Working Group 1. Early Access to Treatment and Stabilization for Individuals Found IST on Felony Charges

•**Goal:** 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 stay

Time-frame	Problem being addressed	Strategy	Type	Impact on waitlist of 1,700+ individuals	Outcome / Measure(s)	Funding Required	Statutory Changes Needed
Short		[CSAC/CBHDA] State Funded Technical Assistance to expand use of IMOs, when appropriate, in jail settings.	TA				
Short		[Devecchio] TA on IMOs	TA				
Short		[Raven] Educational campaign for IMOs for county and sheriff	TA				
Short		[Salzillo] TA and tools for courts and court officers to support making referrals	TA				
Short		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	TA				
Med.		DSH IMO Quality Improvement Project (IMO-QIP). An IMO Statewide Survey could be conducted to better understand if and how IMOs are being established and implemented in each county.	Infra				
Short	The concept of court-ordered Involuntary Medication Orders (IMOs) is not well-understood by justice system partners, and the actual language in the orders might be too prescriptive and inadvertently adding to the confusion. There is a lack of understanding and knowledge about IMOs, including how to administer of medications.	Immediate IMO training/TA for justice system partners (courts/court officers, Sheriff's (jail staff) - still recommend a survey to understand current understanding/practices otherwise risk delays if solutions do not address the *actual* problems; the CSG Justice Center just conducted a similar survey for the CCJBH Diversion Project, which took about 3 months to develop and administer, and the results are being used to develop TA that will be implemented this fiscal year.	TA	Getting individuals stabilized on medications ASAP would allow for them to be expeditiously moved into diversion programs or to be restored and proceed through the court process.	DSH Waitlist Numbers (would anticipate a decrease after TA provided) Could also track IMOs (# established by court and, of those, # implemented in jails). This would be good information to have in case FIST numbers remain the same or increase, thus indicating a different problem than IMOs.	$150,000 Training/TA Contract Costs modeled after CCJBH Diversion Training/TA Contract	None Known
Med.	The concept of court-ordered Involuntary Medication Orders (IMOs) is not well-understood by justice system partners, and the actual language in the orders might be too prescriptive and inadvertently adding to the confusion. There is a lack of understanding and knowledge about IMOs, including how to administer of medications.	EBP Compendium and Toolkit / Quality Improvement	Infra	Maintain low numbers (outcomes) from the initial Training/TA)	DSH Waitlist Numbers (monitor to ensure they remain low)	$420,000 Compendium/Toolkit $150,000 Continued Training/TA for Quality Improvement Costs Modeled after CCJBH SB 823 EBP Compendium and Toolkit and CCJBH Diversion Training/TA Contract	None Known
Short	Many counties, particularly those without access to JBCTs or alienists who can prescribe medication, may struggle with getting medication and treatment determinations for people either found IST or people for whom doubt has been declared are awaiting an IST evaluation.	[Adams] Use of technology/telehealth for IMO and/or other medication/treatment determinations.	Treat		Potential metrics to track: number of facilities in which telehealth technology is used for this purpose; number of telehealth consults (duplicated and unduplicated clients); number of clients served; number of clinicians (alienists or non-alienists) providing telehealth consults; number of resulting IMOs or other medication/treatment determinations.		
Short		[CSAC/CBHDA] Expand the use Long-Acting Injectables in Jail Settings.	Treat		• Adoption of LAIs as part of the jail-based treatment formulary • Updates to P&Ps to encourage the use of LAIs for mental health and substance use disorder conditions when appropriate, including for any patient with psychosis.		
Med.		Increasing the number of county-based restoration programs beyond the 22 that currently exist	CBR				
Med.		Conversation about people's risk to public safety based on something statutory -- 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.	CBR				
Med.		[CSAC/CBHDA] Prioritize community-based restoration and diversion by: 1) Allowing an individual deemed IST with felony charges who is awaiting treatment with DSH to retain their place on the waitlist; and, 2) Improving communication between DSH and local courts so that a person is not removed from diversion prematurely if a bed is available at DSH.	Infra				
Med.		DSH IMO Quality Improvement Project (IMO-QIP). An IMO Statewide Survey could be conducted to better understand if and how IMOs are being established and implemented in each county. This project broken up into two parts (see above).	Infra				
Med.		[Mulkerin] funding "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)	Infra				

Med.		[Barnes] Support for Sheriff subcontracting to other facilities	Infra				
Med.	potential delays in producing the evaluation report due to outside fact-finding, such as time delays in receiving police reports	[Adams] Set time frames for appointments, receipt of reports, etc. Leveraging the suggestion made by Judge Manley and noting comment by Dr. Scott, set time frames may help reduce the amount of time people wait in jail and remain unmedicated/ decompensating as reports are returned to court.	Intake		amount of time people wait in jail and remain unmedicated/decompensating as reports are returned to court.		
Med.		System that would connect (non MD) competency evaluators to clinicians who can write medication orders to expedite treatment	Intake				
Med.		[Manley] Every defendant should receive a mental health as well as a co-occurring substance abuse screen at the time of booking and those screened as mentally ill should be assessed immediately to determine a course of treatment that may begin in the jail, including medications, and discharge planning should start at the time of booking.	Intake				
Med.		[Manley] An experienced District Attorney and Public Defender with authority should be assigned to be present each day to review the cases of each defendant screened as mentally ill at booking to eliminate those cases that will not be filed (defendant to be released), or for those defendants in situations where a complaint is likely to be filed, review as to conditions for release pre-trial into treatment and services for a recommendation to the Judge at or before the time of arraignment. The attorneys would work with a team from Behavioral Health in formulating recommendations.	Intake				
Med.	Individuals kept in jail when decision has already been made about not filing charges.	MH assessment and review of record and BH history. DAs and Public Defenders at jail after arrest to determine next steps -- if steps are taken before court is even involved with ultimate goal of putting less people in jail.	Intake				
Med.		[Pederson] Provide counties with funding to hire peer specialists to support the treatment engagement of county jail inmates with mental illness.	Treat			Forensic Peer Support Specialists (or General Peer Support Specialists) - Recommend 1:8 peer-to-client ratio (based off of LA County MHSA Innovation Plan), $20/hour (based on high-need population and average peer salaries); $200-500 training/certification depending on training agency used. Could prioritize counties with highest FIST numbers. (also in Workgroup 2 CCJBH response).	
Med.		[Devecchio] Direct DSH psychiatrist service for these pts	Treat				
Med.		Requirements and incentives/enhanced rate for contracted providers to serve specific clients	Treat				
Med.		[Manley] Pay for success to support client engagement	Treat				
Med.		Forensic Peer Specialists	Treat			See above.	
Med.		[CSAC/CBHDA] Improved Discharge Planning from State Hospitals	Discharge				
Med.		[Devecchio] ECM and in reach and pre-release application mgmt. (std across counties) linked to CalAIM, can coordinate services prior to and at release with linkage to county BH	Discharge		Recidivism pre/post. % in community based tx. Budget under development.		
Med.		[Regular] Expand diversion funding to follow hospitalization, reducing length of stay, leveraging client incentive to participate	Discharge				
Med.		[Regular] IMO to follow discharge	Discharge				
Med.		[Raven] DSH housing grant pool for community diversion/release	Discharge				
Med.		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	Discharge				
Med.		CalAIM Enhanced Care Management is designed to do some outreach in jails (~70% of people are out of jails in 3-5 days from when they are booked)	Discharge				
Long		Regional community based treatment to meet needs of specialized population who are not tied to any one county	CBR				
Long		[Manley – longer term] Create a triage center (can be called a sobering station -- ILOS) for 23 hours of stabilization as an alternative to booking into jail, appropriately staffed by Behavioral Health to further assess the defendant and place the defendant in a community treatment program	Infra				
Long		[Grealish] Triage center with FQHC in partnership with law enforcement	Infra				