IST SOLUTIONS WORKGROUP – FEEDBACK ON DRAFT RECOMMENDATIONS

REVIEWER NAME: Pamila Lew, Disability Rights California

November 10, 2021

Disability Rights California submits our feedback to the Matrix with the following guiding principles:

- Any solutions should center the right of people with disabilities to live with the greatest freedom, with voluntary access to quality healthcare, housing, and job opportunities.
- Short term solutions should not inadvertently create unintended consequences. Specifically, we oppose the expansion of Jail Based Competency Restoration and other locked inpatient settings.
- All solutions should be implemented holistically, within the continuum of existing community behavioral health services, while simultaneously creating new opportunities to further community- based care in non-institutional settings.
- Individuals with intellectual/developmental disabilities who have been deemed incompetent to stand trial are also waiting for long periods in jail custody. They have unique concerns that were not addressed during this process. We recommend that the Department of Developmental Services, Regional Centers, individuals with intellectual/developmental disabilities, family members, advocates, and stakeholders initiate discussions to address the crisis affecting these individuals.

#	Strategy	Type	Potential Impact	Other Considerations/Recommendations
	SHORT TERM SOLUTIONS			
S.1	Support increased access to psychiatric medications in jail for felony ISTs, 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-psychiatrists to provide medication/treatment determinations, including involuntary medications, when needed. • 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.			DRC opposes the practice of involuntary medication of individuals. While there is a due process procedure before a person can be involuntarily medicated, we are concerned that these procedures are not always correctly followed. Further, we have concerns with the use of involuntary long acting injectables in jail settings. If the Workgroup keeps these solutions, we recommend that there be funding to include specific training for clinicians on rapport building skills and motivational interviewing, and a checklist that demonstrates there is an effort to first obtain voluntary acceptance of medication, even if an individual has an involuntary medication order.
S.2	Improve coordination between State, criminal justice partners, county behavioral/mental health directors, and			Individuals with mental illness, family members, and advocates must be included in stakeholder discussions

	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/business associate agreements • Identifying community based and diversion alternatives			about how to best coordinate these efforts.
S.3	Provide training and technical assistance and develop best practice guides for jail clinical staff and criminal justice partners for effective treatment engagement strategies including • seeking treatment and medication histories from family members, • utilization of incentives and other strategies to engage treatment • providing/obtaining involuntary medication orders and administering involuntary medications, when necessary.			Recommend this additional solution: • Ensure that all training include best practices for developing patient/clinician rapport, continuity, and securing the voluntary consent to medication whenever possible
S.4	Re-assess the DSH current waitlist, in partnership with DSH, county behavioral health, jail treatment providers and criminal justice partners to identify individuals who may be eligible for			Agree with this solution. The workgroups did not fully explore whether CONREP can actually be a barrier to these referrals. Is CONREP too conservative with their

	diversion, CONREP or community-based restoration, address medication/treatment needs to stabilize mental health symptoms in jail, and swiftly move individuals into these programs to maximize their utilization.			recommendations for diversion? If so, they will continue to pose as a barrier to individuals being treated in the community and/or diverted.
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 on use of structured risk assessment tools, which can help address concerns related to public safety			Agree with this solution, with the caveat that "Risk Assessment Tools" can have problems with racial and other forms of bias. Public safety concerns can be addressed without the use of these tools. For example, by having more frequent court check-ins, which could also be done remotely.
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, consider American Academy of Psychiatry and the Law guidelines and/or Judicial Council rules of Court • Develop template evaluation reports that include all checklist items, including short-form report options for when clinically appropriate • Develop technical assistance and training videos to			Particularly support the solution to "Ensure training and technical assistance includes information on discrepancies and biases in evaluations."

	increase knowledge and skills for existing court appointed evaluators Ensure training and technical assistance includes include information on discrepancies and biases in evaluations which can be available on DSH website			
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; and, • Improving communication between DSH and local courts so that a person on the waitlist is not removed from diversion consideration prematurely when a bed becomes available at DSH.			Agree with these solutions.
S.8	Prioritize and/or incentivize DSH diversion funding to support diverting eligible individuals from the DSH waitlist			Agree with this solution.
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			Agree with this solution.
S.10	Augment funding in DSH Diversion contracts with counties to provide for interim housing, including subsidies, and housing-related costs to support increased placements into Diversion.			Agree with this solution.

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.			Agree with this solution.
	MEDIUM TERM SOLUTIONS			
M.1	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 • Treat penal code 1170(h) felonies consistent with SB 317 (Chapter 599, Statutes of 2021) which requires a hearing for diversion eligibility, if not diversion eligible, a hearing to consider assisted outpatient treatment, conservatorship, or dismissal of the charges. • Change presumption of appropriate placement to outpatient treatment or			Support these solutions, except DRC disagrees with this solution: "Statutorily require the use of structured risk assessments to assist in identifying defendants that should be eligible for diversion or community treatment." Structured risk assessments can have problems with racial and other forms of bias. Public safety concerns can be addressed without the use of these assessments. For example, by having more frequent court check-ins, which could also be done remotely.

	diversion for felony IST and require judicial determination based on clinical needs or high community safety risk for placement at DSH or in a jail based treatment program. • 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 risk assessments to assist in identifying defendants that should be eligible for diversion or community treatment. • Mandate judicial consideration of diversion at the outset of criminal proceedings for mentally ill defendants			
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 programs for individuals not tied to any one county			DRC supports the use of Full-Service Partnerships, Forensic Assertive Community Treatment, and Regional community based treatment programs for individuals not tied to any one county. DRC opposes increasing funding for AOT because it is an unnecessary, costly expansion of involuntary treatment.
M.3	Establish a new category of forensic Assisted Outpatient Treatment commitment that includes:			DRC opposes this solution as it is unnecessarily coercive and the same objectives could be achieved within

	• Housing • Long-acting injectable psychiatric medication • Involuntary medication orders, when needed • FACT team • Intensive case management			the existing framework and continuum of diversion and community based restoration.
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 • Increase court funding for court appointed evaluators			DRC recommends adding this requirement: "Train court appointed evaluators in principles of community based mental health care."
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 court need for re-evaluation if someone may have been restored – noted already authorized for those over 60 days			Support this solution.

M.6	Revise items court evaluators must consider when assessing competence to include: • Diversion • Likelihood for restoration • Medical needs • Involuntary medication			Support this solution.
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 providing reports to the court on incompetence to stand trial. • Remove special designation requirements for jails to be able to provide involuntary medications for felony ISTs and allow jails to be able to provide involuntary medications when needed and there is a court order.			DRC recognizes the important role that psychotropic medication plays in stabilizing a person for admission into diversion or community-based restoration programs. However, in implementing solutions related to the involuntary administration of psychotropic medication to people in jail, DSH and counties should adhere to all due process rights afforded to defendants. In addition, all efforts to avoid actual administration of involuntary medication should be taken, including rapport-building, continuity of providers, motivational interviewing, and engagement around the risks and benefits of a proposed medication, as well as alternative medication options. Additionally, DRC does not believe that there is a special designation requirement for jails to be able to

				provide involuntary medications, and requests clarification on this point.
M.8	Develop stabilization inpatient capacity prior to placement in diversion programs			DRC does not support using state funding to expand the supply of locked inpatient capacity. The state should instead focus on expanding the supply of unlocked residential treatment programs, such as Social Rehabilitation, that can provide community-based stabilization for people experiencing more acute symptoms.
M.9	Provide funding to expand support services to increasing utilization of diversion and community based restoration for felony ISTs, 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 nonurgent 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, and diversion and treatment programs.			DRC supports the first two solutions: diversion program provider support/technical assistance and forensic peer support specialists. DRC would need to see additional engagement with community stakeholders (including people with lived experience of incarceration and mental illness, family members, and advocates) before endorsing an expansion of probation partnerships.

	• 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.			
M.10	Support individuals with serious mental illness remaining stable in the community 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			Support involving peers to advance the use of psychiatric advance directives. Would not support the expansion of the use of public guardians without the engagement of community stakeholders (individuals with lived experience of mental illness, incarceration, family members and advocates).
M.11	Explore alternative jail-based competency and community-based restoration contract models to support Sheriff's in subcontracting to community facilities for treatment rather than providing in-jail competency treatment.			Support this recommendation as long as the contracts are for existing beds.

M.12	Expediting assessment and treatment immediately upon booking of defendants with serious mental illness, including: • Completing universal behavioral health and suicide risk assessments and substance abuse screenings, and review of record 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. • 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			Support these solutions.

	for pre-trial release into treatment and services to provide a recommendation to the Jude 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 to: • Increase community providers and facilities willing to serve this population • Increase access to acute inpatient services for inmates under 5150s			Support these solutions.
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			DRC does not support allocating state resources towards easing the licensing processes for locked facilities like PHFs and MHRCs. DRC does support the state allocating resources towards easing the licensing and certification processes for residential treatment facilities such as Social Rehabilitation.
M.15	Revise DSH's Conditional Release Program (CONREP) Community Program Director Role and/or placement criteria to facilitate increased felony IST placement to CONREP and Diversion programs.			Support this solution.
	LONG TERM SOLUTIONS			

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 an 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 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.			Support these solutions.
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,			Support these solutions.

	• 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 supports (food and housing) post release, and • Capacity building for workforce, IT/data systems, infrastructure.			
L.3	Develop quality improvement oversight/peer review of court-appointed evaluators and their reports, 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			Support these solutions
L.4	Increase opportunities for alternatives to arrest and pre-booking diversion, including: • Mobile/non-police crisis response teams • Sobering or triage centers • Diversion centers including Federally Qualified Health Center models			Support these solutions.
L.5	Expand community treatment and housing options for individuals living with serious mental illness justice-involved individuals, including:			Support these solutions.

	• Provide dedicated funding to develop housing to support diversion, and community-based restoration • Provide incentives or flexible housing pool models for housing developers; providers of supportive housing; including peer-run organizations; and owners of rental units to create additional housing resources or provide operating subsidies or supports. 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 • 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: • Explore similar model to the Short-term Residential Therapeutic Programs models that serve children and youth whose • Explore similar licensing categories to those that support adults with developmental disabilities.			Support these solutions.
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 authorizations for release of information and MOU's. • 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			Support these solutions.

	• 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 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. • 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			Support these solutions.

	justice principles, motivational interviewing, assessing and mitigating dangerousness, implicit bias, and other culturally relevant competencies.			
	ADDITIONAL RECOMMENDED SOLUTIONS			
	Eliminate the requirement of a nexus between the defendant's mental disorder and the charged offense (see PC 1001.36(b)(1)(B)); for eligibility for diversion.			
	Establish a presumption of diversion eligibility if a person charged with a crime is declared incompetent to stand trial			
	Establish community-based treatment as appropriate in lieu of restoration for low-level felonies and not just misdemeanors (by expanding SB 317 (2021) to include PC 1170(h) felonies for which the maximum penalty is county jail rather than prison).			
	More entities—including CONREP, county behavioral health systems, and DSH (when it evaluates in the jail or admits to a DSH facility)—should have the obligation to evaluate and recommend candidates for mental health diversion. Such entities			

	should have adequate resources and capacity to do so. The State should also direct funding to county public defender offices to ensure they have capacity to evaluate candidates for mental health diversion programs.			
	The State should provide funding to counties explicitly directed for housing individuals who are participating in MHD. The State should permit individuals placed in DSH facilities to access funding for mental health diversion. This is currently prohibited.			
	State funding must actively incentivize - and avoid disincentivizing - the development and expansion of CBR programs. Specifically, the State should ensure additional funding for counties that are initiating new CBR programming without pre-existing infrastructure. The State should also not add onerous requirements to the acceptance of CBR funding (for instance, a requirement that counties assume responsibility of all people designated FIST or that counties with CBR			

	programs pay more than other counties for access to state hospital beds).			
	More entities—including CONREP, county behavioral health systems, and DSH (when it evaluates in the jail or admits to a DSH facility)—should have the obligation to evaluate and recommend candidates for community-based restoration. Where lacking, they should have adequate resources and capacity to do so.			