

**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 28, 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 said that today's meeting will dive into exploring detailed solutions for the short, medium, and long-term. She reviewed the agenda and noted that questions that were submitted since the last meeting will be addressed. She also reviewed 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.

Karen Linkins asked the co-chairs, Dr. Katherine Warburton and Dr. Melanie Scott, to introduce themselves first and then for all other members to introduce themselves. She requested that non-members in attendance introduce themselves in the Zoom chat with their county and affiliation. All members were present except Kirsten Barlow. The members in attendance were:

- Co-chair Katherine Warburton, Forensic Psychiatrist and DSH Medical Director
- Co-chair Melanie Scott, Assistant Chief Psychologist at DSH
- Deanna Adams, Senior Analyst at Judicial Council of California
- Francine Byrne, Principal Manager in Criminal Justice Services at the 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
- Brandon Barnes, Sutter County Sheriff, representing California State Sheriff's Association

2. Recap Goals of this Working Group

Karen Linkins reminded group members that while there is overlap between the subjects of the three different working groups, it is helpful to try to stay in the bounds of this one when discussing ideas. She asked members to point out overlap in their ideas where it arises. She reminded the group that their purpose is to discuss solutions, not provide oversight or spend much time discussing context or individual experiences. 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 and share ideas. Questions and ideas can also be submitted via email.

3. Recap of Last Meeting's Highlights and Discussion of Strategies

Co-chair Dr. Katherine Warburton provided an overview of highlights from the last meeting:

- Co-chairs gave a data focused presentation showing the process of criminalization of the people currently on the IST waitlist and the people cycling through state hospitals due to mental illness and being unsheltered.
- DSH initiatives to disrupt the cycle have included diversion programs, which faced barriers, and a re-evaluation program for patients in jails that tries to connect people to treatment.
- DSH conducted a survey to try to identify barriers to successful diversion, which found that the primary obstacle statewide was levels of psychiatric instability that were too high for diversion into community programs. The second and third most identified barriers were insufficient suitable housing in county programs and confusion around county programs' ability to use IMOs, respectively.
- Awareness around the need for diversion has increased and the diversion work group is trying to tackle these barriers.
- Rates of IMOs for IST patients committed to state hospitals vary widely between counties across the state, from 0% to 100%. She emphasized the importance of IMOs for stabilization and diversion.

Dr. Christy Mulkerin summarized her presentation from the last meeting:

- SLO county has been able to secure IMOs from courts
- SLO county started JBCT with 5 beds (number determined by DSH based on waitlist)
- Able to medicate people before admittance to either JBCT or state hospital, which has decreased the rate of decompensation and increased diversion eligibility and restoration to competency
- In collaboration with DSH, courts, and county mental health, they have been able to safely implement IMOs and uses of force are incredibly rare

Karen Linkins asked if there were any initial questions about the presentations, which there were not. She opened the discussion about strategies and asked the group to laser in on short and medium-term solutions that could be implemented by April 1, 2022 and January 10th, 2023, respectively.

Karen Linkins read questions submitted by Kim Pederson and posed them to the group. The first question was about what barriers counties are seeing that prevent people from taking medication orally, with or without IMOs.

- Jonathan Raven said that for his county it was Sheriffs being unwilling to use IMOs.
- Brandon Barnes said that it is not necessarily unwillingness and there are other factors that influence the decision. He said more education needs to be done on the benefits of JBCTs.
- Farrah McDaid-Ting said some barriers include the need for medications to be administered safely, which requires workforce capacity, and the fact that jails must be designated as treatment facilities. Both of these things require resources, which is particularly challenging for smaller counties.
- Karen Larsen said she understood the question to be about why people aren't taking medications voluntarily. She said it is because they are gravely disabled to the point of being unable to voluntarily accept medication.
- Christy Mulkerin agreed with Karen Larsen and added that people being off their medications is often what led to the crime they were incarcerated for and they continue to refuse medication. She disagreed with someone in the chat that lack of access to psychiatrists who will prescribe medications is a primary barrier. She suggested that the main barrier is that some forms of mental illness make it hard for people to trust their healthcare providers.
- Melanie Scott agreed with Karen Larsen and Christy Mulkerin. She said that UC Davis and DSH have done research that showed that close to half of patients were homeless when arrested and often not connected to services, and therefore were not medicated.
- Deanna Adams replied to Christy Mulkerin's comment about the availability of psychiatrists and said that she had heard from some counties that that has been a primary issue in securing IMOs.

Karen Linkins read Kim Pederson's second question, which asked in what percentage of cases people are refusing medication and counties do not enforce IMOs and what is driving this phenomenon.

- Christy Mulkerin said that in her experience, the steps for enforcement are not in place in many counties due to reluctance and overwhelm. She said the push needs to come from the top of the county to get all necessary stakeholders on board. If there is not county wide agreement that IMOs are beneficial, there is nothing that the jail can do.
- Melanie Scott added that DSH often hears confusion about which statute to use (Penal Code 1369.1 or 2603) may play a role. She asked if the Sheriff's departments could speak to which one they use. She agreed that people often refuse medication as a result of psychosis and there is nothing aside from IMOs that jails can do.

- Kim Pederson thanked the group for answering these questions. She said she has represented hundreds of clients in inpatient settings including jails and understands the importance of medication in competency restoration. She vocalized concern about the focus on IMOS and said that since jails with IMOs have broad success with getting patients to take medications voluntarily through conversation and education, she did not see why that could not happen instead of having to go through the IMO implementation process of injecting medication.
- Katherine Warburton said that it is very rare that medication is involuntarily forced in state hospitals. She said that IMOs are primarily used as conversational tools to indicate that someone needs to take their medication after they say they do not want to. She said that when paired with relationship building with that person, this is effective in convincing them take their medication. She said that a barrier for many counties is the sense that IMOs are inhumane but they are usually just a conversation and shots are extremely rare. She added that state hospitals have been able to restore the majority of their patients through medication and diversion partners are unlikely to accept patients without stabilization.
- Melanie Scott agreed with Katherine Warburton and added that conversations with patients include very detailed discussions about benefits and risks of medication. She said that patients experiencing extreme psychosis are in medical emergencies and unable to make decisions and since patients with other types of medical emergencies like diabetic shock are medicated, it needs to be an option for these patients as well.
- Christy Mulkerin agreed with Katherine Warburton and Melanie Scott. She said that when she started working on IMOs she thought it always involved force. She said that it is very difficult to engage patients who have been unmedicated and some may start to take medication after engagement with mental health staff but do not do so consistently. In her opinion, IMOs are an effective tool to restore people to the point that they can make decisions for themselves again. She sees patients taking medication as a spectrum from those who do it entirely voluntarily to those who require involuntary injections with the vast majority of patients falling in the middle.
- Brandon Barnes said that Sheriff education is necessary. He reminded the group that different counties have very different levels of medical resources in their jails. He said the type of rapport required to have the kind of conversations that Katherine Warburton and Melanie Scott referred to take resources that not all counties have. He said that long term solutions are not in county jails but short-term solutions are robust JBCTs with support from the state.
- Jonathan Raven clarified that by unwillingness by Sheriffs he meant lack of education around the process. He reiterated that this education is crucial.

Karen Linkins read the third question from Kim Pederson, which was about the difference in challenges experienced by large vs. small counties and urban vs. rural counties.

- Brandon Barnes replied that as a small county, one county north of Sacramento, it comes down to resources. They are aided by proximity to a city but counties further north struggle to find psychiatrists. He said that even in urban areas, there might be insufficient psychiatrists to meet the level of need.
- Kim Pederson thanked everyone again for answering her questions.

Karen Linkins fielded questions and input from people in the chat:

- Julie Enea shared that her county (Contra Costa) has been working on IMOs for a long time and passed a resolution designating their jail as a treatment center. They got the county to pay for a court psychiatrist who can recommend IMOs because the court psychologist will not make this recommendation. They have come up against barriers in the 1370 process around being unable to find ALJs and also face the barrier of cultural opposition to jail-based treatment.
- Christy Mulkerin said that while she agrees with others that these patients should not be in jail, the opposition to it functions as a barrier to create any treatment programs at all in jails because people want to see the state hospitals making room for patients instead.
- Stephanie Regular replied to Julie Enea and said that the question is not if people in jail should receive treatment, but how long should jail be the setting and is it really an appropriate setting. She said that the argument that treatment must be provided in jails since that's where people are functions to keep people and resources in jails instead of elsewhere. She said the question is where the money should be funneled and when thinking about the long-term, JBCTs do not break the cycle they are trying to break and do not accomplish getting people into sustained treatment. She said that not everyone should be at state hospitals but there is a lack of diversion alternatives, and the long-term solution is to create those alternatives.
- Brandon Barnes agreed with Stephanie Regular on her suggestion for a long-term solution but said there needs to be more programming on the front end to address homelessness and addiction before people enter jails.
- Stephen Manley said more engagement needs to happen with community treatment resources because they are reluctant to accept IST placements. He said more coordination needs to happen between the jails and these providers because they are not motivated to take on these patients.
- Brenda Grealish said that Community Infrastructure Grants should be considered in thinking about how to build community treatment capacity. She said that in addition to behavioral health infrastructure, housing capacity must be expanded.

- Jonathan Raven agreed that JBCTs alone are not solutions and community treatment expansion through DSH grant money is necessary. He advocated for stabilization in jail and then diversion into community.
- Stephanie Regular added to Judge Manley's points and said that to address the problem of county behavioral health not accepting diversion placements, regional community-based treatment programs should be established. She said creative solutions need to be established for alternatives to returning patients to jails when things don't go well. The models could perhaps look at LA's CBR program and replicate it across the state. Regional treatment would address the problem of people moving between counties and losing their county MediCal so county don't accept them into diversion.
- Farrah McDaid-Ting agreed that there is a large problem with providers declining IST placements, which she pointed out is not always the counties' faults as many providers are private companies or non-profits. The same phenomenon happens with refusing MediCal patients. She pointed out that for the county-to-county issue that Stephanie Regular raised, MediCal will eventually transfer but it takes 30 days and more work needs to be done with county eligibility people on this. She pivoted and pitched several solutions to the group from her team:
 - Technical assistance from the state with increasing the use of IMO's in jails
 - Increasing the use of long term injectables to more effectively move people into longer term community treatment. She specified that she meant injectables for both psychosis and substance use.
 - Prioritize community treatment and diversion and incentivize diversion placements through letting patients keep their spot on DSH's waitlist. She pointed out that one of the hesitations from the courts and DSH for diversion is that diverted patients lose their waitlist spot.
 - Improve discharge planning process from state hospitals
- Elise Devecchio suggested enhanced care management and MediCal pre-release application management, which are part of the DHC's CalAIM proposal. These programs would provide coordination between medical staff and non-clinical social services prior to and upon jail release with the goal of keeping vulnerable patients out of jails. Enhanced care management goes beyond care coordination and monitors services. The pre-release application mandate is an enhancing tool and the mandate of a standardized procedure to get patients on the track to pre-release by will be rolled out by 2023. She said the goal is for all individuals in need of services to have a referral and linkage to county behavioral health. For outcome measurement, recidivism could be looked as well as percentage of people in community-based treatment. The budget is not yet finalized. She agreed with the suggestion for more technical assistance on IMO's and suggested this could happen through an expansion of DSH direct care service provision by psychiatrists as a short-term goal. Karen Linkins asked her to email any writing on these proposals.

- Stephanie Welch replied to Elise Deveccio that she wants to make sure these solutions are in reach and pre-release to address the current waitlist, and if that is the case she thought it was a great solution. She asked Farrah McDaid-Ting about if counties can mandate contracted providers to accept a certain population of patients and if not, what incentives could be provided to contractors by the state aside from just money.
- Farrah McDaid-Ting replied that requiring that of providers would take mutual agreement and counties cannot just amend those contracts. Stephanie Welch asked about success stories in this area and what incentivized providers. She replied that providers' main hesitancy is taking people with assault charges because they require more supervision which means more cost. Safety is a concern as well expressed by providers, which understanding helps with. She said incentives like higher rates can be effective or the creation of specialized facilities but moving a lot of people from jail to locked facilities doesn't fix this. She said there is disagreement around who (county, DSH, etc) is responsible for patients when they are in treatment.
- Brenda Grealish offered to share her team's proposal on technical/training assistance around IMOs. Their concept is for an IMO QA project (IMOQIP=IMO Quality Improvement Program) beginning with a statewide survey and research on the best practices from the results. From there, educational webinars and a toolkit would be developed, based off another CCGBH project. This toolkit would be used to conduct training and provide technical assistance and quality improvement resources. She suggested that information on the use of peers in IMO implementation as well as long lasting injectables could be incorporated as well as information on transferring patients into diversion. She proposed that DSH contract with subject matter experts on IMOs to conduct this plan. Counties would commit to participation in the program as part of a DSH grant program. Most of the spending would be on the front end and outcome measurements could be created based on the project design.
- Stephanie Regular said she appreciated Elise's suggestions as Public Defenders have to start from scratch when clients lose their MediCal and SSI upon entering a jail. She suggested expanding diversion funding so that counties still receive funding when individuals are diverted within 90 days of entering a state hospital, so as to reduce lengths of stay in hospitals and get people back into the community instead of back into jails. She emphasized the difference between stabilization in jails and stabilization in treatment facilities. She noted that in her county, DSH was largely able to get people to consent to medication without IMOs, which is not the case in jails.
- Brandon Barnes said it would be helpful if the state fiscally supported Sheriffs subcontracting. He gave the example of a new private 24hr mental health facility in his county that he wanted to subcontract with instead of building a JBCT, but the state refused to fund that.
- Judge Manley brought up the idea of pay per success among community providers and said it has worked well in his county to provide much better support to patients.

He emphasized that they should do all they can to keep people out of jail and they should implement a mental health co-occurring substance abuse screening at the time of booking to determine the course of treatment at the front end rather than waiting months. He also stressed the need for better discharge planning. He said that if a DA and PD review cases each day of all patients who are determined to be mentally ill, the DA could determine who they would not be filing charges against and release those people, then treatment plans and supervised release could be arranged for people who charges will likely be filed against, and delays could be largely eliminated. As a long-term solution, he suggested a triage/sobering center funded by infrastructure grants and staffed by BH who could find longer term placements from there as an alternative to booking people into jail.

- Jonathan Raven agreed with Judge Manley's suggestions and said Yolo county is working on a version of a triage center now. He suggested, like others, an educational campaign of training and technical assistance around IMOs. He also suggested a DSH grant be started for housing to support community diversion.
- Kim Pederson agreed with Judge Manley's suggestions. She suggested the need for peers hired by counties throughout the criminal justice system, and specifically to keep people engaged in treatment inside of jails. Data shows this is highly effective. Peers would also be useful outside of jails, helping with transitions and resource connection.
- Brenda Grealish said she did a site visit at a triage center in Sacramento that officers could take people to instead of to jails. They offer to connect people to a variety of treatment and are currently looking for CalAIM funding.
- Cory Salzillo vocalized that all stakeholders are doing the best they can with the resources they have. He emphasized the urgent need for short-term solutions and said that people will continue to end up in jails so jails and Sheriffs will continue to play a role and JBCTs have been successful in restoration. He agreed with the need for education and help around IMOs. He also requested tools and technical assistance for Sheriffs on when and how to declare doubt.
- Katherine Warburton said DSH can immediately (and already have started to) do technical assistance county by county, as well as consultations and reevaluations for anyone on the waitlist to assess diversion eligibility.
- Deanna Adams said she limited her ideas to the period people are physically in jails. She suggested expanding technology and Telehealth for medication determinations including IMOs to address the barrier some counties face of insufficient access to psychiatrists. She brought up Judge Manley's suggestion from last minute on time frame limits for evaluations and agreed with him as she said it may help people get stabilized on medication quicker.

4. Call for Public Comment

Karen Linkins opened the floor to public comment:

- Mark Gale said that he understood that in the general work group, public comment happens at the end, but he thought that the three subgroups were going to have more engagement with the public and opportunities for input. He said that this group has not been in line with that. He suggested that the long-term success of any solution depends upon reducing the number of individuals entering the waitlist in the first place through the state committing money to building more mental health treatment facilities, both inpatient and outpatient, as the reason why people are ending up in jails is because people have not received treatment. He emphasized that JBCTs are not long-term solutions. He said there are lots of options not being explored, including using MHSA money and AOT to build community supports. He mentioned in response to a previous comment that jails and IMDs are not the same thing and he was disturbed that that was suggested, as his son has spent time in both. He said the group needs to construct a budget for expanding diversion options.
- Karen Linkins and Melanie Scott thanked Mark Gale for his comments. Melanie Scott reminded the group that DSH is the end of the line for patients in the system.
- Farrah Mcdaid-Ting apologized for making an equivalence between jails and locked treatment facilities. She said she was trying to emphasize the need for community-based alternatives to locked facilities.
- Michelle Cabrera addressed the question of contract provision and mentioned that BH markets are quite different than physical health markets, mainly because many insurance companies still don't cover mental health treatment and there are federal laws that prohibit reimbursement for larger treatment centers. She emphasized that the system failure is a collective one. She described that part of the problem with turning away patients is the ability of clinicians to engage therapeutic milieu. She suggested that it is important to hold commercial plans accountable and focus on early interventions before people enter the justice system and face further discrimination due to a criminal record.

5. Meeting Wrap Up and Next Steps

Karen Linkins thanked the group for their focus and detailed suggestions. She described the homework assignment to be completed by next meeting, which is to help populate the tables of proposed solutions with contextual details (problems they are addressing, metrics, budgets).

The next meeting for this work group will be October 26th from 1-3pm. The conversation will primarily be focused on specifics and prioritization of solutions, including what connections exist between strategies and touching on long-term solutions. 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. She encouraged everyone to email with ideas and questions.

Katherine Warburton said DSH is available any time to partner with counties to provide treatment to waitlist patients. Melanie Scott thanked the group.

Appendix 1: Chat Transcript

From Connie Draxler to Everyone:
Connie Draxler, LA County Public Guardian

From Debra Buckles to Everyone:
Debra Buckles, Stanislaus County Public Guardian

From Samona Taylor to Everyone:
Samona Taylor, Deputy Attorney General

From Jennifer Brya, DVC to Hosts and panelists:
Jennifer Brya, DVC

From Christopher Geiger to Hosts and panelists:
Christopher Geiger

From Jeremy Oliver to Everyone:
Jeremy Oliver, Kern County Aging & Adult Services Department

From Tyler Rinde to Everyone:
Tyler Rinde, Senior Policy Advocate, County Behavioral Health Directors Association

From Lindsay Schachinger to Hosts and panelists:
Lindsay Schachinger NAMI and family member

From Nina Hoang to Everyone:
Nina Hoang, Dept of Finance

From Christopher Geiger to Hosts and panelists:
Christopher Geiger; Liberty Healthcare Corporation, based in San Diego

From Mark Gale to Everyone:
Mark Gale, Criminal Justice Chair, NAMI Greater Los Angeles County

From Jose Chew to Everyone:
Jose Chew, Legislative Analyst, Los Angeles County, Chief Executive Office -
Legislative Affairs and Intergovernmental Relations Branch

From John Freeman - Desert Vista Consulting to Everyone:
Email: ISTSolutionsWorkgroup@dsh.ca.gov

From John Freeman - Desert Vista Consulting to Everyone:
Website: <https://www.chhs.ca.gov/home/committees/ist-solutions-workgroup>

From John Freeman - Desert Vista Consulting to Everyone:

Questions under discussion:

What are the circumstances that are preventing people from taking medication orally, either with or without an IMO? For example, is it that some county jails don't have psychiatrists to write the prescriptions? Do some counties not have access to the medications? What are other barriers?

A lot of attention has been paid to difficulties in enforcing IMOs. In approximately what percentage of cases are people actually refusing medications and counties are not enforcing the IMO? What are the reasons for this?

How do the challenges differ between large and small counties? Urban and rural counties?

From Mark Gale to Everyone:

Let me be frank. This should not come as a surprise. It is because the patients refuse medication.

From Julie Enea to Everyone:

Barriers for our county are lack of psychiatrist vs. psychologist to recommend IMO to the judge - court cannot afford psychiatrist; lack of ALJs - no capacity statewide; and culture that resists treatment in a jail facility and considers it "inhumane"

From Julie Enea to Everyone:

I wasn't referring to psychiatrists available to write prescriptions. I was referring to getting an IMO order to accompany a DSH commitment.

From Mark Gale to Everyone:

Anosognosia-lack of insight

From Julie Enea to Everyone:

We have trouble getting the court to order an IMO.

From Julie Enea to Everyone:

PC 2603 proceeding requires a psychiatrist to make the IMO recommendation. Our court cannot afford a psychiatrist. County is providing on the County dime, but court will still not order IM.

From Julie Enea to Everyone:

1370 hearing requires an ALJ for medication hearing. No ALJs available.

From Mark Gale to Everyone:

If the patient finally agrees because of the IMO, are they generally given medication orally or with a LAI?

From Samona Taylor to Everyone:

On September 30, 2021 and on October 7, 2021, DSH is hosting a Sheriffs Town Hall event to discuss the changes in law the creation of Welfare and Institutions Code section 4335.2 has brought about. The purpose of this new program is to help reduce the growing waitlist of Incompetent to Stand Trial (IST) individuals pending placement to a state hospital through early identification of individuals in county custody who have already been restored while awaiting placement or are not likely to be restored, so that individuals can be returned to court more quickly, as well as earlier identification and referral of individuals who may be eligible for diversion or other community-based services.

From Christopher Geiger to Hosts and panelists:
Are the Sheriff's town halls virtual?

From Christopher Geiger to Hosts and panelists:
Stephanie - I work with experienced and qualified developers of inpatient facilities, including facilities that could house and provide treatment services to FIST and/or MIST clientele in locked facilities. If your county is interested in developing the same, I would be interested in helping and hearing more. Cgeiger555@gmail.com; 707-344-6429

From Michelle Cabrera to Everyone:
I would be happy to take this question as well.

From Michelle Cabrera to Everyone:
It's higher cost, but it's also liability. The demand is so high for BH services right now, and even commercial beneficiaries lack access, so there's quite a bit of cherry picking among providers, but part of it is managing high-risk beneficiaries.

From Stephanie Welch, CHHS to Hosts and panelists:
thanks for the insights

From John Freeman - Desert Vista Consulting to Everyone:
Go ahead, Brenda!

From Christy Mulkerin, MD to Hosts and panelists:
to add to what Stephanie is saying - can the funding be "protected" in a way so that the eligible people have to come from the DSH waitlist? (to make sure that the group we are talking about are benefiting)

From Mark Gale to Everyone:
Thank you Sheiff Barnes for thinking outside the box

From Christy Mulkerin, MD to Hosts and panelists:
to add to Judge Manley's suggestion of a stabilization center - do we think 23 hours is long enough to stabilize these patients?

From Stephanie Welch, CHHS to Hosts and panelists:
Good suggestion Judge!

From Edens to Hosts and panelists:
Hi Sheriff Barnes - I didn't catch your suggestion. Would you mind sending it in?
Thanks!

From Brandon Barnes to Hosts and panelists:
no problem. Which email should I send it to?

From Karen Linkins, DVC to Hosts and panelists:
ISTSolutionsWorkgroup@dsh.ca.gov

From Edens to Hosts and panelists:
ISTSolutionsWorkgroup@dsh.ca.gov

From Mark Gale to Everyone:
great ideas from Judge Manley

From Michelle Cabrera to Everyone:
CBHDA agrees with Judge Manley's recommendation for a different approach here: immediate screening, fast treatment, and discharge planning upfront.

From Mark Gale to Everyone:
Will anyone from the public ever get to make comments?

From John Freeman - Desert Vista Consulting to Everyone:
Public comment will be at the end of the meeting. Please feel free to provide via chat as well.

From Michelle Cabrera to Everyone:
The longer folks with psychosis go without treatment, the more likely they are to become treatment resistant/unrestorable, which makes the case for the idea that we need to prioritize early access to treatment if individuals are going to be in the jail. In particular, the population that ends up in jail may already be on a path to treatment resistance. It's important to mitigate that.
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4336920/>

From Stephanie Welch, CHHS to Hosts and panelists:
Incredibly constructive recommendations, thanks everyone. I have to run to another meeting.

From Tyler Rinde to Everyone:
Michelle's comment above reinforces the need highlighted by Judge Manley for universal screening and referral for mental health and substance use disorder conditions at booking using validated tools such as brief jail mental health screening.

From Lindsay Schachinger to Hosts and panelists:
Yes!!

From Farrah McDaid Ting (CSAC) to Hosts and panelists:
I apologize to Mr. Gale for the "disturbing "comment." I simply meant to draw an equivalence to a locked facility as opposed to community based treatment. Again, my apologies.

From Mark Gale to Everyone:
Apology accepted.

From Christopher Geiger to Hosts and panelists:
Again, there are several property developers that are qualified and presently gearing up to afford facilities for IST clientele in or near major metropolitan areas throughout the state

From John Freeman - Desert Vista Consulting to Everyone:
Agendas and meeting materials will be posted on the IST Solutions Workgroup webpage at <https://www.chhs.ca.gov/home/committees/ist-solutionsworkgroup/>