Incompetent to Stand Trial Solutions Working Group
Work Group 1: Early Access to Treatment and Stabilization for Individuals Found IST on Felony Charges
Tuesday, September 21, 2021 – 1PM to 3PM
Discussion Highlights

1. Welcome and Introductions

Karen Linkins welcomed all attendees and announced she will be co-facilitating the meeting with Jennifer Brya and John Freeman. She thanked everyone for their dedication to this process and this population and for bringing their wide range of expertise to the table. She reminded the group to be solution-oriented and of the urgency of the work, noting the fact that there are currently over 1,700 people in jail awaiting treatment who have been referred. She reviewed the agenda and the work group goal, which is to identify short-term solutions to provide early access to treatment and stabilization in jail or via JBCTs in order to maximize re-evaluation, diversion, or other community-based treatment opportunities and reduce lengths of stays. She reviewed that the group, led my chairs Dr. Katherine Warburton and Dr. Melanie Scott, will produce concrete recommendations that will be included in November's report. Karen asked members to introduce themselves with their name and organization. All members were present except Kirsten Barlow. The members in attendance were:

- Deanna Adams, Senior Analyst at Judicial Council of California
- Elise Deveccio-Cavagnaro, Consulting Psychologist at the MediCal Behavioral Health Division of the Department of Health Care Services
- Brenda Grealish, Executive Officer at the Council on Criminal Justice and Behavioral Health
- Paige Hoffman, Staff Services Analyst at the Council on Criminal Justice and Behavioral Health
- Kristopher Kent, Attorney for the Department of State Hospitals
- Karen Larsen, Director of Health and Human Services for Yolo County
- Stephen Manley, Superior Court Judge of Santa Clara County

- Farrah McDaid Ting, Senior Legislative Representative for the California State Association of Counties
- Christy Mulkerin, Chief Medical Officer for the San Luis Obispo County Sheriff's Office
- Kim Pederson, Senior Attorney at Disability Rights California
- Dawn Percy, Deputy Director for Department of Developmental Services
- Jonathan Raven, Chief Deputy for Yolo County DA's Office, representing statewide association
- Stephanie Regular, Assistant Public Defender for Contra Costa County, representing statewide association
- Marni Sager, Manager at the Department of Developmental Services State Operated Facilities Division
- Cory Salzillo, Legislative Director at the California State Sheriff's Association

2. Goals of this Working Group

Karen Linkins reminded group members that while there is overlap between the subjects of different working groups, it is helpful to try to stay in the bounds of this one when discussing ideas. The purpose of the Working Group is to discuss solutions, not provide oversight, and the report with recommendations is due by November 30, 2021. She asked members to be brief and raise their hand on Zoom to speak. She asked that the Zoom Q+A feature not be used by workgroup members unless they need assistance with technical issues, but noted the chat is available for both working group members and members of the public in attendance to ask questions after the presentation.

Karen Linkins said the goal of today's meeting is to understand the current challenges associated with early access to treatment. She introduced the co-chairs Dr. Katherine Warburton and Dr. Melanie Scott to present on this topic.

3. Overview of Issues to Address and Q+A

Presentation: "The Case for Early Access to Treatment" by Dr. Katherine Warburton and Dr. Melanie Scott

Katherine Warburton said her aim with this presentation is to provide necessary context for the next presentation on San Luis Obispo. Presentation highlights:

- Slide on the history of state hospital over utilization:

- In 1850, <2,500 patients in state hospitals, then called asylums., These asylums were built for the delivery of human moral treatment, after an era of people with SMI being terribly mistreated in the community.
- Number of patients rises to 150,000 by 1905 and over half a million by 1955; severe overcrowding without budget or infrastructure updates which gained infamous reputation that eventually forced reforms ("deinstitutionalization"—development of medications and closings of hospitals)
- In 1923, Penrose coins term "Balloon Theory" in his research that shows that higher numbers of people in mental health institutions means less people in correctional institutions and vice versa
- In 1972, practitioner notes that as a result of deinstitutionalization, former state hospital patients are being arrested at high rates
- In 1988, research by Arvantites highlights the potential of IST commitments as alternative to civil hospitalization
- In 2010, Torrey reports in paper that more mentally ill people are in jails than in hospitals

- 74% increase of forensic patients in state hospitals and 72% increase of IST patients between 1999 and 2014. 2014 marks beginning of current crisis

- Trueblood v. Washington (2015) instructed that FISTs must receive restoration services within specific timeline, while meanwhile the state has seen a near doubling of referrals. California faces the same problem and COVID posed further capacity issues.

- DSH has steadily increased IST capacity in hospitals but it has not sufficed
    - 3900 patients served in 2014 vs. >6000 in 2019
    - Referrals doubled between January and July 2021

- 30% increase over 5 years period in admissions with 15+ prior arrests

- Majority of IST admissions were experiencing homelessness at time of arrest

- Nearly half of IST admissions had received no mental health services in last 6 months; most common service for those that did was emergency services

- National survey findings showed widespread need for more mental health services (crisis and ongoing), community inpatient beds, and ACT services

- Showed details of one IST arrest as case study

- DSH Diversion Program began 2018 with $100M (one time investment over 3 years) to increase diversion opportunities for people on waitlist; currently partnering with 24 counties
    - UC Davis report found 47% of individuals on waitlist are likely eligible for diversion
    - Only 11% of diversions through the program (424 total) were from IST waitlist
    - Survey of Diversion Program partners found that the primary barrier to diversion is that majority of waitlist patients are too psychiatrically unstable to qualify

- IST recidivism (rearrest) rate after competence restoration is around 70%

- About 25% of IST patients go to prison after discharge, rest back to communities

- During COVID, DSH implemented waitlist re-evaluation program using Telehealth, working with individual counties
    - UC Davis researchers found that 40% of re-evaluations determined competency, usually as a result of administering anti-psychotic medication
    - About 17% refused evaluation, usually because of psychotic symptoms

- Currently, system functions as repeating cycle (unsheltered and untreated leads to arrest, leads to jail, leads to hospital placement, leads to return to community, where they are unsheltered and untreated)
    - Treatment needed at every point in this cycle

Katherine Warburton asked members to hold their questions until the end of all presentations.

Presentation: Dr. Christy Mulkerin

Karen Linkins thanked Katherine Warburton and introduced Christy Mulkerin, Chief Medical Officer for the County of San Luis Obispo's Sheriff's Department, to present on the work their county is doing. Presentation highlights:

- SLO county jail is "medium sized" (500-600 people, less during COVID)

- Started jail-based competency program in 2019 with 5 beds (number determined by DSH based on waitlist)

- Obtained designation as a treatment facility, which allowed them to administer IMOs with court permission

- Created larger housing unit that contains JBCT

- Uses state hospital model of incentivizing behavior (taking medication, hygiene, etc.)

- Dramatically reduced waitlist

- Also started a mental health diversion program, but those that most needed it were least likely to be candidates due to stabilization difficulties

- Worked closely with DSH during COVID as waitlist grew and jail believed they could not legally use IMOs for people not yet admitted to the program. With DSH's help they discovered this was not true and worked with the courts to broaden wording of IMO orders so waitlist patients can have IMOs enforced.
    - This has helped with restoring competency and increasing number of people eligible for diversion

- 20-25% of their overall jail population has serious mental illness

- Katherine Warburton asked how IMOs are enforced and Christy Mulkerin responded that usually the IMO itself is enough to motivate someone but when that is insufficient, it is done by the sergeant after discussion with the patient on days when the most mental health staff is present which has been the case for 50-100 patients total

Christy Mulkerin said she is happy to connect members to resources for help navigating this in their own counties.

Q+A

Karen Linkins fielded questions from group members:

- Farrah McDaid Ting asked what the transition is like after someone has been in the JBCT for 90 days and has been medicated. Christy Mulkerin said there is no single answer because it is coordinated between the jail's psychologist and the state hospital and depends upon bed availability. There is a state hospital within SLO county so some patients go back and forth but generally the state hospital is not utilized, only when necessary because of acuity or waitlist times. Usually if someone is unrestorable in the JBCT, the same is true in the state hospital.

- Melanie Scott added that, in the research literature on IST, psychotropic medication is one of the primary treatments necessary. The most successful JBCTs (highest rates of restoration and shortest lengths of stay) are the ones that use IMOs.

- Cory Salzillo asked Katherine Warburton if the statistic of 75% of discharges that are returned to counties can be broken down to show how many people are essentially serving sentences in county jails vs. reentering communities. Katherine Warburton

said she does not have this number but based on the 70% recidivism rate she assumes most are reentering communities.

- Cory Salzillo asked Christy Mulkerin for recommendations for counties without JBCTs seeking to get IMOs from courts. She replied that a JBCT is not required for IMOs but strong support and coordination between departments (Sheriff, Behavioral Health, etc) is helpful in communicating to the court that obtaining IMOs is necessary. She said they may face resistance, and persistence is necessary. SLO was greatly helped through working with DSH. Cory asked if there was any pushback from labor in the Sheriff's office, to which Christy replied no since it was a welcome change to reduce cell extractions.

- Karen Linkins read a question from the chat from Mark Gale, who asked about the difference in daily activities between JBCT inmates and other inmates and if the only difference is IMOs. He also asked for an explanation about "the packet." Melanie Scott answered that JBCT treatment consists of four hours/week of group education about medication, courts, news, etc. There are also recreational events and weekly meetings with psychiatrists and meetings with psychologists at least monthly that include competency assessments and discovering barriers to competency. The entire JBCT treatment team meets regularly. Some smaller counties only do individual treatment and not group education and there are other variations based on size. Christy Mulkerin said she thinks "the packet" refers to the treatment manual. Melanie Scott explained that the manual addresses different treatment and education modules. Some JBCTs are run by subcontractors as opposed to counties. DSH provides consultation and training when counties are building their JBCTs and treatment manuals.

- Brenda Grealish provided suggestions about how to spread information about IMOs to more counties, such as a statewide technical assistance tool-kit, information about how successful models were built, and best practices for implementation strategies.

- Stephanie Regular asked Dr. Mulkerin what their JBCT is doing differently from state hospitals, besides diversion, to help break the cycle of people transitioning back into communities without care. She responded that she has limited information on this but that one difficulty is that release happens on the same day when charges are dropped. They have done some work to improve transitions including increasing coordination with the Public Defender's office to get more information about what the court is planning, beginning reentry planning sooner, providing people reentering with 30-day med supplies, and trying to coordinate with recovery homes where applicable. The JBCT discharge planner does most of this work. She added that she believes they are underutilizing long-acting medication because it is newer, expensive, and cannot be used for IMOs. She said there is more work to be done on reducing recidivism.

- Stephanie Regular asked Melanie Scott to clarify conflicting information about whether or not IMOs reduce lengths of stay. Katherine Warburton answered that it is hard to compare IMO and non-IMO patients because they have different levels of decision making capacity, so this data is difficult. Melanie Scott clarified that her previous comment (that Stephanie Regular inquired about) was that medications were an important component in *competency restoration*, she did not say IMOs specifically reduced *length of stay*. In response to Ms. Regular's previous question about JBCTs and breaking the cycle, Dr. Scotts stated that JBCTs allow for a quicker entrance into receiving services which can aid in cycle breaking. Stephanie Regular asked if there is data on rates of recidivism in JBCT vs. DSH discharges, to which Melanie Scott replied that she would look into it.

- Karen Linkins read a question from the chat from Tyler Rinde, who asked what percentage of JBCTs in the state do not have IMOs from courts. Melanie Scott answered that 2 JBCTs out of 22 total in the state do not have IMO programs.

- Karen Linkins read a question from the chat from Mark Gale, who asked Christy Mulkerin what percentage of people in their JBCT program are deemed too dangerous to be diverted to community restoration programs. She replied that for felonies, nearly all inmates are referred to inpatient (usually JBCT) rather than community-based programs. The community diversion numbers are higher for misdemeanors but not significantly, though there is an intensive community mental health treatment program that is different than restoration, and has been utilized very successfully. Katherine Warburton added that they reviewed the waitlist for diversion eligibility and believed that 45% would be eligible if they were first stabilized on medication.

- Judge Manley asked what percentage of people in SLO's JBCT are taking medication involuntarily at any given time. He also asked why the program is 90 days long and not shorter to move people into diversion more quickly, since jail is usually a traumatic setting. He said he has not seen a difference in severity of mental illness between misdemeanor arrests and felony arrests and doesn't see why all of these individuals cannot be eligible for community diversion. Christy Mulkerin said she may have misspoken because the typical length of stay in the JBCT is under 30 days and once competency is restored, they are sent back to court and are considered again for diversion. They also try to divert as many people as there are beds before entrance into the JBCT program. Public defenders have Dual Track Program (doubt has been declared and they are considered for diversion simultaneously) which is a new model and allows an IMO to be secured sooner. The primary reason more people aren't diverted is because of the housing shortage. Regarding the question about IMO percentage, it is about one out of 20 patients. Katherine Warburton adds that the primary barrier statewide to diversion is people not being stabilized on medication.

Karen Linkins said that remaining questions from this chat will be documented in the meeting notes and addressed at a future time as there is not sufficient time to address them now.

4. Discussion of Short-Term Strategies

Karen Linkins moved the group into a discussion about strategies and asked the group (and members of the public in the chat) to think about short term solutions today that could be implemented by April 1, 2022. Medium term solutions, which should not be prioritized today, have an implementation timeline of January 10th, 2023. She reminded the group that Brenda Grealish already made one suggestion of a statewide guidebook describing best practices with IMOs. Work group members shared ideas:

- Judge Manley suggested that the earliest intervention that can be made is a mental health assessment and review of their record and behavioral health history. He also suggested that DAs and Public Defenders show up at the jail after an arrest to determine next steps, since someone should not be kept in jail in the instance that a decision has already been made about not filing charges. He said the courts move too slowly and this process can be expedited if steps are taken before the court is even involved with the ultimate goal of putting less people in jail.

- Brenda Grealish responded to Judge Manley's point and mentioned that CalAIM Enhanced Care Management is designed to do some of that outreach in jails. She said she thinks that about 70% of people are out of the jails in 3-5 days from when they are booked, and she is unsure how Judge Manley's suggestions would be accomplished in that short time period.

- Karen Larsen agreed with Judge Manley's suggestion of expedited mental health evaluations. She said Brenda Grealish was right about the 70% of individuals being held briefly (3-5 days) so these evaluations should happen at the time of booking.

- Mark Gale, a member of the public and member of Judge Manley's mental health subcommittee, said he has heard that many DAs and judges are uncomfortable with community-based restoration even though there are successful models such as in LA County. He said he believes that sending people to state hospitals and JBCTs is not geared toward long term planning. He said there needs to be a conversation about people's risk to public safety that is based on something statutory rather than the biases that exist currently. He suggested that people who pass that assessment could be stabilized on medication (IMO or voluntarily) at a community-based restoration program and perhaps this shift could cut the waitlist down significantly. He said the primary problem is the state's lack of investment in county mental health resources. He discussed what he has heard from parents of the people being discussed and concluded that jail should never be the default.

- Deanna Adams said that some counties will get reports from evaluators that state the individual would likely be stabilized on medication, but when the evaluator is a psychologist rather than a psychiatrist, they cannot write that prescription. She suggested a system be implemented that would connect those competency evaluators

to clinicians who can write medication orders to expedite treatment. Karen Linkins asked anyone who may have information on a program like this submit resource materials to ISTSolutionsWorkgroup@dsh.ca.gov to share with the rest of the group.

- Karen Linkins reminded the group that the final recommendations must be grounded in literature or research as well as have their budgets mapped out and a plan for how efficacy will be measured.

- Stephanie Regular said that short term solutions are hard because a paradigm shift on how mentally ill people are treated in the criminal justice system is required. She said that she does not think stabilization in jail is a solution and it must happen elsewhere. Ms. Regular asserted that hospitals are much more effective than JBCTs for her clients. She agreed with previous commenters that early identification and intervention is important and perhaps evaluators should be required to provide a diversion recommendation along with their competency report.

- Kirsten Barlow of NAMI CA asked if any counties are using the MHSA Full Service Partnership continuum of services because most ISTs were unhoused and not accessing county mental health services at the time of arrest, making them perfect clients for FSP programs. This stream of MHSA funding comes from taxes on millionaires. Karen Linkins asked if this is a short- or medium-term goal, to which she replied that MHSA welcomes proposals throughout the year and maybe they could also address services related to housing that Medicaid does not cover. Karen Linkins said this sounds like a medium-term goal.

- Christy Mulkerin stated she agreed with Stephanie Regular that jail is not where treatment should occur but that solutions that jails can implement should still be suggested. She asked if the work group could come up with a statement of intention that we do not condone the arrest and criminalization of people with mental illness, but we do have recommendations for individuals with SMI who are currently sitting in jails and need treatment. Dr. Mulkerin reiterated that IMOs helps with medication compliance, which helps with restoration and connection to treatment. She agreed with Brenda Grealish's suggestion of a toolkit because while jail is not the proper setting, it is the current setting for many individuals and recommendations for how jails can increase access to treatment are needed.

- Cory Salzillo added to the suggestion of a guidebook from the state that provides information to treatment providers in jail and court officers around the competency declaration process and where people end up being referred, as that could potentially result in a reduction of the waitlist.

- Brenda Grealish agreed that jail is not the proper setting but given that is the workgroup parameter, she is thinking about solutions in that context. She seconded Kirsten's suggestion of looking into what role FSPs can play in supporting this

population with connection to treatment given the flexibility in using FSP funds. She said more behavioral health infrastructure is needed and investments are being made in that arena. She responded to someone in the chat who asked about the connection between FSPs and acute care and said that the idea is to have options available along a continuum of care for different needs.

- Farrah McDaid Ting suggested increasing the number of county-based restoration programs beyond the 22 that currently exist. She stated that one challenge of implementing community-based options is the reluctance of providers to take on patients with criminal justice histories.

- Michelle Cabrera said she has seen data showing that FSPs are a highly effective intervention in lowering arrest rates among other factors. She acknowledged that the funding can be somewhat volatile since it is tied to present economic conditions (Prop 63 Millionaire's tax) rather than public demand. Ms. Cabrera also noted that FSPs can only do so much without sufficient corresponding housing slots and that more housing investments need to be made by the state.

- Jonathan Raven said that his DA's office in Yolo County agrees that jail is not the right place for these individuals as they are sitting in jail for 23 hours a day, often decompensating. He further stated that JBCTs are important for public safety interests. He stated that many individuals have multiple misdemeanors prior to their first felony, and that early intervention could prevent felonies.

Karen Linkins asked the group to show up to the next meeting with two solutions in mind as well as what resources they would require and how their success would be measured. She requested that the group members not discuss these with each other ahead of time outside of one on one conversations as that would be a Bagley-Keene violation. She encouraged people to email their questions and comments.

5. Call for Public Comment

Karen Linkins opened the floor to public comment through either raising hands in Zoom, commenting in the chat, or emailing:

- Mark Gale said that in both conversations about short term and long term solutions, it is important to focus on the needs and experiences of the clients (i.e., not getting appropriate community-based care, in cycle of homelessness and incarceration). He said that the group should be looking at how the mental health system failed these people. Were they unable to access acute care or conservatorship? He said releasing people into voluntary treatment is rarely effective. He has seen people who need stabilizing medication be placed in JBCTs without IMO programs rather than in state hospitals where IMO are enforced. He suggested that psychiatrists in the jails should be part of deciding where someone is placed to avoid this.

Meeting Wrap Up and Next Steps

Cory Salzillo asked Karen Linkins to review the homework assignment again for the next meeting, which she did. Each member is to come with two short term solutions that they are ready to propose to the group and an idea of what resources they require. She said it is fine to repeat things brought up in today's meeting.

The next meeting for this work group will be September 28th from 1-2pm and the one after that will be October 26th from 1-3pm. The conversation will primarily be focused on short term solutions but they will move into discussing medium term and perhaps even long term solutions as well. Karen Linkins reminded the group that all working group meetings are subject to Bagley-Keene rules and the minutes and agenda will be posted on the website.

Appendix 1: Chat Transcript

From John Freeman to Everyone:
Email: ISTSolutionsWorkgroup@dsh.ca.gov
Web Site: https://www.chhs.ca.gov/home/committees/ist-solutions-workgroup

From John Freeman to Everyone:
We've opened the chat to allow participants to enter questions here. Working group members, please continue to raise hands and participate verbally

From John Freeman to Everyone:
Questions from Mark Gale:
State hospitals have a more formalized program for restoration. What are the daily activities of a jail inmate in JBCT compared to other jail inmates? Is the only difference the IMO? Please explain "the packet?"

From Tyler Rinde to Everyone:
I think Dr. Scott quickly touched upon that there are JBCT programs that do not universally have from the court/utilize IMOs-- is there data on how many programs/ beds there are across the state that fit into this bucket? Thank you

From Mark Gale to Everyone:
Thank you very much

From Mark Gale to Everyone:
Yes, it did and appreciate the detailed explanation

From Mark Gale to Everyone:
What % of your JBCT inmates/patients would be considered too aggressive or dangerous to restore competency in a community-based restoration program.

From Mark Gale to Everyone:
jail vs. community

From Linda Mimms to Hosts and panelists:
JCBT programs are definitely a humane response to sick people in jail cells but we need a robust continuum of care in our communities with warm handoffs and supervision to help people continue and achieve lasting recovery. Does DSH have an advocacy arm to push for reform in our state laws to allow quicker compassionate involuntary medication and/or temporary conservatorships at the beginning of the psychotic symptoms before criminal justice involvement?

From Mark Gale to Everyone:
Stabilization and the lack of community placements that are appropriate. Thank you Dr. Warburton

From Teresa Pasquini to Hosts and panelists:
Thank you Judge Manley!

From Linda Mimms to Hosts and panelists:
Because we do not have the resources in the community.

From Tracy Weyer to Hosts and panelists:
just to be clear - JBCTs do 4 hours of group treatment daily, not weekly.

From Michelle Cabrera to Everyone:
County behavioral health has reported that we have two areas where we're challenged around getting folks into diversion programs: evaluators (not referring) and courts/DAs (not comfortable with diversion or community based restoration). I would argue that you are the exception, Judge Manley, and it shows in your county's relatively lower referral rate. We have whole diversion programs that county BH has stood up, and we can't get referrals in some regions of the state.

From Teresa Pasquini to Hosts and panelists:
The common comment often heard is “divert to where and what?” This is why I wrote Housing That Heals. We must focus on the full continuum of care and housing if we are going to bend the humanity curve.

From Julie Enea to Everyone:
How can we get better access to ALJs?

From Linda Mimms to Hosts and panelists:
I would add a clinician at the initial assessment including outreach to the family who know the person’s history.

From Linda Mimms to Hosts and panelists:
I would suggest an education program for all law enforcement, jailers, judges, DAs, PDs, on what serious mental illness is and how to spot symptoms.

From Linda Mimms to Hosts and panelists:
Our ultimate goal is proper healthcare for people with no-fault brain diseases — not treatment in jail but in appropriate therapeutic environments like any other organ based illness.

From Linda Mimms to Hosts and panelists:
I agree, Stephanie. There are no short term solutions unfortunately.

From Linda Mimms to Hosts and panelists:
Most of these crimes would not occur if the illness was treated promptly upstream.

From Linda Mimms to Hosts and panelists:
Thank you, Dr. Mulkerin.

From Mark Gale to Everyone:
How will FSPs solve the treatment problem if the population comes from individuals who really need acute and sub-acute care?

From Mark Gale to Everyone:
In other words, let's identify who these individuals are and why did the mental health system fail them in the first place?

From Mark Gale to Everyone:
I don't think they come from FSP dropouts

From Michelle Cabrera to Everyone:
@Mark - How often have these individuals been failed by commercial plans that don't treat and allow psychosis/SUDs to decompensate to the point of homelessness/disability. They come to county when they are then at their sickest and dealing with homelessness and other challenges. This is anecdotal since by the time they come to us they're often already Medi-Cal eligible, but know there are plenty of clients who do not come from Medi-Cal families, based on the personal narratives that are out there, and the stories of family members.

From Mark Gale to Everyone:
Excellent point Michelle