

**Incompetent to Stand Trial Solutions Working Group
Work Group 2: Diversion and Community-Based Restoration for Felony
ISTs**

**Friday, September 24th, 2021 – 10M to 12PM
Discussion Highlights**

1. Welcome and Introductions

Karen Linkins from Desert Vista Consulting 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, medium, and long term strategies to implement diversion and community-based restoration programs. She stated that the goal of the group is to produce concrete recommendations that will be included in November's report. Recommendations should include considerations of costs, funding sources, statutory changes, and trackable metrics. Karen asked members to introduce themselves with their name and organization. She also invited members of the public to introduce themselves in the chat. All members of the working group were present except Jessica Cruz and Marni Sager. The members in attendance were:

- Co-chairs: Katherine Warburton, Forensic Psychiatrist and DSH Medical Director, and Stephanie Welch, Deputy Secretary of Behavioral Health at Health and Human Services
- Francine Byrne, Principal Manager of the Criminal Justice Services Office at the Judicial Council of California, representing the Council along with subject matter experts Judge Stephen Manley and Deanna Adams
- Steven Kite, COO of NAMI CA, standing in for Jessica Cruz
- Dr. Sarah Desmarais, Sr. VP of Policy Research Associates, present as a subject matter expert and trained as a Forensic Psychologist
- Elise Deveccio-Cavagnaro, Consulting Psychologist at the MediCal Behavioral Health Division of the Department of Health Care Services

- Anita Fisher, Member of Council on Criminal Justice and Behavioral Health, NAMI Leader
- Neil Gowensmith, Associate Professor at the University of Denver, Former State Director of Forensic Mental Health for Hawaii, Private Consultant for mental health systems
- Brenda Grealish, Executive Officer at the Council on Criminal Justice and Behavioral Health
- Cathy Hickenbotham, Council on Criminal Justice and Behavioral Health, working on diversion program
- Tony Hobson, Behavioral Health Director for Plumas County, Clinical Psychologist, CCGBH Council Member
- John Keene, Chief Probation Officer in San Mateo County, representing state association
- Dr. Veronica Kelley, Behavioral Health Director for San Bernardino County, President of the County Behavioral Health Directors Association
- Kristopher Kent, Attorney for the Department of State Hospitals
- Pamila Lew, Senior Attorney with Disability Rights California
- LD Louis, Assistant District Attorney for Alameda County, Head of office mental health unit, representing California District Attorneys' Association
- Farrah McDaid Ting, Senior Legislative Representative for the California State Association of Counties
- Dawn Percy, Deputy Director for Department of Developmental Services
- Jonathan Raven, Chief Deputy for Yolo County DA's Office, representing statewide association
- Gilda Valeros (late joining due to technical difficulties), Supervising Attorney for Santa Clara County's Public Defender's Office
- Scarlet Hughes, Executive Director of the California State Association of Public Guardians and Conservators, subject matter expert on conservatorship

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. She said it is helpful to point out overlap where it is identified. She reminded the group that their purpose is to discuss solutions, not provide oversight or necessarily come to consensus. 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 give input.

Karen Linkins said the goal of today's meeting is to understand the current challenges associated with diversion. She introduced Dr. Katherine Warburton to present on this topic.

3. Overview of Issues to Address and Q+A

Presentation: "The Case for IST Diversion" by Stephanie Welch and Dr. Katherine Warburton

Katherine Warburton said her aim with this presentation is to make a case for robust diversion programs for people deemed IST. 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. Awaiting data on past 7 years.

- 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.
 - In CA, 2900 referrals in 2014 and 4500 referrals in 2019. Currently over 1700 on waitlist.

- 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
- UCD research by Dr. Barbara McDermott has shown 30% increase over 5 year period in admissions with 15+ prior arrests
- A majority of IST admissions were experiencing homelessness, many unsheltered, 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 report of three IST arrests as case studies and pointed out that they require treatment rather than incarceration
- Recidivism rate for this population after competency restoration is around 70%, so public safety needs are also not being met
- About 25% of people deemed IST go to prison after discharge, while the rest go back to communities or county jails
- Core issue identified by DSH is that increasing numbers of people with schizophrenia spectrum disorders are unsheltered and untreated, leading to contact with law enforcement
- 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
- DSH Diversion target population:
 - Diagnosed with a schizophrenia spectrum disorder
 - IST or have the potential to be found IST
 - Relationship between charges and disorder and/or conditions of homelessness
 - “Does not pose an unreasonable danger to public safety”
- DSH Diversion Program began 2018 with \$100M (one time investment over 3 years) to increase diversion opportunities for people who meet the above criteria and people on waitlist; currently partnering with 24 counties
 - UC Davis report found 47% of the current waitlist is likely eligible for diversion
 - Only 11% of diversions through the program (424 total) were on waitlist

- Survey found that primary barrier is that majority of waitlist patients are too psychiatrically unstable to qualify for diversion
- DSH currently funding 820 diversion slots
- During COVID, DSH implemented waitlist re-evaluation program using Telehealth working in partnership with individual counties
 - UC Davis researchers found that 40% of re-evaluations determined competent, usually as a result of medication
 - About 17% refused evaluation, usually because of psychotic symptoms

Katherine Warburton turned over the floor to Stephanie Welch who noted:

- With this work group, DSH wants to improve diversion processes and better support counties and community-based options
- Solutions suggested today must be short term and focused on the 1700 people currently on the waitlist

Katherine Warburton asked policy experts, Sarah Desmarais and Neil Gowensmith, to share initial thoughts.

- Neil Gowensmith said California has a solid foundation of data to inform recommendations. He said that while he will try to focus on addressing the current waitlist, funneling people into diversion before they enter the waitlist is important as well, which DSH has already had some success with. He referenced data that shows that the primary barrier to diversion is public safety concerns, so it is important to develop support structures that monitor, manage, and house patients with a pathway established to transfer patients to a higher level of care when necessary. Psychiatric teams report that the primary barrier to diversion is getting people stabilized and perhaps telehealth can play a helpful role in getting people on the waitlist medicated. He suggested that these cases be triaged to prioritize people with severe needs for hospital admission and those with lower levels of need are given increased services. He emphasized that community resources such as housing supports, psychosocial services, and restorations options are crucial in getting people stabilized. He added that a good communication network between stakeholders is necessary in building strong support structures. He also suggested that statutory adjustments for enhanced civil commitments may be useful.
- Sarah Desmarais agreed that fears about public safety are the primary barrier and said that robust risk assessments are the solution to this. She added that more work needs to be done generally to de-stigmatize mental illness. She said that enhanced diversion programming should focus more on higher risk individuals as lower risk people are able to be diverted without needing as many supports. She again agreed with

Mr. Gowensmith that communities require monitoring systems as well as increased resources, which requires education as well as funding. She added that wrap around resources are a lot more intensive than many communities understand.

Q+A

Karen Linkins facilitated questions from group members:

- Farrah McDaid Ting asked how long people spend in diversion slots once diverted. She also asked about for clarification of which counties were participating in diversion and which counties are just adding people to the waitlist. She also suggested that more information be provided to the group on how IMOs function and their impact on stabilization. Katherine Warburton responded that for diversion, DSH funds two years of intensive services and then hopes people are moved into a lower tier of services such as FSPs. Regarding stabilization, she said it is currently a problem that people who have methamphetamine induced psychosis are being diverted into mental health treatment when they need SUD treatment, given there are other people in greater need of mental health treatment. DSH has adapted the requirements somewhat to allow for people with more/unspecified diagnoses to be diverted, but all people diverted must now come from the waitlist. There are a few hundred slots available currently that they are looking to fill.
- Tony Hobson said that his county (Plumas) has a small diversion program, but their primary issue is that they do not have authority to obtain and implement IMOs. The second main issue is a housing shortage that limits diversion options. With these combined factors, they are unable to move anyone off the waitlist. Stephanie Welch asked for clarification on what he meant by “housing,” as she considered the level of care needed for diversion to fall under a different category, such as “facilities” rather than “housing.” He clarified that in his county, they have a diversion program with 10 cabins and wraparound services, including therapy and vocational services. The program is very effective for the people it serves but the capacity is nowhere near large enough to serve the number of people who need it. He said the rhetoric coming from the state feels like it is unfairly blaming counties when in reality, funding (AB 109) is funneled into probation and Sheriff’s departments rather than County Behavioral Health.
- Veronica Kelley seconded Tony Hobson’s call to emphasize housing needs. She said there are housing supports being funded but those are not going to this population. She predicted high levels of pushback from counties on finding this population permanent supportive housing. She asked that counties be able to use behavioral health infrastructure funding for building housing and shelters without having to go through a lengthy grant process. She emphasized that it does not make sense to do IMOs and then release people to live unsheltered on the street. She mentioned also that the discharge planning processes in hospitals is insufficient because outpatient providers are not receiving the necessary information, including diagnoses.

- Francine Byrne asked if there is data on what crimes constitute the high recidivism rates. Katherine Warburton said she will ask the research team what information they have on the charges but to keep in mind that the charges do not provide the type of picture that the arrest report does, and often portrays an inaccurate picture of criminality. A common charge is a misdemeanor paired with assault of an officer. Sarah Desmarais asserted that most of the recidivism are low level crimes, and it would not make sense to assume those crimes wouldn't happen. She said the thinking needs to focus on measuring dangerousness. Neil Gowensmith said that the data nationwide reflects that most of these crimes are nonviolent and low level.
- John Keene also warned against giving the 70% recidivism statistic too much weight as it often works against expanding diversion eligibility. He advocated for redefining recidivism because the impressions people have are inaccurate. Measuring arrests does not speak to public safety in the same way convictions do. He agreed that the low-level offenders often do not need the same type of intensive treatment and it is important to funnel services to people who need them most, even when the outcomes on paper aren't as good. He echoed calls for increased state funding for building housing. Katherine Warburton said they consider recidivism through arrests rather than convictions because IST commitments happen pre-conviction. She shared the data to point out how restoration at state hospitals is not breaking the cycle. John Keene said he understood that and wants to make sure people's perception of the problem and population is accurate. Katherine Warburton said in response to the housing piece that this process will take service providers from every point in the IST cycle coming together. She mentioned that Stephanie Welch will be devoting a meeting of the diversion work group exclusively to discussing housing.
- Jonathan Raven asked DSH representatives what percentage of the waitlist is in counties without DSH diversion grants. Katherine Warburton said she will get him that data but does not believe there is a correlation. Chris Edens added that counties with contracted diversion programs are the ones with the highest number of referrals, as many of those are large counties.
- Stephanie Welch brought up how many different points of view (e.g., public defenders, county behavioral health, etc.) are represented in this working group and said that the solution will come from everyone doing something rather than a few entities doing everything. Karen Linkins clarified that right now is still time for questions then they will move to discussing barriers.
- LD Louis suggested that IST diversion programs take felony probation violations for technical violations as well as misdemeanor crimes. She mentioned that their program only takes placements from the wait list and the people at risk of being IST are supported by the Behavioral Health Court. She requested that the accepted diagnoses category be expanded to include Schizophrenia Spectrum Disorder, as they have had to turn those people away and would have otherwise been able to fill all their slots. She said that her county is not following the law in 4011.6 and the county has a policy of not involuntarily medicating people but also will not 5150 someone unless they

pose a danger. She wants her county (Alameda) to send people who need it in for 72 hour observation where they can be medicated. She suggested that perhaps 4011.6 needs to be revised, to not limit to DTS/DTO but also include those who are gravely mentally ill. She asked if DSH looks at how many 5150s people have had and if they were receiving any community-based services prior to arrest. She also asked what quality control assessments and measures are in place for community-based services. Katherine Warburton said that DSH recently did expand the diagnosis category to include Schizophrenia Spectrum Disorder. She said that her memory of the data is that 5150 rates have declined while arrests have increased but she will find the specific information and send it over. LD Louis asked to distinguish 5150 admissions from police 5150s, as she has seen a pattern in her county of officers holding people for only a few hours then releasing them. Katherine Warburton said data shows that officers' decisions to bring someone to jail or the ER are primarily based on if they believe beds are available and there has been a large decrease in available beds since the 90s (CA has 17 per 100k people while the recommendation is 50).

- Karen Linkins requested that the discussion shift to suggesting solutions to barriers.

4. Discussion of Short-Term Strategies

Work group members shared ideas for solutions:

- Gilda Valeros said that a key barrier to diversion is that the courts want reports from psychologists/psychiatrists with diagnoses and treatment recommendations. She asked if DSH doctors can provide this type of report with recommendations for lower tiers of care to avoid releases to the street. She also suggested that the court alienists could be trained and make these recommendations at the time of IST evaluation. She advocated for expanded funding to community behavioral health programs and structural changes in DSH to improve continuity of care because county case managers lose track of people when they are found IST. Behavioral health needs additional 90-day funding to be able to track those patients and coordinate on step down approaches. She also said there is a need to collaboratively fund regional programs because people move between counties. She added that making a distinction between public safety and patient care is inaccurate, and those ideas should be unified as different stakeholders are defining risk very differently. She referred to Judge Manley's statements and said that many counties don't understand that they have authority to force medication with IMOs and are overly reliant on 5150 rubrics; they should be educated about what they are able to do regarding IMOs under Penal Code 1370.
- Anita Fisher said she is not only speaking as a CCJBH member but as a family member with a schizophrenic son, and someone who has run a family support group through NAMI. She said that in her experience, the criminal justice system doesn't know what to do with families of IST. She said she supports involuntary medication outside of jail and hospital settings to maintain people's path to recovery and reduce people entering the prison system. Katherine Warburton agreed with her. Stephanie Welch asked for discussion to focus on solutions for the people on the waitlist.

- Tony Hobson responded to comments about 5150s and said that even when someone meets the criteria for 5150s and Penal Code 4011.6, hospitals do not want to accept inmates. He said there needs to be pressure put on hospitals to take these people and maybe that would reduce the waitlist.
- Jonathan Raven agreed with Gilda Valeros and Tony Hobson. He said that failure to implement IMOs is a major issue, and their county (Yolo) is just starting to implement them. He suggested that an educational campaign for Sheriffs, led by DSH and representatives from Sheriff's departments in this group is needed. He seconded what others said about needing increased funding from DSH for housing.
- LD Louis discussed that when people are not restored to competency they are sent back to jails and her county jail does not use IMOs in accordance with a decision from the Board of Supervisors. She suggested DSH coordinate with public guardians or community service providers to do a warm hand off into a bed at another treatment facility. This may help recidivism rates even though it will take more resources on the front end. She also mentioned that some licensed Board and Care facilities are shutting down in response to a regulation change. She asked that DSH examine the licensing provisions and see if requirements can be changed to support these types of facilities to remain open as options for diversion; this would also help reduce recidivism and homelessness.
- Veronica Kelley agreed with calls for increased infrastructure funding to build better systems of care. She said it is essential to align licensing bodies because they are not coordinating well which makes it very difficult for people to navigate bureaucracy when trying to set up Board and Care homes.

Karen Linkins said it was time to move to public comment but that these ideas and the questions and ideas from the chat will appear in the minutes and be further addressed next meeting. She asked the group to show up to the next meeting with two actionable short- or medium-term solutions that address the needs of the 1700 people on the waitlist.

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:

- Douglas Dunn discussed Contra Costa County's need for additional mental health funding. Their Mental Health Commission decided they do not want to pursue a JBCT and instead want to develop a full spectrum of care for the 50-75 people who need it.
- Mark Gale agreed with Katherine Warburton that the only people who should be in hospitals rather than diversion are those that pose a risk to public safety. He said

Board and Cares are not a high enough level of service for this population. He advocated for Enriched Residential Service (ERS) facilities which are outpatient programs with 24/7 staff. They are higher level than Board and Cares but lower than IMDs. He added that ultimately funding for beds, housing, and community resources is needed to move forward with any expansion of diversion options. He called for the creation of a timeline that lines up hospital discharge with appropriate placements.

Meeting Wrap Up and Next Steps

Karen Linkins reminded the group that they are subject to the Bagley-Keene Act, which necessitates that conversations on this topic are public. She asked that large conversations not take place outside of the meetings, but it is ok to touch base with others about solutions.

The next meeting for this work group will be October 1st from 9-11am and the one after that will be October 26th from 1-3pm, which will focus on housing and other longer term solutions. Karen Linkins encouraged the group to email with any questions, information, or ideas. She reminded attendees of the homework assignment and that the minutes and agenda will be posted on the website.

Appendix 1: Chat Transcript

From Stephanie Welch, CHHS to Hosts and panelists:
Jessica Cruz has a family emergency and in her place Steven Kite is joining from NAMI-CA if someone can add him in as a panelist

From John Freeman to Everyone:
Good morning! John Freeman, with Desert Vista Consulting

From Tara Ames to Everyone:
Tara Ames, Project Coordinator for Siskiyou County Behavioral Health

From Lindsay Schachinger to Hosts and panelists:
Lindsay Schachinger

From David Evans to Everyone:
Good morning - David Evans from Sonoma County

From Teresa Pemberton to Everyone:
Teresa Pemberton, San Luis Obispo Behavioral Health

From Emilou MacLean to Everyone:
Good morning. Emi MacLean from ACLU of Northern California

From James Russell to Everyone:
James Russell, Santa Cruz County Behavioral Health Program Manager

From Lindsay Schachinger to Hosts and panelists:
Contra Cost County — parent

From Melissa Noone to Hosts and panelists:
Melissa Noone, Riverside County

From Michelle Cabrera to Everyone:
Michelle Cabrera, County Behavioral Health Directors Association (CBHDA)

From Diane Lucas to Everyone:
Diane Lucas, MHC CONREP Placer County ASOC

From Stephanie Regular to Everyone:
Gilda Valeros has been unable enter the meeting with her link.

From Kim Pederson to Everyone:
Kim Pederson, Disability Rights California (also a member of working group #1)

From Kim Hoang to Everyone:

Good morning! Kim Loan Hoang from Santa Clara County Behavioral Health

From Catherine York to Everyone:
Catherine York, Sacramento County Criminal Justice Cabinet

From Stephanie Costa to Hosts and panelists:
Stephanie Costa, Recovery Specialist with Kern Behavioral Health and Recovery Services

From Stephanie Regular to Everyone:
Stephanie Regular, California Public Defender Association

From Blake Hickman to Everyone:
Good morning. Blake Hickman, County of Humboldt

From Douglas Dunn to Everyone:
Good morning: Douglas Dunn, Mental Health Commissioner--Contra Costa County and parent of a loved one who has been IST in another state.

From Brian Bloom to Hosts and panelists:
Good morning, I'm Brian Bloom, recently retired 30-year public defender from Alameda County and current member of the county's Mental Health Advisory Committee.

From Lindsay Schachinger to Hosts and panelists:
Lindsay Schachinger - NAMI and parent - Contra Costa County

From Ronnie Potts to Everyone:
Hi everyone I'm Ronnie Potts from Contra Costa County Forensic Mental Health

From sarah gordon to Everyone:
Sarah Gordon, San Diego County, Public Safety Group

From Rosie Rios to Everyone:
Rosie Rios, Holistic Defense Advocate, Santa Barbara Public Defender's Office

From Sheri Akins to Everyone:
Good MORning

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

From Sheri Akins to Everyone:
Sheri Akins, LMFT from Kern County

From Lisa Pedlar to Everyone:
Lisa Pedlar, analyst with the DSH, FSD, Diversion Project

From Robin Daniels-Wilson, Santa Clara County BHSD to Everyone:
Robin Daniels-Wilson, Santa Clara County Behavioral Health Services Department

From Earliana Vang to Everyone:
Earliana Vang, Fresno County Department of Behavioral Health

From Chandra Campbell to Everyone:
Chandra Campbell, Stanislaus County Behavioral Health and Recovery Services

From Stephanie Regular to Everyone:
Ms. Valeros has still not received a working link. Please resend.

From Katie Herman to Hosts and panelists:
Katie Herman, Senior Policy Analyst at the CSG Justice Center

From John Freeman to Everyone:
I have resent the link to Ms. Valeros.

From John Freeman to Everyone:
We have now disabled the chat for participants and will re-enable it during Q&A.

From Manley to Sheri Akins and all panelists:
Why is there no ongoing training regarding IMO's for custody health in our County jails. They are not experienced in how to successfully carry out these orders.

From Brian Bloom to Hosts and panelists:
Two thoughts re solutions:

From Diane Lucas to Everyone:
CA needs the ability to do a civil commitment for people who need involuntary medication, similar to what Wisconsin uses (Chapter 51). This can be used without removing a person's rights (conservatorship) and can be utilized before the person is ending up in custody.

From Tara Ames to Everyone:
We have the same issue with housing and forced medications in Siskiyou. It affects diversion and AOT

From John Freeman to Everyone:
An attendee has also asked "What is the thinking behind excluding diversion participants who previously received DSH services from DSH diversion funding?"

From Michelle Cabrera to Everyone:

One thing that jumped out to me in reviewing the DSH vignettes was the types of charges imposed on the individuals who committed crimes while in the midst of a psychotic episode. For example, the scenario about the person who cleaned the bathroom at the sandwich shop, but was then charged with kidnapping. We understand that there are significant differences from county to county in the willingness of our law enforcement and DA partners to do "diversion" before diversion in these sorts of cases.

From Douglas Dunn to Everyone:

When will funding be available at the county level for a full spectrum diversion program?

From Manley to Sheri Akins and all panelists:

The IMO's should follow the defendant from the jail to the community provider and this needs to be clarified because the issue often is that the defendant can quickly decompensate once in the community, and that results in a return to jail.

From Brian Bloom to Hosts and panelists:

1. If you're charged with a crime(s) for which you cannot go to prison (so-called 1170(h) felonies), it makes little sense to spend resources to restore to competency. One way to reduce the waiting list is to tweak PC 1367 so that competency restoration only happens if your charged with a "prison" felony. People charged with non-prison felonies would fall under the purview of PC 1367, as amended by pending bill SB 317. Or a step further would be to only allow competency restoration for defendants charged with serious (PC 1192.7) or violent (PC 667.5(c)) felonies.

From Mark Gale to Everyone:

Dr. Hobson is 100% correct. We cannot pretend that by declaring diversion is the means to a remedy without solid state funding of community resources.

From Mark Gale to Everyone:

And why can't we use AOT for diversion treatment programming. It doesn't solve the IMO problem, but it will help many

From Douglas Dunn to Everyone:

AOT diversion treatment would depend on contracted staff training (FACT as well as ACT). Housing is also a huge issue. Also, careful step down from AOT is another big issue.

From Sheri Akins to Everyone:

I totally agree with regard to the charges. Our team is noticing that without the complete record it is very difficult to decide if the charge is too severe.

From Brian Bloom to Hosts and panelists:

I don't think that getting folks psychiatrically stable should be such an obstacle. Aren't folks who meet diversion criteria and also who cannot consent to treatment (due to the severity of their illness) by definition gravely disabled? Why can't these folks be

5150'd/5250'd and when appropriate, put on a conservatorship? California has the legislative scheme to involuntarily treat folks suffering from schizophrenic related illnesses. Wouldn't using the civil commitment system for this population help to solve the obstacles to diversion that were noted on the slide?

From Douglas Dunn to Everyone:

There is a DHCS funding listening session being held concurrently on Zoom with this meeting.

From Michelle Cabrera to Everyone:

Completely agree with CPO Keene, we need different strategies to align housing resource for this crisis/priority population.

From Tyler Rinde to Hosts and panelists:

Agree with Chief Keene. Measuring recidivism through arrest data is problematic as many individuals are not charged, convicted and are released within several days of booking. Would recommend looking into felony conviction data and the recidivism rates of folks that return to DSH for restoration.

From Mark Gale to Everyone:

Some JBCT's are not utilizing IMO's. This means people are being diverted but not getting medicated. Should be changed

From Douglas Dunn to Everyone:

In addition to Dr. Welch's comments, family members have to navigate the entire spectrum of care or the lack thereof on behalf of their severely mentally ill loved ones. This is extremely daunting.

From Douglas Dunn to Everyone:

This includes both civil and criminal justice "systems of care."

From Teresa Pemberton to Everyone:

A ongoing barrier with us has been due to lack of knowledge on the legal ability to divert someone who has been deemed IST. Educating our Judges was the one thing that helped open the pathway. What can be done now is education for Judges AND attorneys on the legal process once IST established.

From Manley to Sheri Akins and all panelists:

In my experience, 80% of those diverted have a co-occurring substance use disorder. What data do we have as to how many counties have the capability to provide this needed treatment?

From Kim Pederson to Everyone:

I think that DA Louis is asking about what can be done when hospitals refuse to admit people brought in on 5150s.

From Michelle Cabrera to Everyone:

Want to appreciate some of these comments from our DA Association colleague. CBHDA asked to expand diagnoses for diversion pilots and we're happy to see those moving forward. Our Bay Area region counties are doing better in not having such high increases in rates of IST referrals, and it is likely due to these partnerships. We have found that in other counties we face barriers with some courts/DAs not willing to play on diversion. There's a lot of variation across the state.

From Lindsay Schachinger to Hosts and panelists:

Don't people who are incarcerated lose their Medi-Cal and have to be reenrolled, which takes weeks? If so, how can we have a continuum of care?

From Steven Kite - NAMI He/Him to Everyone:

Families are a real key to helping keep continuity in a lot of these areas. NAMI stands ready to help at all levels to make sure individuals and their family members aren't lost in each part of the circle of recidivism to be source of interruption to that cycle. We've appreciated a lot of the efforts to bring families in as a part of the conversation and we look forward to continuing and expanding that partnership as we tackle this together.

From Neil Gowensmith to Hosts and panelists:

In response to Gilda's comment about alienist evaluators including opinions about diversion in their reports — several states do indeed do this, and it is a successful approach.

From Sheri Akins to Everyone:

In Kern County we have a Family Advocate within our PRA team. This individual can be very helpful in educating and supporting our Families and support people for our individuals served.

From Douglas Dunn to Everyone:

Anita Fisher gets it!!!!

From Douglas Dunn to Everyone:

Anita gets the full spectrum of care challenges from a family member perspective.

From John Keene- CPO San Mateo County to Hosts and panelists:

Well said Ms. Fisher!!!

From John Keene- CPO San Mateo County to Hosts and panelists:

Hello Everyone. Unfortunately I need to jump over to another meeting. I look forward to continuing the conversation.

From Douglas Dunn to Everyone:

Have a public comment.

From Chris Edens to Hosts and panelists:

@LD Louis. We can revisit the unsecured residential housing utilized by the Los Angeles Community Based Restoration and Diversion programs that were presented to the IST Solutions Workgroup on August 30. This would be a great model to look to as an alternative to board and cares.

From Chris Edens to Hosts and panelists:

Correction - presented on August 31.

From Michelle Cabrera to Everyone:

We have heard from some of our counties that there is at times a reluctance on the part of our Public Defenders to agree to participation in diversion where the PD believes that their client could benefit from the treatment provided at the state hospital, and they are concerned that their client will lose their place in line for DSH. We have been promoting the idea that we need to look at DSH more as a level of care determination, and believe that we should be encouraging diversion. One suggestion is: could we incentivize diversion by guaranteeing a person's spot in line (at a minimum) in case they're not successful in diversion?

From Douglas Dunn to Everyone:

Per Mark Gale and myself, significant funding is the key.

From John Freeman to Everyone:

Email: ISTSolutionsWorkgroup@dsh.ca.gov

From Jennifer Garcia to Hosts and panelists:

can you please repeat the email address?

From Jennifer Garcia to Hosts and panelists:

got it. thx