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**Incompetent to Stand Trial Solutions Working Group**  
**Tuesday, August 17, 2021 – 10:00 AM to 12:00 noon**  
**Discussion Highlights**

**1. Introductions & Opening Remarks**

Stephanie Clendenin, workgroup Chair and Director for the Department of State Hospitals (DSH), opened the Zoom meeting. She thanked members of the workgroup for dedicating their time to address the issue of the felony incompetent to stand trial (IST) population and thanked the members of the public in attendance, mentioning that comments and input would be welcome at the end of the agenda.

Stephanie Clendenin outlined that members from the workgroup will introduce themselves and then DSH leaders will provide a data overview.

Secretary Mark Ghaly from the Health and Human Services Agency (CHHS) expressed hope for finding short- and long-term solutions through this collaborative process with workgroup members that bring diverse experiences and perspectives. He posed the question of which patient and human-centered programs and strategies have already worked on a small scale across the state that can be expanded. He emphasized that Gov. Gavin Newsom has allocated \$75 million this fiscal year and up to \$175 million (depending on the solutions identified) ongoing toward this project. Ultimately a report of suggestions will be produced to Secretary Mark Ghaly and the Director of the Department of Finance.

Workgroup members introduced themselves. These members are:

- Stephanie Welch (Deputy Secretary, Behavioral Health, California Health and Human Services Agency)
- Nancy Bargmann (Director, Dept. of Developmental Services)
- Adam Dorsey (Program Budget Manager, Department of Finance)
- Brenda Grealish (Executive Officer, Council on Criminal Justice and Behavioral Health, Dept. of Corrections and Rehabilitation)
- Tyler Sadwith (Assistant Deputy Director, Behavioral Health, Department of Health Care Services)
- Brandon Barnes (Sutter County Sheriff)
- John Keene (San Mateo County Chief Probation Officer and President-Elect, Chief Probation Officers of California)

- Stephanie Regular (Contra Costa County Assistant Public Defender and Co-Chair, Mental Health Committee, California Public Defender Association)
- Michelle Cabrera, Executive Director, California Behavioral Health Association, who represented appointed member Veronica Kelley (San Bernardino County Behavioral Health Director and Board President) for this meeting, California Behavioral Health Directors Association)
- Josh Gauger (Legislative Representative, Administration of Justice, California State Association of Counties)
- Scarlet Hughes (Executive Director, California Association of Public Administrators, Public Guardians, and Public Conservators)
- Jessica Cruz (Executive Director, NAMI California)
- Pamila Lew (Senior Attorney, Disability Rights California)
- Francine Byrne (Judicial Council of California)
- Jonathan Raven (Yolo County Chief Deputy District Attorney)

Stephanie Clendenin introduced Karen Linkins (Principal, Desert Vista Consulting) who will serve as a facilitator for the workgroup throughout this process.

## **2. Ground Rules and Workgroup Process**

Karen Linkins reviewed ground rules including the goals outlined by the statute (generate ideas and solutions for the short, medium, and long-term and present these recommendations to CHHS and the Dept. of Finance by November 30, 2021) and the process for meetings (solution-oriented, no voting or providing oversight, brevity is appreciated, raise hand on Zoom to speak, can appoint one alternate per member). Full workgroup and sub-workgroups will meet at least monthly through November, all subject to Bagley-Keene requirements. Public comments can be spoken (two minutes max) or written.

## **3. Presentation: DSH Overview of Felony Incompetent to Stand Trial Challenges, Data, and Efforts**

Presentation and data were provided by Stephanie Clendenin, Chris Edens, and Dr. Katherine Warburton. DSH has been working to address this issue for over a decade and IST population is increasing. Dr. Katherine Warburton, a forensic psychiatrist, discussed the criminalization and over-institutionalization of people with mental illnesses and the corresponding rise in IST commitments.

Presentation highlights:

- DSH gathered national data in 2014 when they noticed IST referrals were starting to surge
- The percentage of state mental health spending nationally on forensic patients jumped in the mid-90s

- This is a national phenomenon and many states do not have the capacity to handle the influx of IST patients and many stay in jails, and many states face litigation (e.g., Trueblood v. Washington)
- Nationally there has been a 72% increase in the number of IST patients from 1999 to 2014, 74% increase in all forensic patients; California has nearly half of all forensic patients nationwide
- The pandemic has increased waitlist times
- California has been steadily been adding more beds, serving more IST patients but the county IST referrals continue to outpace these efforts.
- A University of California Davis study explored various possible explanations, key finding was a sharp increase in criminal history (number of prior arrests) in the population of people with psychotic disorders in the span of just a few years
- This rise of criminal charges corresponds with the rise of homelessness, as the majority of IST patients are homeless
- There is an underutilization of Medi-Cal mental health services for IST population
- DSH performed a nationwide survey to states, finding a majority of states are facing the same challenges
- 47% of ISTs were arrested due to factors associated with conditions of homelessness and untreated mental illness, not criminal intent, making them eligible for diversion
- IST commitments do not serve public safety interests, 70% of patients restored to competency by state hospitals are arrested again.
- About a quarter of IST referrals ultimately go to prison, less than 1% are committed to state hospitals as Not Guilty by Reason of Insanity, and a vast majority return to the county.
- DSH has focused their response strategy on increasing bed capacity (over 1000 beds in the last decade), improving and systems and processes, reducing length of stays, and pursuing legislative changes, including Mental Health Diversion and funding for the DSH diversion program (one-time \$100M investment over 3 years)
- The 2021-22 budget provides funding for further increases in capacity (including sub-acute capacity, Diversion, and Community Based Restoration)
- Effective in the 2021-22 fiscal year misdemeanor ISTs can no longer be referred to DSH for treatment.
- The 2021-22 budget also provides funding for DSH to conduct re-evaluation of competency for IST referrals waiting in jails over 60 days.
- Additional significant investments to invest in and build out the behavioral health care continuum and community care expansion are provided in the 2021-22 Budget Act.

Karen Linkins fielded questions from workgroup on presentation.

- Adam Dorsey asked why California represents 44% of forensic commitments nationwide, to which Dr. Katherine Warburton says they have several theories but no conclusive answer.
- Michelle Cabrera noted, via chat, that “One idea @Adam is that I know from exchanges with colleagues in other states that other states use their state hospitals VERY differently. In some states, any/most involuntary treatment, even those that would be considered a basic 5150/go to psych hospitals here, for example, are handled at the state hospitals. The populations served are different. I'm sure DSH has a perspective on this, but it was interesting to hear that in other states, they use their state hospitals for a different range of populations.”
- Tyler Sadwith asked, via chat, “What impact does DSH anticipate AB 1976 (Laura’s Law/assisted outpatient treatment) will have on IST admission/eligibility rates?”
- Dr. Katherine Warburton noted that the primary intervention of state hospitals is to provide treatment and stabilization through medication.
- A workgroup member asked if Los Angeles county will be able to present their community-based restoration program, to which Karen Linkins answered yes.
- Secretary Mark Ghaly asked about regional differences in IST commitments. Chris Edens answered that factors include available bed capacity in the counties and the varying justice and behavioral health partners involved across the different counties and whether there advocates amongst them for doing things differently.
- A workgroup member asked about Forensic Assertive Community Treatment, which Dr. Katherine Warburton indicated is a best practice that could be expanded.
- Stephanie Regular asked if DSH has seen a decrease in the number of civil commitments as the number of forensic commitments have increased, to which Stephanie Clendenin replied that they have seen increases in both commitment types.
- Chief Keene pointed out the variation in definition of common terms and data tracking practices and hopes to work toward greater standardization. He then asked about how recidivism is being defined with this population (e.g., recidivism as arrests or conviction) and if there are harm reduction efforts in place. Dr. Katherine Warburton said recidivism is arrests, and John said that may not be the best way to define it given how many arrests do not lead to anything.
- Sheriff Barnes emphasized the need for wraparound services to decrease recidivism.
- Michelle Cabrera pointed out the variation by county in how Behavioral Health services are funded and delivered, saying effective programs are county specific and need to be standardized and that housing assistance needs to be prioritized. She asked if trends have been disaggregated to see if any counties have seen felony IST commitments decrease to see where to look for effective strategies. Stephanie doesn’t believe any county has had a consistent decrease but will bring more data to the next meeting on this.

- Francine Byrne asked for a universal definition on homelessness, recidivism and other terms and Karen Linkins said that would be important to include.

### **3. Discussion on Assessment of IST Challenges & Opportunities**

Karen Linkins emphasized that solutions should improve lives, break cycles of criminalization, provide alternatives to state hospitalizations, and be actionable, sustainable, and measurable.

Workgroup thoughts:

- Francine Byrne pointed out the importance of keeping county and regional differences in mind.
- Michelle Cabrera urged the group to consider dedicated housing slots with a variety of housing available. She also brought up that County Behavioral Health can have public safety concerns about in-community restoration options and that county departments have additional costs per patient (e.g., transportation, etc.) compared to state hospitals.
- Adam Dorsey brought up resource constraints and that all ideas need to make sense fiscally. Karen Linkins added that they also need to be feasible in the allotted timeframe.
- Stephanie Regular agreed with Michelle Cabrera that housing is the top priority and mentioned that county run CONREPs increase the rate of community-based treatment. Sometimes the state and county CONREPs present conflicting opinions on diversion eligibility to the courts. Stephanie Clendenin said CONREP funding is being expanded and pointed out that CONREPs recommending against diversion and the state hospitals advocating for it may be a result of the timeline of when patients are being evaluated. Chris Edens agreed and talked about how quickly they are increasing diversion programs so there is not yet standardization between candidates. Stephanie Clendenin indicated that diversion candidates are not always stabilized but would need to be stabilized before diversion.
- Brenda Grealish discussed the difficulty of increasing service utilization without forcing people to access treatment.
- Jonathan Raven brought up the frustration of repeated misdemeanors by people with psychotic disorders and how their county does not feel like they have services to help them until they commit a felony. He asked about the role of Sheriff departments. Stephanie Clendenin talked about how high of a percentage of the IST wait list are not stabilized and sees opportunities for Sheriffs' departments in increasing the rate of stabilization through medication, often involuntary. Dr. Katherine Warburton raised how helpful it would be if these services could happen more quickly within counties. Jonathan noted that many Sheriff's departments are reluctant to engage with IMOs and wondered what percentage of Sheriff's departments are engaging these options. Sheriff Barnes proposed putting a poll out to other Sheriffs. He noted that in his personal experience, many inmates will take medication voluntarily after education.

#### **4. Public Comment: 15 mins**

Douglas Dunn, Mental Health Commissioner from Contra Costa County shared that the County has no capacity to house IST commitments. They do not currently have the funding to meet the aggressive timeline, and many other counties are in a similar situation.

Mark Gale from Los Angeles believes this problem cannot be solved without accountability. He says the IST population has been cycling through the system for years due to insufficient state resources and this workgroup should have formed years ago before the state invested in building new jails. He believes the vast majority of patients can be restored in communities once the right investments are put into place. He emphasizes that people cannot get well in jail and wonders what the long-term vision is.

Christopher Geiger asked, via chat, “In terms of reducing the felony IST waitlist what would be optimum community-based solution the workgroup would like to see become available (e.g., activation of community psychiatric inpatient programs with sufficient capacity to significantly impact the waitlist?), or alternative vision?”

Theresa Pasquini discusses her adult son with schizophrenia who was criminalized after going to Napa State Hospital. He was eventually diverted to an IMD. With another mom, she travelled the state looking at diversion options and wrote a report. Stephanie Clendenin says she can share a copy of the report with members. [See Appendix 2 with Ms. Pasquini’s follow-up email message as well as the report referenced.]

Stephanie Clendenin closes and mentions the next meeting time, August 31, 2021 from 3-5pm. She welcomes thoughts and comments submitted to the IST Solutions Workgroup. She reminds the workgroup that they can appoint an alternate if they cannot attend a meeting. She thanks the people behind the scenes, especially Diane Renee and Karen Linkins, for coordination and facilitation efforts.

## Appendix 1: Chat Transcript

From Karen Linkins to Hosts and panelists: Panelists — If you have specific questions, please enter them here. There will also be brief Q&A at the end of this presentation.

From Adam Dorsey to Hosts and panelists: One of the early slides indicated California had 44% of the forensic population (I believe it was). What are we doing to make that number so high relative to the rest of the country, or what are other state's doing that is making their numbers so low? I assume (based on later slides) there is a correlation to homelessness. But are there other factors to consider?

From Michelle Cabrera to Everyone: One idea @Adam is that I know from exchanges with colleagues in other states that other states use their state hospitals VERY differently. In some states, any/most involuntary treatment, even those that would be considered a basic 5150/go to psych hospitals here, for example, are handled at the state hospitals. The populations served are different. I'm sure DSH has a perspective on this, but it was interesting to hear that in other states, they use their state hospitals for a different range of populations.

From Tyler Sadwith, DHCS to Hosts and panelists: What impact does DSH anticipate AB 1976 (Laura's Law/assisted outpatient treatment) will have on IST admission/eligibility rates?

From Pamila Lew to Hosts and panelists: Will LA County's Office of Diversion and Reentry have a formal opportunity to present their community-based restoration program to the workgroup?

From Tyler Sadwith, DHCS to Hosts and panelists: Any experience or knowledge of local assertive community treatment programs specific to the forensic/CJ population?

From Stephanie Regular to Hosts and panelists: Have you seen a decline in civil commitments during the period of time that DSH has experienced an increase in forensic commitments?

From Pamila Lew to Hosts and panelists: Is the expansion of funding for diversion time-limited and does this represent a disincentive for counties to participate?

From Michelle Cabrera to Hosts and panelists: Agree with John's points about comparing apples to apples

From Jonathan Raven to Hosts and panelists: BSCC and State Probation define recidivism as convictions.

From John Keene to Everyone: Thanks Jonathan!

From Jonathan Raven to Hosts and panelists: Why only 11 new JBCTs? Is funding for these new JBCTs sufficient to incentivize sheriffs to have interest?

From Tyler Sadwith, DHCS to Hosts and panelists: Is DSH able to provide more detail about the MH service utilization data during the 6 months prior to arrest as represented on slide 20? For example, which data sources are included here?

From Michelle Cabrera to Hosts and panelists: Has DSH review how many DSH clients started out as Medi-Cal beneficiaries, or how many became Medi-Cal beneficiaries by virtue of their BH conditions going unaddressed, which then led to their becoming unsheltered homeless, etc.?

From Jessica Cruz to Hosts and panelists: Piggy backing on Michelle, each county should have housing available that has services for this population as they re-enter into the community to continue to heal. There are great solutions out there, but they are few and far between.

From Stephanie Welch to Everyone: Would be helpful to know how many counties have FACT programs and what their capacity is and if they are interested or willing to expand their capacity with future investments

From Francine Byrne to Hosts and panelists: Agree about the comment on evaluators. Finding qualified evaluators is very challenging in some counties.

From Tyler Sadwith, DHCS to Hosts and panelists: @ Stephanie agreed. In addition to addressing housing needs as Michelle has highlighted, scaling FACT seems like a key opportunity.

From Michelle Cabrera to Hosts and panelists: Agree with Stephanie that we need more alignment with our goals in the Conrep/Eval processes

From Brenda Grealish to Everyone: Echoing need for prioritizing/dedicating housing. We also need to address the issue of engagement in treatment. Individuals cannot (and should not) be "forced" into treatment, but "force" is not the only way to engage in / adhere to treatment. We should identify best practices for engaging these individuals into treatment, including the necessary training/TA for local entities implement these practices. This will be necessary to maximize success for housing placements.

From Jonathan Raven to Hosts and panelists: On that note (stabilization), how many sheriffs are willing to administer IMOs?

From Michelle Cabrera to Hosts and panelists: The IMO question is a good one.

From Michelle Cabrera to Hosts and panelists: Also, would note that Medi-Cal generally does not pay for outreach/engagement

From Michelle Cabrera to Hosts and panelists: So many of the "solutions" for getting folks treated and stable are funded outside of Medi-Cal services.

From Douglas Dunn to Everyone: I have a public comment. 1-2 minutes at most.



From Mark Gale to Everyone: My hand is raised, and I have a comment

From John Freeman to Mark Gale and all panelists: Thank you. We will get to you next.

From Christopher Geiger to Hosts and panelists: In terms of reducing the felony IST waitlist what would be optimum community-based solution the workgroup would like to see become available (e.g., activation of community psychiatric inpatient programs with sufficient capacity to significantly impact the waitlist?), or alternative vision?

From Teresa Pasquini to Hosts and panelists: I just raised my hand.

From John Freeman to Teresa Pasquini and all panelists: Thank you Teresa

From Siobhan King to Hosts and panelists: Alameda County agrees with Mr. Dunn, We need more housing desperately and probably more Assertive Case mgmt. services and wrap around services. We also are concerned that some folks really are best suited for LPS beds at Napa or other State Hosp. (no need to make public comment)

From Mark Gale to Hosts and panelists for the \$250 million for subacute FIST facilities. How many facilities and beds will that build?

From Michelle Cabrera to Hosts and panelists: On the points made by others about treatment capacity, investments in treatment need to factor in the co-occurring criminogenic needs of this population.

From Douglas Dunn to Everyone: When will new funding for facilities provided in the state budget be available to counties?

From John Freeman to Everyone: Thank you for these comments. Any additional comments may be sent to [ISTolutionsWorkgroup@dsh.ca.gov](mailto:ISTolutionsWorkgroup@dsh.ca.gov)

From Michael Lisman to Everyone: Solution recommendations: More affordable housing for very low-income individuals; more funding for severely underfunded licensed residential care facilities; more funding for FACT Teams; CONREP Teams; More Mental Health Rehab facility beds to meet the need when appropriate - currently extremely long wait times for all LPS clients. Better coordination between forensic and Behavioral Health; Improve laws that require some clients to accept treatment in the community after discharge.

From Michael Lisman to Everyone: To what extent does the voluntary nature of laws in California interfere with compelling individuals to participate in treatment, including medications once the individual is discharged from jail without any holds? Con Rep has been effective, but it isn't in place in all counties and doesn't apply to all discharged forensic clients.

From Michael Lisman to Everyone: Some issues that we face in California that could be contributing to the high numbers in our forensic population is that we have the highest number of homeless in the country and the cost of housing is out of reach for most homeless; as well as an increasing loss of licensed residential care facilities in which to

house individuals with increased needs for support due to their disabilities and challenges in functioning in the community. Could the increase over these past several years be due to these factors?

From John Freeman to Everyone: Again, all materials and information will be posted at the website: <https://www.chhs.ca.gov/home/committees/ist-solutions-workgroup>

From Chris Edens to Everyone: [ISTSolutionsWorkgroup@dsh.ca.gov](mailto:ISTSolutionsWorkgroup@dsh.ca.gov)

From Christopher Geiger to Hosts and panelists: Great job - especially for a first meeting!

From John Keene to Hosts and panelists: Great job hosting today! Looking forward to next steps!

## Appendix 2: Follow-up Email from Teresa Pasquini

Good morning,

This is a follow-up to my public comment at the August 17th meeting of the IST Solutions Workgroup. My name is Teresa Pasquini. I am a local, state, and national advocate for all who live heroically with severe mental illnesses. I am a lifetime resident of Contra Costa and served on the Contra Costa Mental Health Commission for 9 years (2006-2015). I was an original member of our county's MHSA Stakeholder group and a founding member of the Behavioral Health Care Partnership where I served as the Chair for 5 years and was a member of the Executive Team of Contra Costa Regional Medical Center. I also served on the Board of NAMI Contra Costa for two years and have been a long-time NAMI member. I currently serve as a Board Member of the newly formed Hope Street Coalition.

Most importantly, today, I am speaking as the proud mom of a Contra Costa County client who has been 5150d over 40 times, conserved by the Contra Costa Public Guardian's Office for 20 years, placed in multiple out-of-county placements, both locked and unlocked. As I stated in my public comment, my son was arrested as a patient, criminalized, deemed Incompetent to Stand Trial, and held in solitary off and on for 4 years before finally having all charges dropped after being diverted to a Mental Health Rehab Center in Merced County. That placement allowed him to recover, achieve medical and psychiatric stability and successfully transfer to a community placement in Santa Clara County where he has lived for two years. I am hopeful that he will one day be able to re-enter the Contra Costa community and receive the medically necessary and safety net protections that he needs to remain healed, housed, and healthy.

Because of my family experience, I began a journey in 2019 with another mom, Lauren Retagliata, in search of a place like home for families like ours. That journey was described in the Housing That Heals paper, [https://hth.tinet.com/Housing\\_That\\_Heals\\_2020.pdf](https://hth.tinet.com/Housing_That_Heals_2020.pdf), released in May 2020. Please see attached summary also.

The Housing That Heals paper, describes "Housing That Heals" as a system of care that wraps a person in all of the necessary medical, clinical, rehabilitative, and social supports they need in order to live and die in dignity. The paper describes how an LPS Conservatorship helped to free Danny from a solitary cell and a potential state prison sentence (p. 31\* and 52\*\*.) That involuntary medically necessary care also restored his stability, safety, and health allowing him to transition to an Adult Residential Facility in the community while remaining on an LPS Conservatorship. Housing That Heals is a system of care that provides the right care, at the right time, in the right place.

A question often heard in all state and local meetings for criminal justice reform is "divert to where and what?" Lauren Retagliata and I tried to answer that question in our Housing That Heals paper. The paper outlines the funding disparities for the Specialty MH population. Those disparities have simply not been adequately addressed in California for years. They cannot be forgotten now.

All stakeholders must understand that not everyone can be diverted from jail, a hospital bed, or involuntary treatment. However, there are promising opportunities such as this one that Lauren and I recently visited in Napa. We have shared this resource with our county partners. See this post for photos: <https://www.facebook.com/teresa.pasquini.3/posts/10215270987806576>. As described in the Gray Haven post, NIMBYism may prevent this amazing facility from expanding. This isn't stigma, this is discrimination. Discrimination is keeping this population from living in dignity and health and preventing housing solutions from being created. It must be addressed if we are to move IST alternatives from jails and scarcity to abundance.

We need a system of solutions that is flexible, funded, and full. We now have a system of care that is broken and incomplete for gravely disabled people who need treatment before tragedy. We must no longer cherry-pick which brain illness deserves a right to treatment and dignified housing or who is left to die on the streets with their rights on. Housing That Heals provides a road map that will meet the purpose of the IST Workgroup "to advance alternatives to placement in DSH restoration of competency programs."

Please remember my Danny when you are considering short, medium, and long-term solutions. He was not a throw-away human being. He was not just a "FIST" or a risk assessment number. He is more than a number. He is my son, a young man with a severe brain illness who needed help and hope. Because people literally thought outside of the box, he is now a survivor of solitary and suffering.

It is time to break the rules, shatter the status quo and redesign a system of care for families like mine in California. I have seen it happen. I know it is possible.

Thank you for your commitment to this critical issue.

Respectfully,

Teresa Pasquini, Danny's mom

### **"Heart Notes" from Housing That Heals paper released in May 2020**

#### **\*Housing That Heals page 31:**

Teresa's son, Danny, was sent to CPT in 2016 on a 1370 IST in a unique arrangement between Contra Costa County and the Napa Superior Court. Because Contra Costa had maintained Danny's LPS Conservatorship during a four-year effort to establish competency, the Napa Superior Court, in partnership with the DA, Public Defender, and CCC, agreed to send Danny to CPT instead of back to a state hospital. This freed up a state hospital bed and allowed Danny to go to a smaller, more therapeutic environment with a bed instead of a solitary cell. All criminal charges were eventually dismissed and the LPS

Conservatorship was maintained. Danny was still in an involuntary program but free to heal and stabilize. He needed to be in a locked facility for a period of time in order to learn life skills that allowed him to successfully transition to a community placement at Psynergy in 2018. CPT was the "least restrictive" care that allowed Danny to free himself from the symptoms and the broken California system of care. For 20 years, Danny and his family endured several acute hospital stays, PHFs, two state hospitals, many IMDs, MHRCs, and both small and Super Board & Care facilities. However, none were as successful as CPT. There should be a facility like CPT in every county. However, we need to stop federal, state, and local funding discrimination to make that happen. Some people think that people like Danny need to live in a state hospital for life. Not true. But people like Danny cannot live alone either without the right support and Housing That Heals. In Danny's case, CPT was the right level of Housing That Heals that allowed for his successful transition to a community placement.

**\*Housing That Heals page 52:**



Heart Note from Teresa My son had been in many IMDs but was unable to successfully sustain stability once in the community until the past year. We were told that the "best" IMD in California was California Psychiatric Transitions (CPT) in Merced County. BUT... we were told that it was a higher-cost contract that was not available unless you were only on Medi-Cal. We had maintained our son's private Kaiser Insurance as a disabled adult for 8 years and tried to support the horrors of juggling his private insurance and public LPS Conservatorship which often pitted one system against the other with our family stuck in the shuffle. So, we were encouraged to drop the private insurance in order to get our son access to CPT. He was placed at CPT twice, and both times were successful. The first time resulted in a failed transition due to the community placement's failure to provide my son's injection of anti-psychotic medication. This cost him a lot. He ended up being re-hospitalized and nobody would take him back. So, he ended up at Napa State Hospital as one of the small percentages of patients placed there on a civil, not criminal commitment. The medical care was not collaborative, the medications were wrong and my son ended up lashing out and was arrested as a patient. He was IST for four years, in and out of two state hospitals and solitary confinement in jail before being diverted back to CPT. He soared to success and stability on his second stay at CPT. He was given the perfect combination of medication, structure, and compassionate care, allowing him to graduate for the first time from an IMD and successfully transfer to a community placement at Psynergy, Inc. in Morgan Hill. For the first time in 20 years, he was given the right amount of time to stabilize and move through the CPT levels of care. He then transitioned successfully to the community through the Psynergy model of outreach and engagement. Danny has continued his recovery process at Psynergy for a year due to their on-site clinical, medical, and recovery supports. This is prevention, intervention, and person and family-centered, value-based care. Danny would not have survived solitary confinement in jail if he had not been provided the tiered levels of both CPT and Psynergy. I consider CPT to be the gold standard for IMDs in California. CPT was the least restrictive care at that time. A locked IMD is less restrictive and more therapeutic than a solitary jail cell. Psynergy is one of the few gold-standard ARFs in California. CPT is locked. Psynergy is unlocked. My son needed CPT in order to be accepted into Psynergy. Both are what I call "Housing That Heals" We need a both/and state of mind in California, not either/or. Medicaid should

pay for both if medically necessary. No one should be forced into solitary confinement and criminalized for their illness when there are models of less restrictive care that must be used, funded, and replicated.

*Appendix 3: Housing That Heals: Finding a Place Like Home for Families Like Ours*