutes of 2014) – Involuntary Medication Orders and Court Reports

- Amended the law to require courts to reassess the authorization of Involuntary Medication Orders (IMOs) upon the filing of the initial competency progress report and any ongoing progress reports to the court and that a petition may be filed within 60 days of the expiration of the one-year IMO. This change created efficiency and consistency in the application for and use of IMOs at DSH. The use of medications is a core component of the treatment of IST patients

- AB 2625 (Statutes of 2014) – Unlikely to Regain Competency and Unrestored Defendants – 10 Days to Return to Court
    - Amended the law to require that IST patients who are determined to be unlikely to restore to competency be returned to court within 10 days and required that IST patients who had been committed to DSH up to the maximum time allowed by law (in 2014, the maximum length of commitment to DSH for an IST defendant was 3 years) to be returned to court 90 days prior to the expiration of their commitment. This change was intended to help DSH discharge patients more quickly so additional IST patients could be admitted into the system, increasing the number of IST patients that could be treated per year.

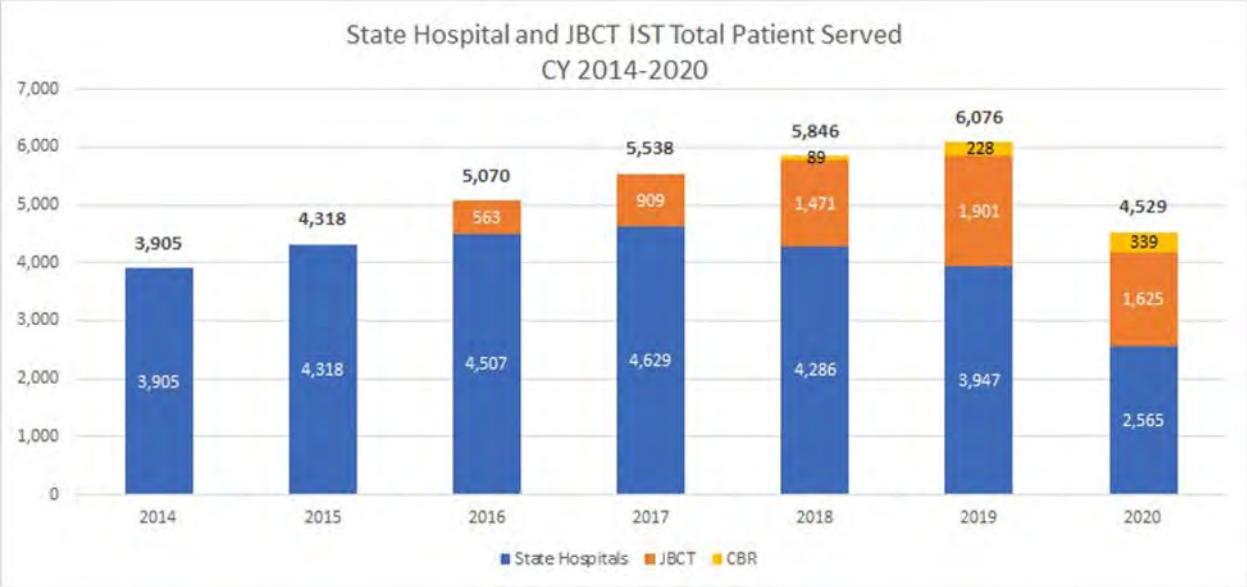
- AB 1810 (Statutes of 2018) – Prevents Transfer of Competent Defendants to DSH
    - Amended the law to allow courts to order a re-evaluation of an IST defendant pending transfer to a State Hospital if they receive information from the jail treatment provider or defendant's counsel that the defendant may no longer be incompetent. DSH found that a significant number of IST patients committed to DSH had regained competency prior to admission to DSH; this change was intended to prevent the transport and admission of IST patients who had regained competency and maintain limited DSH resources for those who were still IST.

- SB 1187 (Statutes of 2018) - Reduced the maximum length of stay for felony IST patients from 3 years to 2 years.
    - Amended the law to reduce the maximum commitment of IST patients to DSH from 3 years to 2 years. This change was intended to discharge patients from limited DSH beds more expeditiously to admit additional IST patients and increase the potential number of IST patients served in a year.

- Assembly Bill 133 (Statutes of 2021) – Misdemeanor IST Patients and Charges for Non-Restorable IST Patients
    - Amended the law to remove DSH as a county placement option for IST patients with misdemeanor charges to preserve all appropriate state

hospital beds for felony IST patients. Also amended law to charge counties a daily bed rate for IST patients that have been found non-restorable that are not transported from DSH by the county within the statutorily required 10-day timeframe.

Each of these systems improvements has helped DSH reduce the length of stay of IST patients in a DSH bed and, in conjunction with the capacity DSH has added to its system of care, allowed the department to increase the number of IST commitments served year-over-year[6]:



However, the demand for IST treatment has continued to outpace all efforts to create enough capacity and system efficiency to reduce the number of IST patients pending placement to DSH and reduce the length of time between commitment to the department and receipt of substantive competency treatment.

Demand

By FY 2017-18, DSH recognized that the demand for IST treatment services was not going to be met by capacity created within the State Hospital system. At this time the department began working to establish treatment pathways in the community with the long-term goal of decreasing demand for State Hospital services by connecting more people with Serious Mental Illness into ongoing community care. The Budget Act of 2018 included funding for two major new programs to help DSH realize this vision.

The Budget Act of 2018 allocated $13.1million for DSH to contract with the Los Angeles County Office of Diversion and Reentry (ODR) for the first community-based restoration

[6] The table below, "State Hospital and JBCT IST Total Patients Served" reflects a drop in total patients served in 2020; this anomaly was caused by the SARS COVID-19 pandemic. State Hospitals ability to admit and discharge patients during the first twelve months of the pandemic was significantly limited by necessary infection-control measures taken by the Department to protect patients and staff in its congregate living treatment environment.

(CBR) program in the state. In this program, ODR subcontracts for housing and treatment services for IST patients in the community. Most IST patients in this program live in unlocked residential settings with wraparound treatment services provided on site. The original CBR program provided funding for 150 beds; investments in the LA program since 2018 has increased the program size to 515 beds. In addition, DSH has received funding to implement additional CBR programs across the state. The Budget Act of 2021 included ongoing funding to add an additional 252 CBR beds in counties outside of Los Angeles, bringing the total number of funded CBR beds to 767.

The Budget Act of 2018 also allocated DSH $100 million (one-time) to establish the DSH Felony Mental Health Diversion (Diversion) pilot program. Of this funding, $99.5 million was earmarked to send directly to counties that chose to contract with DSH to establish a pilot Diversion program (the remaining $500,000 was for program administration and data collection support at DSH). Assembly Bill 1810 (2018) established the legal (Penal Code (PC) 1001.35-1001.36) and programmatic (Welfare & Institutions Code (WIC) 4361) infrastructure to authorize general mental health diversion and the DSH-funded Diversion program. The original Diversion pilot program includes 24 counties who have committed to serving up to 820 individuals over the course of their three-year pilot programs. In FY 2021-22, DSH received additional funding to expand this pilot program as follows:

- $17.4 million to expand current county contracts by up to 20%; WIC 4361 updated to require any expansion be dedicated to diverting defendants who have been found IST by the courts and committed to DSH
- $29.0 million to implement diversion programs in any other county interested in contracting with DSH

The goal of both the CBR and Diversion programs is to demonstrate that many of the individuals committed to DSH as IST patients can be treated effectively and safely in the community. Since launching these programs in 2018, DSH has partnered with some of the most preeminent authorities in the treatment of individuals with Serious Mental Illnesses and criminal justice involvement to provide technical assistance and training for counties across the state implementing a DSH Diversion program and has shared many of those resources with all counties, regardless of their participation in the DSH program, through the Diversion program's public webpage:

https://www.dsh.ca.gov/Treatment/DSH_Diversion_Program.html

Since 2018, DSH has provide over 100 hours of free training and technical assistance to counties and continues to build out the resources it has to offer as the CBR and Diversion programs grow. As of June 30, 2021, counties participating in the Diversion pilot had diverted 458 individuals (some had been found IST and some were defendants the county determined to be likely-to-be IST) and the Los Angeles CBR program had served 641 IST patients.

IV. IST Solutions Workgroup Process

In accordance with Assembly Bill 133 and the 2021 Budget Act, the California Health and Human Services Agency (CalHHS) and DSH established a statewide IST Solutions Workgroup in August 2021. The IST Solutions Workgroup members were appointed by CalHHS Secretary Mark Ghaly and the composition of the Workgroup, as required in statute, included representatives from several state agencies, the Judicial Council, local government and criminal justice system representatives, and representatives of IST patients and their family members.

This Workgroup met five times (8/17/2021, 8/31/2021, 10/12/2021, 11/5/2021, 11/19/2021) as part of the IST solutions development process. To advance the development of short-, medium-, and long-term strategies, three sub-working groups were established that focused on specific areas of opportunity (See Appendix A for a full list of working group members). All three groups were called on to focus all recommendations of short-term solutions on the individuals currently on the waitlist. These three working groups generated strategies for consideration by the full IST Solutions Workgroup for inclusion in the final report to CalHHS and DOF. The three topic-focused working groups included:

Working Group 1: Early Access to Treatment and Stabilization for Individuals Found Felony IST

The goal of Working Group 1 was to identify short-term solutions to provide early access to treatment and stabilization in jail or via Jail Based Competency Treatment (JBCT) programs to maximize re-evaluation, diversion or other community-based treatment opportunities and reduce IST length-of-stay in jails. Working Group 1 met on 9/21/2021, 9/28/2021, and 10/26/2021.

Working Group 2: Diversion and Community-Based Restoration for Felony ISTs

The goal of Working Group 2 was to identify short, medium, and long-term strategies to maximize the implementation of IST Diversion and Community-Based Restoration (CBR) programs across the state. Working Group 2 met on 9/24/2021, 10/1/2021, and 10/22/2021.

Working Group 3: Initial County Competency Evaluations

The goal of Working Group 3 was to identify solutions to reduce the overall number of individuals found IST by strengthening the quality of the initial competency evaluations ordered by the courts (also known as alienist evaluations). Working Group 3 met on 9/17/2021, 9/24/2021, and 10/15/2021.

Due to COVID restrictions and the tight time frame of the process, meetings were held virtually using Zoom technology that enabled full participation of all members, as well as the public, who were routinely invited to comment using the Zoom “chat” feature, as well

as verbally as time permitted. The goal was to establish a transparent and inclusive process that allowed active participation from a diverse spectrum of participants. All meetings followed the requirements of the Bagley-Keene Open Meeting Act.

Meeting agendas, presentations, written input from members and the public, responses to information requests, and meeting minutes from the IST Solutions Workgroup and the three topic-focused working groups are available on the IST Solutions Workgroup web site.

Guiding Principles for Generating Recommendations

The statute provided guidance for what the IST Workgroup solutions should focus on when generating solutions to the IST crisis. This guidance included:

1. Reduce the total number of felony defendants determined to be IST
2. Reduce the lengths of stay for felony IST patients
3. Support felony IST defendants to receive early access to treatment before transfer to a restoration of competency treatment program to achieve stabilization and restoration of competency sooner.
4. Support increased access to felony IST diversion options.
5. Expand treatment options for felony IST individuals, such as community-based restoration programs, jail-based competency treatment programs, and state hospital beds.
6. Create new options for treatment of felony IST defendants including community-based, locked, and unlocked facilities.
7. Establish partnerships to facilitate admissions and discharges to reduce recidivism and ensure that the most acute, high-risk, and at need patients receive access to State Department of State Hospitals beds, while patients with lower risk of acuity are treated in appropriate community settings.

In addition to this statutory guidance, the IST Solutions Workgroup adopted the following guiding principles to frame its recommendations:

- Mental health treatment should be delivered in community-based treatment options to the greatest extent possible.
- While jail is not the appropriate setting for mental health treatment, jails need to be able to provide mental health treatment for individuals who are in jail and require treatment.
- Engagement of individuals with lived experience and family members in planning and implementing solutions and programs is critical.

- Short-term solutions focus on treating the 1700+ individuals found incompetent to stand trial on felony charges and waiting in jail for access to treatment or diversion programs.
- Medium-term solutions focus on increasing access to community-based treatment and diversion for individuals found incompetent to stand trial on felony charges.
- Long-term solutions aim for system transformation and to reverse the trend of criminalizing mental illness.
- Implementing solutions to achieve the short-, medium- and long-term goals requires collective, multi-sector solutions and collaboration.
- To address the current IST crisis, implementation of short-term strategies that are not in alignment with long-term goals may be needed, but should be time-limited, phased out when medium- and long-term solutions are implemented, and not detract from the focus and implementation of the long-term goals.

Process for Synthesizing Recommended Solutions

Over the course of the topic-focused working group meetings, more than 100 potential solutions were generated by members and the public through an iterative process of idea generation, reflection, and refinement within each of the three working groups, as well as the larger Workgroup. Additionally, these solutions were assessed to determine which were most feasible, actionable, and relevant to addressing the short-, medium-, and long-term timeframes and goals, which enabled the team to reduce and consolidate the total number of potential solutions from 100 to ~35. Any recommendation that did not represent an actionable solution was not included. A draft compilation of the solutions was presented to the full workgroup for discussion. Through that discussion and additional solutions submitted from workgroup members and other organizations and members of the public who participated in the meetings, a final list of 41 recommended solutions was generated to be presented to the CalHSS and DOF.

V. Census of Recommended Solutions from the IST Workgroup Meetings for Submission to CalHHS and Department of Finance

Short Term Strategies: Solutions that can begin implementation by April 1, 2022

Goals:

a. Provide immediate solutions for 1700+ individuals currently found incompetent to stand trial on felony charges and waiting in jail for access to a treatment program.
b. Provide quick access to treatment in jail, the community, or a diversion program.
c. Identify those who have already restored.
d. Reduce new IST referrals.

#	Strategy	Type	Potential Impact	Other Considerations
S.1	Support increased access to psychiatric care, including stabilizing medications in jail for felony ISTs while pending transfer to other IST treatment programs or when returning from IST treatment programs to jail pending court proceedings, including: • Provide funding to jails to expand the use of long-acting injectable psychiatric medications (LAIs) in jail settings. • Use of technology/telehealth for jail clinicians to access tele-	Funding/ Policy	Provides opportunities for faster stabilization of mental health symptoms in jail and increase opportunities for individuals to be candidates for Diversion or community-based restoration programs. While jails are not the recommended treatment setting, recognizes there is an immediate crisis	Jails do not receive state funding support for treatment and housing of individuals found IST on felony charges unless they have been admitted to a DSH-funded jail-based competency treatment program. However, individuals who have been deemed incompetent to stand trial on felony charges and are not yet transferred to a Diversion or other treatment program should receive appropriate mental health treatment until they are transferred to a treatment program. Funding to jails to support the resources and costs to providing these services may also need to be considered. Jail formularies may need to be updated to include long-acting injectable medications (LAIs).

	psychiatrists to provide medication/treatment determinations, including involuntary medications, when necessary, ordered by the court and appropriate due process procedures are followed. • Increase opportunities to rapidly connect a court-appointed competency evaluator's opinion that a patient needs medication to jail providers for consideration in an individual's treatment plan. • Support training opportunities for jail clinicians on patient engagement, including rapport building skills and motivational interviewing.		and responses must address the crisis in the short-term. There is not currently sufficient community capacity for stabilization of acute mental health conditions. Individuals who are currently waiting in jail for admittance to treatment programs are more likely to access treatment in existing Diversion and community-based restoration programs if their acute mental health symptoms are rapidly stabilized. Lack of symptom stabilization has been identified as the primary barrier to Department of State Hospitals (DSH) IST Diversion Program placement.	
S.2	Improve coordination between State, criminal justice	Operations/ Funding	Increased partnership and	Short-term bridge solutions may need to be implemented to advance these solutions until

	partners, county behavioral/mental health directors, and county public guardians, for IST patients, including: • Transition/treatment planning to ensure continuity of care between systems and providers. • Providing a 90-day medication supply for individuals discharging to the community from jail, Diversion, or restoration of competency treatment programs. • Use of common drug formularies, wherever possible. • Data sharing/use of business associate agreements. • Identifying community based and Diversion alternatives.		opportunities for Diversion and community-based treatment for felony ISTs. Increased support for transitions and re-entry after felony IST finding or release to reduce destabilization and re-arrest.	the CalAIM reforms, addressing enrollment in Medi-Cal prior to release and enhanced care management, noted in Strategy L.2 are implemented. Individuals with mental illness, family members, and advocates should be included in stakeholder discussions about how best to coordinate these efforts.
S.3	Provide training and technical assistance and develop best practice guides (toolkits) for jail clinical staff, criminal justice partners, boards of supervisors, and county	Training	Increased early treatment engagement and stabilization of individuals will reduce the	DSH Clinical Operations is actively providing technical assistance and training, as well as psychopharmacology consultation, to any county partners who request it.

	administrators for understanding and implementing effective treatment engagement strategies including: • Seeking treatment and medication histories from family members. • Utilization of incentives and other strategies to engage treatment including best practices for developing patient/clinician rapport, continuity, and securing the voluntary consent to medication whenever possible. • Obtaining involuntary medication orders and administering involuntary medications, when necessary, ordered by the court, and appropriate due process procedures are followed.		symptoms of psychosis such as hallucinations, delusions, and disorganized thinking. This will provide increased opportunity for placement in Diversion or community-based restoration programs, as well as decrease the length of stay for individuals on the pathway to JBCT or State Hospital placement.	This recommendation focuses primarily on training and technical assistance needs. Implementation of these strategies may require funding or other support.
S.4	Re-assess the DSH current waitlist, in partnership with DSH, county behavioral health, jail treatment providers, and criminal justice	Operations	Reduce current waitlist and increase access to community-based	The 2021 Budget Act included funding for DSH to re-evaluate individuals on the IST waitlist after 60 days to determine if an individual has been restored to competency or stabilized enough to be considered for

	partners to identify individuals who may be eligible for release into community treatment programs such as MH Diversion, DSH IST Diversion, CONREP or community-based restoration, address medication/treatment needs to stabilize mental health symptoms in jail, identifying individuals who, due to their psychiatric acuity, may need priority transfer to a state hospital pursuant to California Code of Regulations Section 4177, and swiftly move individuals into these programs to maximize their utilization.		treatment for felony ISTs.	Diversion or CONREP placement. Further opportunities exist to actively partner with counties prior to 60 days to identify individuals who may be candidates for placements in Diversion/CONREP.
S.5	Expand technical assistance for Diversion and community-based Restoration, including: • Developing best practice guides in partnership with key stakeholders. • Providing training and technical assistance to newly developing programs. • Providing training and technical assistance on	Training	Supports increased utilization and expansion of Diversion and community-based treatment options for felony ISTs.	DSH developed and implemented a Diversion Academy for counties who plan to implement DSH Diversion programs for ISTs. This was offered in the fall 2021 to counties who have applied for funding to establish new Diversion programs. DSH also maintains a website of technical assistance resources to support Diversion. Additionally, DSH plans to expand technical assistance opportunities to counties to support implementation of community-based restoration programs.

	options to assess and mitigate public safety risks.			
S.6	Provide training and technical assistance for Court appointed evaluators to improve the quality of the reports used by courts in determining a defendant is incompetent to stand trial: • Develop checklists for court appointed evaluators to follow of items to be considered when making competency recommendations, including American Academy of Psychiatry and the Law guidelines and/or Judicial Council rules of Court and considering defense counsel observations and concerns regarding their client's ability to participate rationally in their defense. • Develop template evaluation reports that include all checklist items, including short-form report options for	Training	Improves quality of court-appointed evaluator reports to inform the court whether an individual may be incompetent to stand trial and the basis of that determination including an individual's diagnosis, whether they require an involuntary medication order (IMO), or if they are malingering symptoms. May reduce the number of individuals found incompetent to stand trial and increase access to treatment and stabilization when treatment engagement is difficult due to an individual's severe symptoms of psychosis.	This recommendation focuses primarily on training and technical assistance needs. Implementation of these strategies may require funding or other support.

	when clinically appropriate • Develop technical assistance and training videos to increase knowledge and skills for existing court appointed evaluators, including principles of community based mental healthcare, which can be available on DSH website. • Ensure training and technical assistance includes information on discrepancies and biases in evaluations.			
S.7	Prioritize community-based restoration and Diversion by: • Allowing individuals placed into Diversion to retain their place on the waitlist should they be unsuccessful in Diversion and need inpatient restoration of competency services. • Improving communication between DSH and local courts in collaboration	Policy	Addresses concerns from Diversion providers that individuals will not have timely access to a DSH treatment program if the individual's mental health symptoms and community safety risk significantly increases. Additionally, reduces	DSH issued Departmental Letter 21-001 on November 3, 2021, to implement this recommendation. It outlines the process to facilitate coordination between Diversion programs, the courts, and DSH when an individual is being considered for Diversion to ensure the individual is not inadvertently transferred to a DSH hospital or jail-based competency treatment program. It also establishes the procedure for a Diversion program client to reenter the waitlist with their original commitment date when an individual is revoked from Diversion and needs to be transferred into a secure treatment program.

	with the Judicial Council so that a person on the waitlist is not removed from Diversion consideration prematurely when a bed becomes available at DSH.		instances where individuals are transferred to a DSH hospital or JBCT pre-maturely when an individual is being considered for Diversion.	
S.8	Prioritize and/or incentivize DSH Diversion funding to support diverting eligible individuals from the DSH waitlist.	Policy/ Statutory	Assists in reducing the DSH waitlist by prioritizing individuals on the waitlist for Diversion over individuals likely to be found incompetent to stand trial. Individuals likely to be found incompetent to stand trial are also eligible for DSH Diversion.	The 2021 Budget Act included funding for existing programs to expand Diversion programs to divert individuals who have been found incompetent to stand trial on felony charges from DSH waitlist. Welfare and Institutions Code 4136 by trailer bill, SB 129 (Committee on Budget, Statutes of 2021), also amended to prioritize expansion funding to individuals found incompetent to stand trial.
S.9	Include justice-involved individuals with serious mental illness as priorities in state-level homelessness housing, behavioral health, and community care infrastructure expansion funding opportunities	Policy	Supports increased access to community-based treatment for justice-involved individuals including felony ISTs.	While funding and capacity expansion are longer-term strategies, inclusion in priorities and planning that is underway now or in the short-term should occur.
S.10	Augment funding in DSH Diversion contracts with counties to provide for interim housing, including subsidies,	Funding	Addresses concerns of DSH Diversion program providers about insufficient	

	and housing-related costs to support increased placements into Diversion.		funding to access housing for the DSH Diversion population	
S.11	Local planning efforts for homelessness housing, behavioral health continuum, and community care expansion should include behavioral health and criminal-justice partners and consider providing services for justice-involved individuals with Serious Mental Illness to reduce homelessness and the cycle of criminalization.	Policy	Supports local efforts and inclusion of justice-involved individuals in planning and strategy development for local investments and state-level grants.	

Medium-Term Strategies: Solutions that can begin implementation by January 10, 2023

Goals:

a. Continue to provide timely access to treatment.
b. Begin to implement other changes that address broader goals of reducing the number of ISTs.
c. Increase IST treatment alternatives.

#	Strategy	Type	Potential Impact	Other Considerations

	Statutorily prioritize community outpatient treatment and Diversion for individuals found incompetent to stand trial on felony charges for individuals with less severe behavioral health needs and criminogenic risk, and reserve jail-based competency and state hospital treatment for individuals with the highest needs. Options include: • Require consideration of Diversion for anyone found incompetent to stand trial on felony charges. • Treat penal code 1170(h) felonies, for which the maximum penalty is a prison term served in the county jail rather than in state prison, consistent with SB 317 (Chapter 599, Statutes of 2021) which requires a hearing for Diversion eligibility, if not	Statutory/ Funding	Establishes priority for Diversion and community-based treatment for felony ISTs whenever appropriate based on an individual's treatment needs and criminogenic risk. Prioritizes utilization of state-hospital and jail-based competency treatment programs for those with the highest needs.	Corresponding operational changes could be implemented to also develop clinical factors for determination of treatment in State hospitals versus jail-based competency treatment programs. Currently, over referral to state hospitals and jail-based competency treatment programs and under-utilization of Diversion programs and lack of community-based treatment programs results in lengthy waitlists and inefficient utilization of inpatient and jail-based beds. Implementation of statutory changes may require funding or other supports related to court hearings and treatment capacity.

	Diversion eligible, a hearing to consider assisted outpatient treatment, conservatorship, or dismissal of the charges. • Change presumption of appropriate placement to outpatient treatment or Diversion for felony IST, require judicial determination based on clinical needs or high community safety risk for placement at DSH or in a jail-based treatment program, and a determination that community resources are available to meet the treatment needs of the individual. • Reform exclusion criteria of Diversion under PC 1001.36 to "clear and present risk to public safety" rather than			

	"unreasonable risk to public safety." • Statutorily require the use of structured mental health risk assessments to assist in identifying defendants that should be eligible for Diversion or community treatment. • Require judicial consideration of Diversion at the outset of criminal proceedings for mentally ill defendants. • Eliminate the requirement of a nexus between the defendant's mental disorder and the charged offense for individuals diagnosed with a serious mental illness or establishing a rebuttable presumption of nexus. • Establish a presumption of			

	Diversion eligibility if an individual is determined to be incompetent to stand trial and meets clinical and legal eligibility, subject to the availability of a treatment plan.			

M.2	Provide increased opportunities and dedicated funding for intensive community treatment models for individuals found IST on felony charges. Options include: • Assisted Outpatient Treatment (AOT) • Forensic Assertive Community Treatment (FACT) • Full-Service Partnerships (FSP) • Regional community-based treatment and Diversion programs for individuals not tied to any one county • Crisis Residential • Substance abuse residential treatment • Psychiatric health facilities • Mental Health Rehabilitation Centers • Transitional residential treatment	Funding/ Policy	Increases access to community-based treatment alternatives for justice-involved individuals with serious mental illnesses and reduces the incarceration.	
M.3	Establish a new category of forensic Assisted Outpatient	Statutory	Increases access to community-based treatment	Establishing category would be a medium-term strategy. However, implementing programs would be a long-term strategy.

	Treatment commitment that includes: • Housing • Long-acting injectable psychiatric medication • Involuntary medication orders, when necessary, as ordered by the court, and appropriate due process procedures are followed. • FACT team • Intensive case management		alternatives for justice-involved individuals with serious mental illnesses and reduces the incarceration. A forensic AOT commitment would ensure access to, and engagement with an intensive level of outpatient services designed to interrupt the cycle of criminalization in lieu of inpatient restoration commitment.	
M.4	Establishing statewide pool of court-appointed evaluators and increase the number of qualified evaluators: • Request counties to share their lists of court-appointed evaluators. • Identify demographics and cultural and linguistic competence of evaluators.	Funding/ Operations	Assists courts in access to expanded statewide pool of court-appointed evaluators and potentially reduces the amount of time individuals wait in jail for a court-appointed evaluation. Establishing a diverse pool of court appointed	

	• Increase court funding for court appointed evaluator pay.		evaluators reduces the risk that individuals are determined to be incompetent to stand trial due to cultural and linguistic differences.	
M.5	Improve statutory process leading to finding of incompetence or restoration to competence: • Set time frames for appointments of court appointed evaluators and receipt of reports. • Set statewide standards for court evaluations and reports. • Expand list of individuals who can recommend to the court a need for re-evaluation if someone may have been restored – noted already authorized for those over 60 days.	Statutory	Reduces time in jail for individuals awaiting competency assessments and increases quality of court-appointed evaluator reports. Allows an individual to be reevaluated for competency after the initial finding and before transfer to a treatment program.	Penal Code 1370 in 2019 was amended to allow jail providers and public defenders to request the court to appoint an evaluator to reevaluate a person's competency. Welfare and Institutions Code 4335.2 was added in 2021 to allow DSH evaluators to reevaluate an individual for competency after they have been on the waitlist for 60 days. Implementation of statutory changes may require funding or other support. Establishing timeline for court-appointed evaluators would be dependent upon increasing the pool of evaluators.

M.6	Revise items court-appointed evaluators must consider when assessing competence to include: • Eligibility for Diversion • Likelihood for restoration • Medical needs • Capacity to consent to medications • Consideration of malingering	Statutory	Assists the court in determining an individual's potential eligibility for Diversion or whether another treatment pathway to competency restoration is more appropriate.	Important to ensure appropriate training, technical assistance, and quality assurance measures for court-appointed evaluators are also implemented in conjunction with this recommendation, otherwise individuals may unnecessarily be excluded from Diversion opportunities. May also consider whether the court-appointed evaluator competency assessment could also include placement recommendations rather than having a separate placement performed by the CONREP Community Program Director. Would require significant training and technical assistance on increasing knowledge of the statewide continuum of placement options.
M.7	Revise/improve involuntary medication order statutory process: • Involuntary medication orders follow the person and are not specific to the placement locations. • Court-appointed psychologists may opine on consent capacity and potential need for involuntary medications when	Statutory	Provides treatment access and stabilization for individuals who do not have the capacity to consent to treatment due to the current severity of the symptoms of their mental illness. Facilitates improved care coordination and rapid re-stabilization to prevent	

	providing reports to the court on incompetence to stand trial. • Remove special designation requirements in Penal code 1369.1 requiring jails to be designated to provide involuntary medications for felony ISTs and allow jails to provide involuntary medications, when necessary, ordered by the court, and appropriate due process procedures have been followed.		rehospitalization in locked settings when a justice-involved individual decompensates.	
M.8	Provide access to community-based inpatient treatment, when needed, for stabilization of acute mental health symptoms prior to placement in Diversion programs.	Funding/ Capacity	Provides increased mental health stabilization services to reduce barriers to Diversion eligibility and increase access to Diversion for felony ISTs.	The 2021Budget Act includes $250M for DSH to increase IMD and sub-acute capacity in the community for felony ISTs, which can be utilized to provide stabilization services.
M.9	Provide funding to expand support services to increasing utilization of Diversion and community-	Funding/ Operations	Supports providers in treatment and support plan development for	Could pilot these support services in counties with the greatest number of ISTs to facilitate greater number of individuals placed in Diversion.

	based restoration for felony ISTs and enhance services for existing jail-based competency treatment programs including: • Diversion Program Provider Support/Technical Assistance - develop Diversion technical assistance/support teams consisting of psychiatrists and criminal justice experts to provide 24 hours a day 7 days a week non-urgent and emergency technical assistance and support. • Forensic Peer Support Specialists (or General Peer Support Specialists) – Provide funding to support utilization of peer support specialists in the courts, jails, Diversion, and treatment programs.		difficult cases and responding to emergent/urgent Diversion program and treatment challenges. Increases treatment engagement and success in Diversion/community-based treatment for felony ISTs. Assists court and jails with navigation, identification, and connection to system partners to facilitate dismissal/Diversion, case planning, and effective reentry to the community. Expands opportunities for higher-risk individuals to be served in community programs.	The 2021 Enacted Budget includes funding to support probation services for a subset of IST defendants served in the Los Angeles community-based restoration program. In addition, a portion of funding is available to expand community-based restoration programs to other counties and can be used to support probation services.

	• Probation Partnerships - Leverage potential opportunity for probation partnerships to provide community Diversion supervision and rapport building and increasing client engagement in treatment for higher-risk individuals. Integration of the SSI/SSDI Outreach Access, and Recovery (SOAR specialists in Diversion programs to increase SSI/SSDI application success rates and increase individual funding for community-based housing. Forensic navigators – provide funding to support utilization of liaisons or navigators in courts/jails to identify those who may need		Increases funding for community-based housing.	

	community-based treatment and supports and make appropriate connections with system partners to facilitate dismissal/Diversion, case planning, and effective reentry to the community.			
M.10	Support individuals with serious mental illness remaining stable in the community by: • Implementing Psychiatric Advance Directives (PADs) - peers would assist with the completion of the PADs (see above for peer costs). • Enhance funding to the public guardians to ensure people with serious mental illness are appropriately placed in the continuum of care.	Policy/ Funding	Reduces homelessness and the cycle of criminalization of individuals with serious mental illness.	Disability Rights California is in the process of updating their PAD resources and can be a resource for guidance, forms, etc.

M.11	Explore alternative jail-based competency and community-based restoration contract models to maximize utilization of community facilities for treatment rather than providing in-jail competency treatment.	Policy	Increases community-based treatment options and reduces reliance on jail-based treatment to serve felony ISTs.	Existing authority to expand community-based restoration programs may be used to support this contract model.
M.12	Expediting assessment and treatment immediately upon booking of defendants with serious mental illness, including: • Completing universal behavioral health and suicide risk assessments, substance abuse screenings, and review of records and behavioral health history by jail providers. • Performing a housing and service needs assessment to inform early consideration of housing and service needs for treatment of ISTs in the community.	Policy/ Funding	Increases early access to treatment and opportunities for community-based treatment options.	Additional funding/resources may be needed by jails, district attorneys, and public defenders to increase early access to treatment and increase the number of behavioral health providers qualified to perform the assessments and provide immediate treatment.

	• Implementing consideration of the family perspective and documentation of the mental health history and treatment of a loved one and including co-occurring substance use disorder challenges. • Determine a course of treatment that may begin in the jail, including medications, and discharge planning should start at the time of booking. • Early review of cases at booking or as soon as possible by District Attorney and Public Defender, in partnership with county behavioral health and jail treatment providers, for each defendant screened as mentally-ill to			

	eliminate those cases that will not be filed (defendant to be released), or for those defendants in situations where a complaint is likely to be filed, determine if there are opportunities for pre-trial release into treatment and services to provide a recommendation to the Judge at or before the time of arraignment.			
M.13	Establish requirements and/or provide incentives/enhanced rates to support increased community-based treatment and housing for justice-involved individuals with SMI, including: • Increase community providers, facilities willing to serve, and landlords willing to provide housing for this population.	Funding/ Statutory	Eliminates barriers and discriminatory practices in access to community-based treatment for justice-involved individuals.	Consider utilizing pay for success models.

	• Increase access to acute inpatient services for inmates under 5150s.			
M.14	Provide flexibilities, and expedited licensing to increase access to inpatient beds and housing, including: • Expedited licensing of Psychiatric Health Facilities (PHFs) and Mental Health Rehabilitation Centers (MHRCs). • Streamlining/coordination of licensing bodies when trying to establish new adult residential facilities and other treatment facilities.	Policy	Facilitates faster expansion of community treatment and housing resources. Eliminates perceived licensing barriers to quick expansion of treatment/housing resources.	
M.15	Revise DSH's CONREP Community Program Director Role, placement criteria, and assessment process to facilitate increased felony IST placement to CONREP, community-based restoration and Diversion programs and increased transitions from state	Statutory	Increases access to Diversion and community-based restoration programs for felony ISTs. Increases state hospital capacity for ISTs with highest level of treatment	

	hospitals to the CONREP community treatment continuum for individuals committed to DSH as Not Guilty by Reason of Insanity or Offenders with Mental Health Disorders.		needs by stepping down individuals from state hospitals to CONREP continuum.	
M.16	Allow access to and regularly assess eligibility for transition to DSH funded Diversion opportunities for individuals who are treated at DSH hospitals and jail-based competency treatment programs.	Policy/ Funding	Provides pathway to community treatment and supports reduction in recidivism for individuals who have received restoration of competency treatment in a DSH hospital or JBCT program.	
M.17	Provide increased and ongoing funding to support expansion of DSH Diversion and community-based restoration programs.	Funding	Provides increased access to community-based treatment options.	Existing funding and expansion funding contained in the 2021-22 Budget Act for DSH Diversion programs is one-time funding. Currently community-based restoration programs are only operated in partnership with Los Angeles County. The 2021-22 Budget Act provides funding for 552 additional beds to expand the existing program and develop new community-based restoration programs in other counties across three fiscal years.

				Support for housing and infrastructure needs when establishing new programs should be considered.

Long-Term Strategies: Solutions that can begin implementation by January 10, 2024 and January 10, 2025

Goals:

a. Break the cycle of criminalization.
b. Reduce the number of individuals found incompetent to stand trial on felony charges.
c. Provide bridge funding or strategies until broader behavioral health transformation initiatives are fully implemented including CalAIM, Behavioral Health Care Continuum Expansion, and Community Care Expansions.

#	Strategy	Type	Potential Impact	Other Considerations
L.1	Partner with the Homeless Coordinating and Financing Council (now the California Interagency Council on Homelessness) to: • Advocate to HUD to include the definition of at-risk of homelessness as and eligible population for resources. • Advocate with HUD to leverage existing allocations from federal government to local Continuums of Care (CoCs). • Consider flexibilities around housing first approaches and ensure definition of homelessness	Policy	Increased coordination and access to housing resources for individuals with serious mental illness to eliminate cycling in and out of homelessness.	

	includes at-risk of homelessness populations. • Provide training and technical assistance to CoCs, Criminal Justice, and Behavioral Health partners on how to provide effective housing services to this population. • Explore and support strategies to exchange data to ensure that the Behavioral Health/Criminal Justice population is included in CoC resourced efforts. The Criminal Justice system needs to be connected to the homeless crisis response system. • Encourage local housing system leaders to participate in existing interdisciplinary meetings focused on			

	justice-involved populations. • Support inclusion of individuals with serious mental illness and justice involvement in housing priorities/ preferences for housing funding.			
L.2	Support effective implementation of the proposed Cal-AIM (California Advancing & Innovating Medi-Cal) components that impact the justice involved, including: • Enrollment in Medi-Cal prior to release. • 90-day in-reach to stabilize health and wellness, provide warm hand-offs and prepare for community reintegration. • Intensive community-based care and coordination – enhanced care management (ECM). • Access to community support (food and	Funding/ Policy	Provides coordination of medical, behavioral health, and non-clinical social services for justice-involved individuals prior to and upon release from county jails. Access to services upon release from jail can help reduce the cycle of criminalization for individuals with serious mental illness.	Department of Health Care Services (DHCS) has submitted application for Medi-Cal waiver to the Centers for Medicare and Medicaid Services for approval. While overall implementation is a longer-term strategy, planning for implementation is occurring with stakeholders in the short and medium-term.

	housing) post release. • Capacity building for workforce, IT/data systems, infrastructure. • Seek the IMD exclusion waiver.			
L.3	Develop quality improvement oversight/peer review of court-appointed evaluators and their reports, which may include: • Developing a certification program. • Implementing pay for performance strategies to tie funding to quality. • Requiring standardized training. • Implementing a peer review process to improve quality of reports.	Funding/ Statutory	Increased quality and timing of court-appointed evaluator reports. Reduced time in jail for individuals pending competency assessments. May reduce the number of individuals found incompetent to stand trial due to poor quality reports.	Consideration should be given to whether a certification, quality improvement, and oversight program should be implemented at the state level, by the Judicial Council or by a private/other certification program provider. Increased funding for court-appointed evaluator pay (strategy M.4) could be linked to quality improvement strategies. Individuals participating in quality improvement efforts/training or who are certified are eligible to receive higher pay for evaluations.
L.4	Increase opportunities for alternatives to arrest and pre-booking Diversion, including: • Mobile/non-police crisis response teams.	Funding	Reduces incarceration and increases access to community-based treatment for individuals with serious mental illnesses.	There may be opportunities to leverage resources with court pre-trial programs. While overall implementation is a longer-term strategy, planning for implementation with stakeholders would be in the short and medium-term.

	• Sobering or triage centers. • Diversion centers including Federally Qualified Health Center models.			
L.5	Expand community treatment and housing options for individuals living with serious mental illness and who are justice-involved, including: • Provide dedicated funding to develop housing to support Diversion and community-based restoration. • Provide funding to incentivize the development and expansion of community-based restoration programs across the state. • Provide incentives or flexible housing pool models for housing developers, providers of supportive housing (including peer-run organizations), and owners of rental units	Funding/ Policy	Increases access to Diversion and community-based treatment for felony ISTs. Provides treatment and housing options to provide community-based treatment and Diversion. Supports infrastructure development and prioritization for justice-involved individuals including felony ISTs.	

	to create additional housing resources or provide operating subsidies or supports for justice-involved individuals with serious mental illnesses. • Include justice-involved individuals with serious mental illness as priorities in homelessness, behavioral health, and community care infrastructure expansion funding. • Provide landlord incentives. • Expand Social Rehabilitation facilities. • Develop unlocked residential housing with treatment and supports. • Support regional programs and approaches for behavioral health and housing strategies, especially in less			

	densely populated regions. • Increase permanent supportive housing opportunities for justice-involved individuals with serious mental illnesses. • Consider funding support for Accessory Dwelling Units (ADU) development to support families' ability to provide independent housing for loved ones with SMI on their properties.			
L.6	Develop new licensing category for enriched and intensive community treatment options for individuals living with Serious Mental Illness including individuals who are justice-involved which may include provisions of mental health, health care, and intensive support services in a home-like setting:	Statutory	Increases intensive community-based treatment options for individuals with serious mental illnesses to prevent homelessness and criminalization.	

	• Explore similar model to the Short-term Residential Therapeutic Programs models that serve children and youth whose needs create barriers to placement in family-based care. • Explore similar licensing categories to those that support adults with developmental disabilities.			
L.7	Facilitate appropriate information sharing and support cross-system data initiatives across State, courts, and local entities that serve ISTs. • Develop State Health Information Guidance on sharing health and housing information in the context of serving people involved in the criminal justice systems, including the development of standard	Policy	Facilitates improved treatment/coordination. Supports research, evaluation, and policy development to inform ongoing strategies and investments.	

	authorizations for release of information and MOU's and provide training and technical assistance on guidance implementation. • Provide funding to support counties to undertake analyses of their criminal justice populations, including those with behavioral health needs to understand trends and identify data-driven strategies to reduce the number of ISTs. • Provide funding to develop a state approach to monitor key data at the intersection of criminal justice, behavioral health, and homelessness.			
L.8	Support the development and expansion of a culturally and linguistically competent workforce to meet an individual's forensic	Funding/ Policy	Provides a diverse workforce trained to provide services and support to justice-involved individuals	

	and behavioral health needs, including: • Funding for forensic fellowships. • Utilizing 4th year residents and psychology students to provide court-appointed evaluations. • Support increased psychologist education and training and psychiatric residency programs with rotation requirements to serve justice-involved individuals. • Explore expansion of mental health and other professionals to serve justice-involved individuals. • Expand the use of peer support specialists and family members. • Support care team models so individuals are working at the top of their licensure.		with serious mental illness.	

	• Provide recruitment and retention incentives. • Identify funding streams that could be braided (and augmented) to address workforce shortages. • Educate workforce on serving in the role of the housing advocate, collaborative justice principles, motivational interviewing, assessing and mitigating dangerousness, implicit bias, and other culturally relevant competencies.			
L.9	Phase out the reliance and utilization of jail-based competency treatment programs as community-based treatment and Diversion program options for felony ISTs are expanded.	Policy	Prioritizes community-based treatment options for individuals with serious mental illness to provide for improved outcomes and connection to long-term	

			community treatment and supports.	
L.10	Explore and, if needed, implement improvements to policies and practices governed by the Mental Health Services Act and the Lanterman-Petris-Short Act to facilitate access to care and treatment for individuals who are experiencing severe and disabling mental health crisis.	Statutory	Increased access to treatment and reduced criminal-justice involvement for individuals with serious mental illness.	
L.11	Provide funding support to counties to expand access to AB1810 Mental Health Diversion (Penal Code 1001.36), including for misdemeanors.	Funding/ Policy	Increasing access to mental health Diversion opportunities for misdemeanors can reduce the cycle of incarceration at an earlier stage reducing the potential for future felony arrest and IST determination.	Consider eliminating county matching requirements which can create barriers to MH Diversion expansion. Include funding for housing individuals participating in Mental Health Diversion
L.12	Provide increased access to permanent supportive housing for individuals with serious mental illness who are justice-involved.	Funding/ Policy	Individuals found incompetent to stand trial on Felony charges and referred to DSH are often unsheltered	

			homeless at the time of arrest and have had multiple prior criminal justice encounters. Providing permanent supportive housing will help reduce the cycle of criminalization for individuals with serious mental illness.	
L.13	Revise incompetent to stand trial statutes to require the prosecution to establish competency, rather than current requirement of the defense to establish incompetency.	Statutory	Streamlines pathway to treatment for individuals with serious mental illness where there is clear evidence of incompetence.	

[1] Incompetent to Stand Trial Solutions Workgroup Website: https://www.chhs.ca.gov/home/committees/ist-solutions-workgroup/

Appendix A: IST Solutions Working Group Membership and Affiliations

Working Group 1: Early Access to Treatment and Stabilization for Individuals Found Felony IST

- **Co-Chair: Melanie Scott**, PsyD, Assistant Chief Psychologist, California Department of State Hospitals
- **Co-Chair: Katherine Warburton**, DO, Medical Director, Deputy Director of Clinical Operations, California Department of State Hospitals
- **Deanna Adams**, Senior Analyst, Judicial Council of California
- **Kirsten Barlow**, National Alliance of Mental Illness (NAMI) – California
- **Francine Byrne**, Principal Manager, Criminal Justice Services, Operations & Programs Division, Judicial Council of California
- **Elise Devecchio-Cavagnaro**, Ph.D., Consulting Psychologist, Department of Health Care Services
- **Brenda Grealish**, Executive Officer, Council on Criminal Justice and Behavioral Health (CCJBH), California Department of Corrections and Rehabilitation (CDCR) Office of the Secretary
- **Paige Hoffman**, Staff Services Analyst, Council on Criminal Justice and Behavioral Health, California Department of Corrections and Rehabilitation
- **Karen Larsen**, Health & Human Services Agency Director, Yolo County & County Behavioral Health Directors Association (CBHDA)
- **Kristopher Kent**, Attorney, California Department of State Hospitals
- **Farrah McDaid Ting**, Senior Legislative Representative, Administration of Justice, California State Association of Counties (CSAC)
- **Stephen Manley**, Superior Court Judge, Santa Clara County
- **Christy Mulkerin**, MD, Chief Medical Officer, San Luis Obispo County Jail
- **Kim Pederson**, Senior Attorney, Disability Rights California
- **Dawn Percy**, Deputy Director, Department of Developmental Services
- **Jonathan Raven**, Chief Deputy District Attorney, Yolo County (CDAA)
- **Stephanie Regular**, Assistant Public Defender, Contra Costa County Public Defender Office & Co-Chair of the Mental Health Committee of the California Public Defender Association (CPDA)
- **Marni Sager**, Manager, Department of Developmental Services
- **Cory Salzillo**, Legislative Director, California State Sherrif's Association

Working Group 2: Diversion and Community-Based Restoration for Felony ISTs

- **Co-Chair: Katherine Warburton**, DO, Medical Director, Deputy Director of Clinical Operations, California Department of State Hospitals
- **Co-Chair: Stephanie Welch**, Deputy Secretary of Behavioral Health, California Health and Human Services Agency

- **Francine Byrne**, Principal Manager, Criminal Justice Services, Operations & Programs Division, Judicial Council of California
- **Jessica Cruz**, MPA/HS, CEO, National Alliance of Mental Illness (NAMI) – California
- **Steven Kite**, COO, National Alliance of Mental Illness (NAMI) – California
- **Sarah Desmarais**, PhD, Senior Vice President, Policy Research Associates, Inc.
- **Elise Devecchio-Cavagnaro**, Ph.D., Consulting Psychologist, Department of Health Care Services
- **Anita Fisher**, Council on Criminal Justice and Behavioral Health / Family Member
- **Neil Gowensmith**, Ph.D. Assistant Professor, University of Denver, Licensed Clinical & Forensic Psychologist
- **Brenda Grealish**, Executive Officer, Council on Criminal Justice and Behavioral Health (CCJBH), California Department of Corrections and Rehabilitation (CDCR) Office of the Secretary
- **Cathy Hickenbotham**, Council on Criminal Justice and Behavioral Health (CCJBH), California Department of Corrections and Rehabilitation (CDCR)
- **Scarlet Hughes**, Executive Director, California Association of Public Administrators, Public Guardians and Public Conservators (CAPAPGPC)
- **Tony Hobson**, PhD, Behavioral Health Director, Plumas County
- **John Keene**, Chief Probation Officer, San Mateo County & President-Elect, Chief Probation Officers of California CPOC)
- **Veronica Kelley**, Director, San Bernardino County Department of Behavioral Health & Board President, California Behavioral Health Directors Association (CBHDA)
- **Michelle Cabrera**, Executive Director, California Behavioral Health Directors Association (CBHDA)
- **Kristopher Kent**, Attorney, California Department of State Hospitals
- **Pamila Lew**, Senior Attorney, Disability Rights California (DRC)
- **LD Louis**, Assistant District Attorney, Alameda County District Attorneys Office & California District Attorneys Association (CDAA)
- **Farrah McDaid Ting**, Senior Legislative Representative, Administration of Justice, California State Association of Counties (CSAC)
- **Dawn Percy**, Deputy Director, Department of Developmental Services
- **Jonathan Raven**, Chief Deputy District Attorney, Yolo County (CDAA)
- **Marni Sager**, Manager, Department of Developmental Services
- **Gilda Valeros**, Supervising Attorney for Santa Clara County's Public Defender's Office
- **Stephen Manley**, Superior Court Judge, Santa Clara County

Working Group 3: Initial County Competency Evaluations

- **Co-Chair: Charles Scott**, MD, Chief, Division of Psychiatry and the Law, Forensic Psychiatry Training Director, and Professor of Clinical Psychiatry at the University of California, Davis Medical Center
- **Co-Chair: Katherine Warburton**, DO, Medical Director, Deputy Director of Clinical Operations, California Department of State Hospitals
- **Deanna Adams**, Senior Analyst, Judicial Council of California
- **Francine Byrne**, Principal Manager, Criminal Justice Services, Operations & Programs Division, Judicial Council of California
- **Katherine Clark**, Assistant Program Budget Manager, California Department of Finance
- **Matthew Greco**, Deputy District Attorney, San Diego County District Attorney's Office
- **Scarlet Hughes**, Executive Director, California Association of Public Administrators, Public Guardians and Public Conservators (CAPAPGPC)
- **Stephen Manley**, Superior Court Judge, Santa Clara County
- **Farrah McDaid Ting**, Senior Legislative Representative, Administration of Justice, California State Association of Counties (CSAC)
- **Danny Offer**, National Alliance of Mental Illness (NAMI) – California
- **Ira Packer**, PhD, Clinical Professor of Psychiatry & Director, Forensic Psychology Residency, University of Massachusetts Medical School
- **Neil Gowensmith**, Ph.D. Assistant Professor, University of Denver, Licensed Clinical & Forensic Psychologist
- **Dawn Percy**, Deputy Director, Department of Developmental Services
- **Jonathan Raven**, Chief Deputy District Attorney, Yolo County (CDAA)
- **Stephanie Regular**, Assistant Public Defender, Contra Costa County Public Defender Office & Co-Chair of the Mental Health Committee of the California Public Defender Association (CPDA)
- **Marni Sager**, Manager, Department of Developmental Services
- **Todd Schirmer**, PhD, CCHP, Forensic Division Director, Marin County Behavioral Health & Recovery Services & County Behavioral Health Directors Association (CBHDA)

Department of State Hospitals
Incompetent to Stand Trial Solutions Proposal

The 2021 Budget Act included $75 million in fiscal year (FY) 2021-22 and $175 million in FY 2022-23 and ongoing to support the immediate implementation of actionable solutions, based on recommendations identified by the Incompetent to Stand Trial Workgroup, to provide timely access to treatment for individuals with serious mental illnesses who are found incompetent to stand trial (IST) on felony charges. The Administration proposes a total of $571 million ongoing beginning in FY 2022-23 to support implementation of solutions to provide timely treatment and support the ongoing efforts to decriminalize mental illness in California.

This document provides background regarding California's IST crisis, describes the elements in the Administration's proposal and serves as the basis for further discussions with stakeholders and the Legislature regarding the proposed solutions to be implemented.

Background

Like most states in the country, California is home to thousands of vulnerable and sick individuals who, as a result of not being engaged in early, upstream treatment and support interventions, decompensate to a point where engagement and treatment is difficult. The lives of many of these Californians are lives of illness, vulnerability, and homelessness, and they often cycle in and out of incarceration. Criminal defendants who are unable to understand criminal proceedings or assist counsel in their defense are determined by a court to be Incompetent to Stand Trial (IST). If these individuals are charged with a felony, they can be committed to the Department of State Hospitals (DSH) to provide clinical and medical services with the goal of restoring their competency and enabling them to return to court to resume their criminal proceedings.

Although the 2022-23 Governor's Budget and recent prior budget acts make significant investments that will expand community based behavioral health infrastructure and services, there is still an increasing number of individuals with under or untreated mental health conditions who are being found IST and referred to DSH. Despite recent efforts including increased bed capacity, decreases to the average length of stay, and the implementation of county-based treatment programs, the increasing number of county IST referrals has resulted in a large waitlist and long wait times for defendants pending placement to DSH. Furthermore, the impacts of the COVID-19 Pandemic and necessary infection control measures put in place at DSH facilities resulted in slower admissions and reduced capacity for the treatment of felony ISTs at DSH.

In 2015, the American Civil Liberties Union sued DSH (*Stiavetti v. Clendenin*) alleging that the amount of time IST defendants were waiting for admission into a DSH treatment program violated individuals' due process rights. The Alameda Superior Court ultimately ruled that DSH must commence substantive treatment services within 28 days from receipt of commitment for felony IST patients, with a specified timeline for meeting that standard over the next three years.

In 2021, the Legislature enacted Welfare & Institutions Code (WIC) section 4147 through the passage of Assembly Bill 133 (Chapter 143, Statutes of 2021) and the Budget Act of 2021 (Chapter 69, Statutes of 2021), which charged the California Health & Human Services Agency (CalHHS) and DSH to convene an IST Solutions Workgroup (Workgroup) to identify actionable solutions that address the increasing number of individuals with serious mental illness who become justice-involved and deemed IST on felony charges. The legislation also includes triggers that will authorize DSH to stop admission of Lanterman-Petris-Short (LPS) patients and impose LPS census reduction targets if satisfactory progress towards implementing Workgroup solutions is not made within the outlined timeframes.

The IST Workgroup convened between August 2021 and November 2021 with several representatives and stakeholders from multiple state agencies, the Judicial Council, local government, and justice system partners, as well as representatives from patients' rights and family member organizations. Per the statute, the Workgroup identified short-, medium-, and long-term solutions to advance alternatives to placement in DSH restoration of competency programs. The Workgroup report released on November 30, 2021 summarizes identified strategies and solutions and can be reviewed at: https://www.chhs.ca.gov/wp-content/uploads/2021/12/IST_Solutions_Report_Final_v2.pdf.

DSH IST Solutions Proposal Summary

DSH proposes to implement the following solutions informed by the recommendations developed by the IST Solutions Workgroup. Utilizing a combination of existing funding for IST programs, the $75 million in FY 2021-22 and $175 million ongoing that was set aside to support IST solutions implementation, the Governor's Budget proposes a total of $571 million in ongoing funding beginning in 2022-23. The components of the proposal below will provide early stabilization, care coordination, expand community-based treatment and diversion options for felony ISTs that will help end the cycle of criminalization and increase community transitions for state hospital patients. Collectively, these proposals will also assist the state in meeting treatment timelines ordered by the Superior Court in *Stiavetti v. Clendenin*. These proposals also have corresponding proposed trailer bill language, which will be made publicly available in the near future.

Early Stabilization and Community Care Coordination

The goal of Early Stabilization and Community Care Coordination is to provide timely access to treatment and to promote stabilization of IST defendants to increase community-based treatment placements.

1. Stabilization and Early Access Treatment

   $24.9 million from the $75 million current year set-aside and $66.8 million ongoing will be dedicated to providing essential treatment services to individuals on DSH's IST waitlist. This robust program will provide access to treatment at the earliest point possible upon IST commitment when individuals are arrested and booked into jail. Treatment will be facilitated in partnership with county jail mental health providers for individuals found to be IST on felony charges and will include administration of medications, increased clinical engagement, and competency education. Existing Jail-Based Competency Treatment (JBCT) program infrastructure and resources will be leveraged to offer early access to treatment services for additional felony IST defendants waiting in jails.

   In addition, resources are included to support the cost of psychotropic medications including long-acting injectable (LAI) medications. The goal is to facilitate the stabilization and medication compliance of IST patients, both of which will promote increased eligibility and placement in a diversion or other community-based treatment programs.

2. Care Coordination and Waitlist Management

   As DSH continues to add community-based programs to the menu of patient placement options to mitigate the IST crisis, DSH's Patient Management Unit's (PMU) role as the hub of patient information and coordination continues to grow more complex. $1.7 million from the current year set-aside and $4.9 million in budget year is included to further enhance the tracking and management of all felony IST patients committed to the department. Teams will screen all felony IST patients to determine eligibility for community-based programs, provide enhanced monitoring of the waitlist, and provide commitment-to-admission case management to coordinate appropriate placements and maximize bed usage for ISTs. Resources are included to enhance existing technology systems and to develop a statewide transportation contract to transport patients between facilities within the DSH continuum of care to better facilitate inpatient admissions and transfers. Also included are resources to assist with gathering and maintaining high data quality and meeting data reporting requirements under *Stiavetti*.

Expanding Felony IST Community Programing via Community Based Restoration and Diversion

The goal of expanding Community Based Restoration (CBR) and Diversion programs is to provide care in the most appropriate community-based setting as an alternative to a placement in a DSH bed. The DSH-Diversion program is designed to serve eligible felony IST defendants in intensive community-based services and, if defendants are successful in the program, to have the current charges dropped. DSH's CBR program is also community-based treatment, but with the focus of restoring competency so a defendant's criminal proceedings can resume. Once an individual is restored to competency and their charges are resolved or an individual completes diversion and the charges are dropped, the goal is to transition them to long-term community treatment and support to ultimately reduce the cycle of criminalization. DSH estimates that 60-70% of IST commitments will be eligible for services each year in a community-based program, for a total of approximately 3,000 felony ISTs based on the current (first quarter of 2021-22) monthly average referral rate of 455 ISTs.

The expansion of existing CBR and Diversion programs are made alongside an investment in infrastructure funding to support a dedicated inventory of community placements, most notably housing, to serve felony ISTs in these programs. The following program enhancements were developed in response to the recommendations of the IST Solutions Workgroup.

1. Housing Augmentation for Current Diversion Contracts

   $42 million of the $75 million IST Solutions current year set-aside is dedicated to a one-time interim housing investment for felony IST clients participating in the DSH Diversion program. An additional $18 million in funds from the existing Diversion program will also be leveraged. $75,000 per client will support the cost of appropriate housing to facilitate increased placements into county Diversion programs. This funding will be limited to new clients who have been found felony IST and may not be used to support likely-to-be IST defendants. Counties can utilize this funding to provide housing to diversion clients in the most appropriate level-of-care including, but not limited to short-term treatment facilities such as Institute for Mental Disease (IMD) and Mental Health Rehabilitation Centers, residential housing with clinically enhanced services, board and care homes, or other appropriate residential facilities.

   These resources are designed as a short-term solution to increase the number of felony ISTs served in county diversion programs. Limited placements and housing inventory in the community, as well as the stigma associated with this population, creates barriers for counties that current

Diversion funding levels cannot overcome. This additional funding will support county efforts to secure appropriate placements and housing for Diversion clients until DSH is able to partner with counties to establish long-term residential housing infrastructure (see next section).

2. Felony IST Residential Housing Infrastructure Investments – 5,000 CBR or Diversion Beds

   $6.4 million from the current year set-aside and $233 million one-time funds are dedicated to infrastructure to develop residential housing settings to support felony IST individuals who are participating in either community - based restoration or diversion programs. DSH estimates that approximately 3,000 of the individuals found IST annually are eligible for participation in community-based treatment programs. Average lengths of stay of 18-20 months results in a housing deficit of approximately 5,000 beds. The proposed funding level assumes these beds will be spread across approximately 700 housing units of 8-10 beds each and approximately $350,000 in start-up funds will be provided for each unit to cover the down payment, necessary retrofitting, and furnishings for staff and patients. The ongoing cost of operating the homes will be provided through a per-patient rate (described below), paid to counties or to service providers, who are responsible for securing client housing and providing wrap-around treatment services.

   This residential housing program will complement the IMD, and Sub-Acute infrastructure program funded in the 2021 Budget Act. IMD and sub-acute beds are a key component for treating felony ISTs in the community. DSH is currently developing new IMD and Sub-Acute capacity across the state, and these beds will be available as a step-down stabilization option for ISTs transitioning from jail to the community and can also be utilized when IST clients in the community need a higher-level of care. Together, these programs will create a complete continuum of community placement and housing options for ISTs across the state.

3. Felony IST Community Program Funding for CBR or Diversion Clients

   In combination with current budget authority to support existing CBR and Diversion programs, DSH will invest $136.5 million from the $175 million set-aside in the budget year for IST solutions and an additional $130 million ongoing to the creation or expansion of permanent community-based treatment programs for felony IST patients. These resources will support a robust per-patient rate, non-treatment costs of managing community-based programs, transitional housing support for IST defendants released

directly from custody, and substantial technical assistance resources for participating counties.

Counties will receive $125,000 per felony IST client treated in either a CBR or Diversion program. This rate is intended to support an intensive community treatment model with increased frequency of clinical contacts and access to psychiatry services, as well as all wrap-around services, and housing costs for an average 18-month length of stay. In addition, this rate is intended to support the use of both forensic peer specialists and partnerships with county probation departments to increase treatment engagement and success in community programs.

DSH acknowledges that County costs for establishing and maintaining this programming goes beyond the direct costs of care for the clients. Ongoing new funding is also included to assist counties with the additional costs incurred by the county implementers and stakeholders involved in planning and running these programs. Funds will be allocated based on the county's baseline number of actual IST referrals, and can be used by counties to pay for expenses such as a community care coordinator to facilitate client placement, a forensic evaluator, additional positions for the District Attorney and Public Defender offices, pre-trial probation services, additional Public Guardian services, and data collection activities. In addition to this allocation, every participating county will receive $100,000 per year to support local behavioral health and justice stakeholder collaborative efforts to identify solutions that target the overall reduction of felony IST commitments in their county.

DSH also proposes to work with counties to explore opportunities for transitional placement services to support client housing needs if an IST is restored in jail and released back to the community. The goal is to facilitate a smooth community transition and allow time for the county's coordination of benefits and qualified services.

Finally, $6 million ongoing is included for robust technical assistance for counties, an external program evaluation of the community programs established, and resources for DSH to provide administrative and clinical support to the community programs. These components are intended to fully support counties in effectively managing the treatment of felony ISTs in their communities through workforce development initiatives, clinical and psychopharmacological support and training, and data-driven decision-making.

Increased Placements to CONREP and Transitions to County Services

$433,000 ($1.2 million ongoing) is included to pilot a new independent placement determination panel to increase the number of individuals served in the community via Conditional Release Program (CONREP). This new panel will revise the Community Program Director (CPD) role as part of CONREP and improve the assessment process for patients who are committed to DSH as Not Guilty by Reason of Insanity (NGI) or as an Offender with Mental Health Disorder (OMD). The overall increased utilization of CONREP will free beds in the state hospitals. While CONREP CPDs will continue to be responsible for placement determinations of ISTs prior to DSH commitment, future consideration will be made to revise this responsibility and pilot an independent evaluation model for IST placement determinations.

Felony IST Growth and County Share of Costs

These investments support the goal of providing care in the least restrictive, community-based settings while maintaining public safety. The growing number of county IST referrals is largely driven by insufficient appropriate community treatment services which leads to under or untreated individuals with serious mental illnesses being increasingly involved in the justice system. To ensure that the expansion of DSH funded community-based care does not create unintended incentives that drive additional IST referrals, the state will implement a growth cap that will include a county cost sharing methodology if the growth cap is exceeded.

DSH proposes to set each county's referral cap at the total number of felony ISTs committed to DSH in the current fiscal year (FY 2021-22). If counties exceed their baseline referral rate, they will be responsible for a portion of treatment costs for IST patients that are referred above their baseline. The total share of cost of care will be based on the treatment location for each IST patient (DSH in-patient or community-based programs) and will apply to all counties, regardless of whether they contract with the department for community-based programming.

Proposal Funding Summary

	(Dollars in Thousands)	
Program Costs	**CY**	**BY Ongoing**
Early Stabilization and Community Care Coordination		
Stabilization and Early Access Treatment	$ 24,900	$ 66,800
Care Coordination and Waitlist Management	$ 1,700	$ 4,900
Subtotal, Stabilization and Community Care Coordination	**$ 26,600**	**$ 71,700**
Funding - IST Solutions $75M & $175M	*$ 26,600*	*$ 38,500*
Additional Funding Needed	$ -	$ 33,200
Expanding Felony IST Community Programming via Diversion and Community Based Restoration		
Housing Augmentation for Current Diversion Contracts	$ 60,000	$ -
Felony IST Residential Housing Infrastructure Investments - 5,000 CBR or Diversion Beds	$ 6,400	$ 233,000
Felony IST Community Program Funding for CBR or Diversion Clients	$ -	$ 266,500
Subtotal, Expand Community Capacity	**$ 66,400**	**$ 499,500**
Existing Diversion and CBR Authority	*$ 18,000*	*$ 46,000*
Funding - IST Solutions $75M & $175M	*$ 48,400*	*$ 136,500*
Additional Funding Needed	$ -	$ 317,000
Increased Placements to CONREP and Transitions to County Services		
Increased CONREP Placements	$ -	$ 433
Subtotal, Increased CONREP Placements and Transition Services	**$ -**	**$ 433**
Funding - IST Solutions $75M & $175M	$ -	$ -
Additional Funding Needed	$ -	$ 433
Total, DSH IST Solutions Proposal	**$ 93,000**	**$ 571,000**
Existing Diversion and CBR Authority	$ 18,000	$ 46,000
Funding - IST Solutions $75M & $175M	$ 75,000	$ 175,000
Total Additional Funding	$ -	$ 350,000