



CBHDA and CSAC IST Working Group #2 Diversion and Community-Based Restoration for Felony ISTs Recommendations

The Department of State Hospitals (DSH) has identified through a survey of counties barriers preventing additional diversion, community-based restoration, and treatment of individuals deemed incompetent to stand trial (IST) on felony charges. This list includes lack of stabilization of IST patients, inability to involuntarily medicate participants, appropriate housing and available, and disagreement among court and county partners of who is suitable for diversion.

While the County Behavioral Health Directors Association (CBHDA) and California State Association of Counties (CSAC) agrees that these are challenges, we would note that county behavioral health does not make the decision regarding who is placed on diversion or not, and so has very little control over the extent to which individuals are appropriately routed to diversion or community-based restoration, even when their clinical and public safety risk factors indicate they may be a strong candidate for these community-based alternatives. Such decisions are at the discretion of the justice partners including the community program director, court, district attorney, and public defender. Any adopted recommendations must consider that these are decisions that are in the hands of multiple actors with individual considerations and independent decision-making authority. Much of what CBHDA recommends here is drawn from the elements of the Los Angeles Office of Diversion and Reentry (LA-ODR), which could be scaled in other jurisdictions with sufficient resources. CBHDA will submit recommendations for short, medium, and long-term solutions and this set of recommendations focuses only on those recommendations that can be initiated or implemented in the short-term timeframe as per the request of the working group. If you have any questions, feel free to reach out to Michelle Cabrera (mcabrera@cbhda.org) or Farrah McDaid Ting (fmcting@counties.org). CBHDA and CSAC proposes:

Proposed Short-Term Solutions:

- **Immediately Partner with County Behavioral Health to Jointly Triage the Existing DSH Waitlist.** CBHDA and CSAC recommend DSH partner with county behavioral health, and Conditional Release Program (CONREP) contractors in applicable counties to do joint triage and assessments of the existing waitlist to determine who can be served in the community through CONREP, existing diversion programs, or community-based restoration to maximize the efficiency of existing programs. This means treatment and clinical decision making being used to lead to the most appropriate placement of individuals on the waitlist where their needs are best met while still accounting for public safety.

This would require DSH and CONREP to provide county behavioral health with additional information on individuals on the existing felony IST waitlist, including diagnosis, symptoms, charges (including arson and Penal Code (PC) 290 registrant), co-occurring SUD needs, housing status, Medi-Cal enrollment, and more to make appropriate placement decisions for individuals that may be placed in the county.

- **Include Funding in Diversion Contracts for Housing.** One of the main challenges identified by county behavioral health in operating successful diversion pilots is the lack of identified housing for diversion participants. While DSH's funding is flexible and can be used for housing,

the current rates are insufficient to fund the engagement and treatment needs of this population, along with expanded housing options for this population. CBHDA and CSAC recommend expanding the existing DSH contracts to be utilized for rental subsidies and housing-related costs. Alternatively, the state could consider housing set asides of existing housing investments to prioritize the needs of county behavioral health clients who are at risk of justice involvement or engaged in diversion or community-based restoration.

- **Provide flexibilities, and expedited licensing to stand up access to inpatient beds and housing which is critical in LA-ODR model.** Critical to the success of diversion and community-based restoration efforts championed by LA-ODR is the ability to access needed housing and inpatient beds. Not all counties have the same access to land, or availability to site and source affordable housing options and inpatient beds for clients. In fact, in the midst of a shortage of inpatient beds willing to accept Medi-Cal beneficiaries, counties are often faced with providers who opt not to accept individuals with forensic needs, of any kind. These challenges are felt especially with the need to stabilize clients before placement into a community-based unlocked residential setting. As such, CBHDA believes it will be necessary to build new capacity to serve this population outside of DSH and jail settings.

In the short-term we recommend the state partner with counties to plan and develop needed infrastructure and associated flexibilities in order to replicate the positive work that LA-ODR is doing including CEQA exemptions, expedited licensing of Psychiatric Health Facilities (PHFs) and Mental Health Rehabilitation Centers (MHRCs), including operating costs. In the medium-term, we hope that the state's investment in the behavioral health infrastructure continuum will complement the momentum of the short-term efforts above.

- **Support Diversion by Aligning Statute to Facilitate Additional Diversion in Appropriate Clinical Settings.** CBHDA and CSAC recommend reforming PC 1001.36 to reform the definition of “unreasonable risk to public safety” to “clear and present risk to public safety” and to allow the judge to offer and authorize diversion over the objection of the prosecuting attorney similar to PC 1001.95. We believe that existing risk assessment tools and practices overvalue the public safety risk of defendants with mental illness and that, in order to achieve the goal of breaking the cycle of incarceration, California law must be aligned with our policy goals to facilitate diversion for a broader number of individuals with behavioral health treatment needs that can be appropriately addressed outside of carceral settings. For example, some court and probation department protocols artificially raise the risk of a defendant from low to high if they have a mental illness and only look at static risk indicators (e.g., number of priors) which miss important contextual factors such as employment, housing, social relationships, existing links to community treatment, etc. Risk assessments may also have an unintended racial/ethnic bias as individuals targeted by law enforcement skew Black and Latino. By weighting prior offenses, these groups are less likely to be approved for a diversion program which reinforces those biases.

We believe through these changes that clinical decision-making can be at the forefront and more appropriately allow the diversion of individuals with behavioral health conditions out of the justice system.

Proposed Long-Term Solutions:

- **Reform State Law to Prioritize Clinical Level of Care Placement Determinations for Felony ISTs.** CBHDA and CSAC strongly believe that decisions to place individuals in the

community, Jail-Based Competency Treatment Program (JBCT), or state hospital should be more uniformly made based on a streamlined and standardized set of policies and protocols that place the most acute/high-risk individuals at the State Hospital, and which quickly assesses and places those with less severe behavioral health or criminogenic needs into diversion and community restoration. The workgroup should consider which cohort is most appropriate for JBCT. For example, placement in a JBCT should also be based on level of care determinations, and a failure to restore an individual in JBCT should not be reason to determine an individual as non-restorable, given the possible lack of access to IMO's in jail or community-based settings. This includes improved coordination and communication across programs that serve felony ISTs so that individuals can shift up or down levels of care based upon an evolving clinical presentation.

Clinical placement may include a locked treatment facility including the use of acute hospitalization, mental health rehabilitation center, or IMD based upon the individual's needs and the mandate to ensure placement in the least restrictive setting possible.